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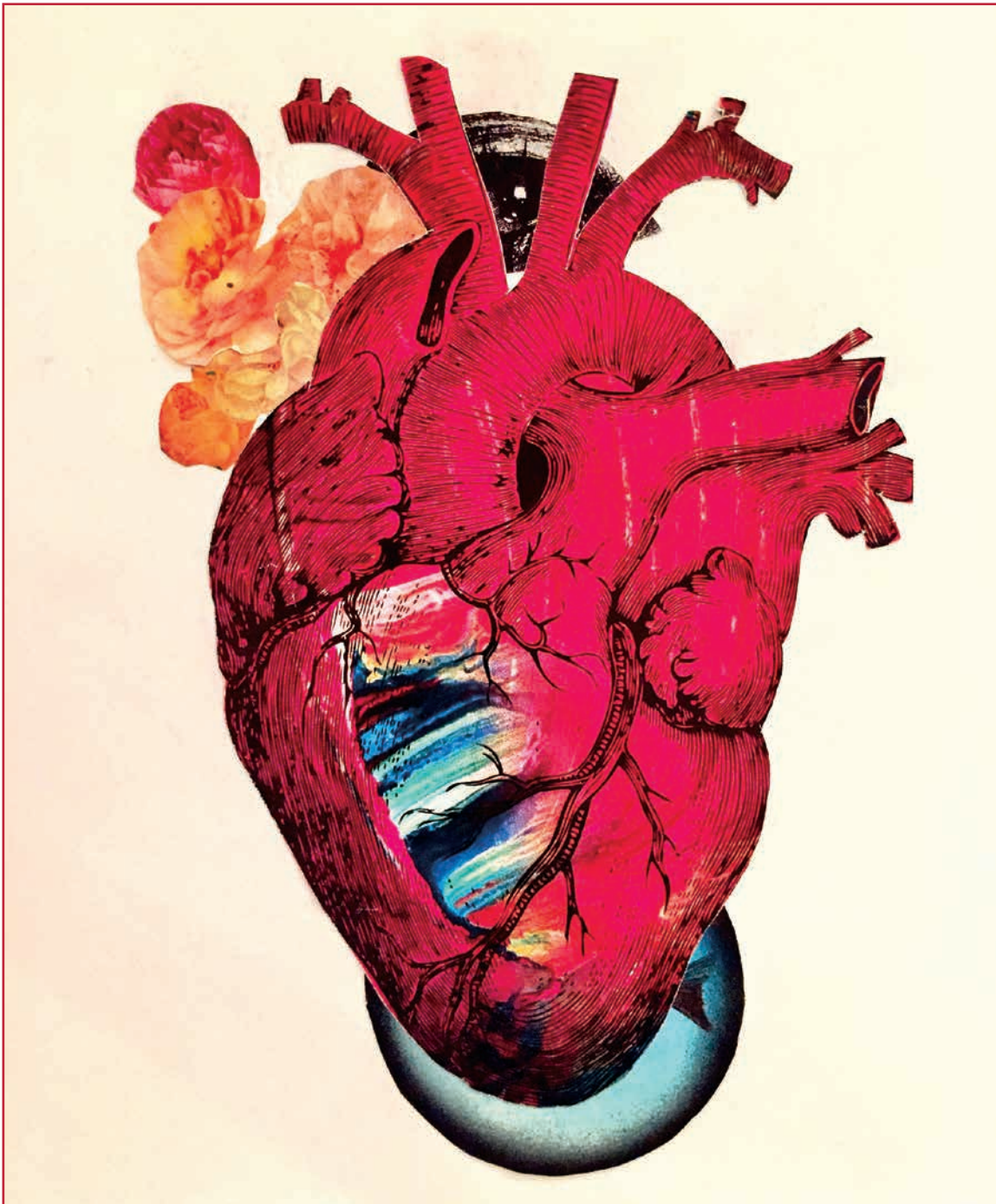
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The Journal of Clinical Art Therapy is dedicated to the scholarly and clinical exploration of art psychotherapy within a systemic framework. The philosophy that guides this journal asserts that the systematic exploration of the systemic and cultural dimensions of art psychotherapy enhances the meaning and usefulness of this work.

SCOPE:

The journal accepts articles that are theoretical, research based, or clinically based inquiries of art therapy. Systematic works that explore new clinical interventions, specific populations, cultural considerations, and art therapists' creative explorations which expand art therapy practices are particularly encouraged.

We invite you to submit a full length article describing original research or discussing theory and practice in clinical art therapy. We welcome scholarly or systematic exploration of clinical topics that contribute to art therapists' professional development and the expansion of our field's body of knowledge. Submissions, which must be less than 5,500 words and adhere to APA format, will follow a blind review selection process. More details for the submission requirements are provided under the "Policies" link at <http://digitalcommons.lmu.edu/jcat/>.

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About the Cover Art: "Heart" by Jillien Kahn.

Jillien is an art therapist and sex therapist in New York. This collage, like much of her work, represents many aspects of our culture's complex relationship with sex and sexuality. Hearts offer a representation of intimacy and passion, both symbolically and literally, first by symbolizing intimacy and connectedness, then literally by creating the increased blood flow and body heat indicative of sexual response. The heart rests in water, showing the depth and fluidity of sexuality at every level. The eye peeking through represents our cultural experience of sexuality, hidden, unsure, but insatiably curious, while flowers represent the beauty and fragility of sexual experience.

Exploring Ranges, Tensions, and Potential Integrations: Editorial Notes

This third edition of the *Journal of Clinical Art Therapy* (JCAT) celebrates the vitality of art therapy as a modality and showcases magnificent breadth of art therapy inquiries. The first paper, written by Bat Or and Megides (2016) is in many ways a traditional art therapy inquiry. The paper explores the use of art making with found objects (readymade, a term coming from the fine arts) through case illustrations in thoughtful, psychoanalytic frame (Bat Or & Megides, 2016), and does so with a deep appreciation for the possibilities of artistic and clinical discovery. Second, through in-depth interviews of art therapists and a sex therapist, Jillien Kahn (2016) discusses the possibilities and challenges of integrating both disciplines. She is also the artist of this edition's cover page, depicting a heart, which represents the integration of love, intimacy, and life. Third, Rafferty and Parcell (2016) explore the verbal conversations that occur during art therapy treatment for pediatric chronic clients and their families. As researchers coming from family communication studies, they apply relational dialectic theory (RDT), inviting us to expand what we pay attention to and how (Rafferty & Parcell, 2016). They explore art therapy by moving beyond the art process and product, and systematically investigating the conversations around those engagements. Finally, Kaimal, Rattigan, Miller, and Haddy (2016) provide an overview of national trends in visual art-making and art sharing using digital media, based on the 2012 Survey of Public Participation in the Arts administered by the National Endowment for the Arts. Their methodology serves to remind us that as a field we can learn not only from our own inherent tools (as in the first paper) or tools developed by related fields (as in the third paper), but by building upon relevant findings from related fields (e.g., National Endowment for the Arts, 2013). This fourth paper by Kaimal et al. (2016) also connects the beginning considerations about the digital age and media use in art therapy (e.g., Asawa, 2009; Belkofer & McNutt, 2011; Choe, 2014; Peterson, 2010; Potash, 2011) and linking those to the findings from a large and well stratified survey.

The authors of this edition of JCAT are a diverse group: affiliated with different art therapy programs in the United States and internationally, or researchers whose discipline (RDT) provided tools to explore our work as art therapists from a different perspective. The foci of the research – exploring the uses of readymade in art therapy, integrating treatment of sexual issues into art therapy, working with chronically ill children, and paying attention to digital media trends around art making and art sharing – all expand our current body of art therapy knowledge in profound ways.

Beyond being expansive, relevant, and unique contributions to our field, the four papers raise important epistemological

questions. For example, the Bat Or and Megides' (2016) paper invites us as art therapists to consider the potential of a more solid integration of aesthetic, symbolic, and expressive engagement grounded in the art world's approach with our responses to traditional clinical foci such as treatment of trauma. It challenges us to integrate more actively psychodynamic frames with art making in its fullness, transcending the use of art in therapy as image making to ground verbal communication.

Considering the richness of what art can offer, and recognizing that is not always possible, I wonder how we strike that balance with our own clients. What stands in our way of offering the richest creative experience? Do we see ourselves as much as artists as we see ourselves as clinicians? Do we let go of the centrality of the art due to the setting in which we work or due to therapeutic standards of treatment or clinicification of our profession which sway us to see art as one modality, one type of intervention of many to choose from?

Jillien Kahn's (2016) paper raises similar questions about why sexual issues are not addressed more regularly or fully in art therapy. She considers possible hesitations for integrating art making in exploring sexuality, and interestingly some hesitations seem to come from the therapists while others from clients' expectations. This raises questions about how as a profession we prepare to address issues that are commonly not talked about, often emotionally charged (shame, guilt), and where societal, political, and religious pressure are major players. In some ways, these would be all the reasons to see art therapy as the modality of choice, or at least one of the most commonly used therapeutic interventions, no? However, that is far from the case. Do we, as art therapists, feel ill prepared to intervene with sexual issues? Are our own sensitivities and hesitations around sexuality holding us back? How can we, as Kahn is offering here, integrate what we do know and provide, as art therapists, with knowledge and interventions from fields such as sex therapy?

Which professional bridges need to be fortified in building effective interventions is a question that is also raised differently in Rafferty and Parcell (2016). The illustration of art therapy in a pediatric setting raises inherent systemic considerations of what is necessary to work within a medical setting, and how art making and its products can best facilitate post-traumatic growth (Beebe, Gelfand, & Bender, 2010; Parisian, 2015). The findings of this paper illustrate how art-making can serve as a way for families to tell stories *through* art, tell stories *about* art, and tell stories *while engaged in* art-making (Harter, Quinlan, & Ruhl, 2013). Finally, Rafferty and Parcell's (2016) research confronts us with profound existential questions regarding our roles as art therapists, represented here as the three tensions which emerged from the find-

ings: understanding the impossible tension between wanting to maintain normalcy and proportional responses (keeping an eye on one's life outside the hospital) while also attending to the severity and pull of managing emergency here and now (being in the hospital); needing, yet struggling, with both certainty and uncertainty in life; and striving for privacy and protection while also seeking expression and connection to others.

In other words, Rafferty and Parcell's (2016) paper challenges us to think about how we are exploring those in therapy, and how we increase our expertise of attending to the conversations that take place around the creative fireplace we provide. Do we need to learn more from disciplines such as communications about ways that people converse, moving away again from clinical models' dialogue charts? How do we responsibly facilitate, beyond the art making and individual responses to the art, the meaning making through verbal exchange? A big take away from this paper might be a reminder that being an art therapist includes being a verbal therapist, considering how we use language switching (Morrell, 2011) as we consciously shift our attention between art based and verbal communication, threading those as places of connection and meaning making.

Finally, how might we as art therapists keep up with current uses of art? How much are we holding on to how we were trained, and what uses of art making are comfortable for us? Are we truly considering a plethora of creative mediums in our practice? Where does awareness to cultural and generational biases support us in challenging our clients effectively, and where could we be more attuned? When is awareness not effective enough? These questions and others related to prominent art therapy theories of media use, for example, the expressive therapies continuum (ETC) model (Lusebrink, 2010) might need to come to the forefront of our field in lieu of Kaimal et al.'s (2016) paper. May this edition continue to challenge us to expand our collaborations with other fields and to challenge ourselves as clinicians to systematically explore our work through looking at case illustration, interviewing experts, paying attention to conversations, and being informed by relevant large surveys.

If the reader of this journal were to take a couple of things with her, may it be the methodological range of engaging in solid art therapy research, the worthy topics and populations which art therapy can serve to promote, and how compelling every story, case, or cause is when art brings voice to it.

Einat Metzl, Editor

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Found Object/Readymade Art in the Treatment of Trauma and Loss

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Found object/readymade art is a familiar expressive medium in art therapy that has been insufficiently explored. The present article theoretically and clinically examines found object/readymade art as a progressive therapeutic intervention in the treatment of trauma and loss. It aims to show how creating found object/readymade art enables the client to encounter and contain damaged/disconnected memories and provides a space for integrating and meaning-making in the face of rupture and loss. This is discussed through a review of found object/readymade art medium in the history of art and in art therapy and by phenomenological observation of its creating process. Specific links to the treatment of trauma and loss are incorporated, as well as the therapist's role. Clinical vignettes and examples from found object/readymade art workshops illustrate these therapeutic qualities through art therapy, psychoanalytic, and neuroscience lenses.

Keywords: found object, readymade art, trauma, loss

PSYCHOTHERAPY INTERVENTIONS WITH TRAUMA AND LOSS

Both trauma and loss are stressful life events that confront individuals with a force stronger than their ability to resist. They usually elicit distress and painful emotions, challenging coping strategies and sense of wellbeing. They are associated with the breaking of continuity and/or the sense of being whole, and challenge the individual to contain the event and its implications. The need to integrate memories and mental representations is one of the cornerstones of the healing process in both experiences. In order to transform their suffering, individuals may need a space in which they can be involved in a process of re-establishing psychological wellbeing through recognition of the event's impacts, mourning process, and meaning-making, which would also illuminate the individual's strengths, creativity, and vitality. We will first elaborate on the similarities and differences of trauma and loss.

Psychological Trauma

Psychological trauma is one of the most important public health challenges in the world (Bessel & van der Kolk, 2003) and has been acknowledged as having a pervasive role in mental

disorders (Ross, 2015). Even though the *Diagnostic and Statistical Manual of Mental Disorders-V* limits traumatic events to "exposure to actual or threatened death, serious injury, or sexual violence," many events may be traumatic even if life threat or injury is absent (Anders, Frazier, & Frankfurt, 2011). We will thus use the classic definition of psychic trauma, which specifies that the ego has been overwhelmed by stimuli in a dangerous situation and produces lasting psychological symptoms (Blum, 2004). However, it is important to keep in mind that we tend to view trauma from our own cultural perspective even though cultures and religions may differ in how traumatic events are interpreted and impact on individuals' meaning-making of such events (Levy, Slade, & Ranasinghe, 2009).

Psychological trauma results in feelings of intense fear, helplessness, and loss of control (Renn, 2012). These feelings overwhelm adaptations and undermine sense of self-agency, emotional connection, and meanings (Herman, 1992). Traumatized individuals who develop posttraumatic stress disorder (PTSD) are characterized by three clusters of response: intrusion – in which the traumatic event continues to preoccupy them; avoidance – whereby they try to distance themselves from anything that might trigger memories and feelings associated with the trauma; and hyper-alertness – which is a general elevation of tension and vigilance.

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In PTSD, a traumatic event is not remembered and registered as a past event in the same way as other life events are. Trauma continues to intrude on individuals through visual, auditory, and/or other somatic reality, in which the traumatic experience is relived as though the event is still occurring (Rothschild, 2000). Dissociative responses as a defense mechanism display an absence or avoidance of recall and contribute to fragmentation of memories (Vasterling & Brewin, 2005). Memories of the traumatic event are stored primarily as implicit, behavioral, and somatic, with no linking narrative (van der Kolk, 1994). Trauma is thus a psychophysical experience (Rothschild, 2000) with relatively weak verbal representations and poor mental integration.

A central characteristic in psychic trauma is the fragmentation of the self through dissociative coping strategies, resulting in fragments of memories that are split off from conscious awareness (Ogden & Fisher, 2015). Hence, fragmentation of experience may be related to fragmentation of personality (Renn, 2012).

Based on accumulated neuroscience knowledge of trauma that demonstrates that traumatic experience gets locked into the body, a paradigmatic shift is indicated for psychotherapy for trauma that takes into account the dominance of nonverbal, body-based, implicit processes over verbal, linguistic ones (Ogden, Minton, & Pain, 2006; Schore, 2011). The action of art-making in the context of art therapy is a mind-body practice that might offer safe processing of traumatic memories (Gantt & Tinnin, 2009). Art therapy provides stimulating and kinesthetic activities, along with verbalizing and meaning-making, and may serve as a therapeutic method in the treatment of trauma (Hass-Cohen, Findlay, Carr, & Vanderlan, 2014). Specifically, sensory vividness, expressive emotions, and visual linkage in art therapy practice can be used to update and reconsolidate autobiographical memories (Hass-Cohen & Findlay, 2015). However, due to embodied experiences in art therapy in the treatment of trauma, trauma-related issues must be addressed sequentially: safety, trust, power/control, esteem, and intimacy (Graca, Palmer, & Occhietti, 2014).

Loss

Loss may be defined as a reduction of resources in which a person has an emotional investment. Such resources may include the presence of and interactions with close others, as well as loss of identity, self-esteem, hope, trust, opportunity, and health (Harvey, 1996). Most of us experience losses (minor to major) during our lives, and they have an impact on our emotions, cognition, and behavior. The importance of loss events can frequently be seen in culture and art. Funerals are among our powerful social and religious ceremonies. Support groups abound for almost any type of loss experience (Miller & Omarzu, 1998). Harvey and Miller (1998) have suggested that major losses (e.g., death, divorce, loss of employment, chronic disease, brain injury, political repression) and the pile-up of these losses require from us the maximum effort in order to cope.

Traditional perspectives about loss (e.g., psychoanalytic and attachment theories) view grief as a form of emotional pain or dis-ease that one has to “get over.” However, current perspectives accept loss as an expected part of life that produces permanent change (Rubin, Malkinson, & Witztum, 2012). These

theories also underscore the social context of grief. Culture, for example, is a crucial part of the context of bereavement, and it is often impossible to separate an individual’s grief from culturally required mourning (Rosenblatt, 1993). Sensitivity to cultural differences should help prevent ethnocentric assumptions. The major literature on loss focuses on the death of a loved one. Such a death is associated with powerful emotions and reactions that are apparent in the grieving and mourning processes and are explained primarily by the fact that we develop deep emotional connections in close relationships and struggle to maintain our bonds with our lost loved ones (Rubin et al., 2012). Theories that explain bereavement underscore the post-loss affective states of distress and describe the changes in grieving that occur as time elapses, for example, individual differences in the ability to move from loss-oriented to restoration-oriented coping (Stroebe, Schut, & Stroebe, 2005). Bereavement theories also stress the need of the bereaved to make sense of what has happened to them and their efforts to regain the ability to care about current and future life (Weiss, 2008). Two main tasks for the bereaved are apparent: accepting the death and returning to mundane activities, and in the same time maintaining symbolic relationships to the deceased (Rubin, 1981). In other words, integrating the lost relationship within a new reality (Mikulincer & Shaver, 2008).

Psychological trauma and loss are thus related phenomena. Both may affect individuals’ biopsychosocial functioning, challenging and dislocating the routine of life; both may be seen as stressful experiences of which individuals must make sense, including their impacts; both events bring about the awareness of the fragility of life, shaking the sense of the individuals’ safety and security; both are bound with discontinuity and inconsistencies. Moreover, severe trauma may result in loss of one’s former identity, self-confidence, self-esteem, and self-reliance, as well as trust in others (Blum, 2004). “There is some loss, grief, and mourning with all traumatic experience, and the potential for trauma with all object loss” (Blum, 2004, p. 32). However, while trauma is by definition an unusual type of loss, there are many losses that do not constitute trauma (Harvey & Miller, 2000). In these cases, the therapeutic process may focus on clients as meaning-making agents struggling to assimilate the loss within frames of significance, to make sense of the loss, and to move toward a meaningful future (Neimeyer & Levitt, 2000).

For the purpose of this paper, we focus on the therapeutic need to rework trauma and loss as stressful events that need to be recognized, contained, and claimed by the individual, as well as to find possible meaning. However, careful attention must be paid by the art therapist to specific therapeutic needs that characterize each event. Specifically, found object/readymade art as a therapeutic intervention may be helpful for reprocessing the traumatic memories; however, it may also consist of an exposure component, in which the client is subjected to some aspects of the original trauma. This suggests major importance of the intervention’s timing in the treatment course.

The current article will focus on found object/readymade art as a medium that may be especially suited to enabling the individual to work through trauma and/or loss. We will first present an overview on found object/readymade art from the perspectives

of art history and art therapy as related to therapeutic qualities, and then we will delineate the process of creating found object/readymade art through a phenomenological lens.

FOUND OBJECT/READYMADE ART IN ART HISTORY AND ART THERAPY

Four aspects integral to found object/readymade art may facilitate its functioning as a therapeutic method providing a space in which to explore, to be in touch with, and to play with fragmented and affect-loaded memories that need to be recognized and rejoined.

The term “readymade” was coined by the artist Marcel Duchamp at the beginning of the twentieth century to describe work that consisted of found objects selected and displayed as works of art. Since the artist selects the object, his/her intention intrinsically alters the context of the object in daily life, giving it an entirely new meaning (Hsu & Lai, 2013). Duchamp is generally identified with the avant-garde, specifically Dadaism, a movement that began in Zurich during the First World War and challenged conventional conceptions of art (Graham, 2005). Through their art, the Dadaists protested entrenched political and social values (Waldman, 1992) and promulgated anti-war messages. Thus, Dada basically stems from and binds with wounded and traumatic human society.

Found object/readymade art has had a notable presence in art practice since then. It can be described as an avant-gardist response to aesthetic convention, as “anti-art,” something that causes the “shock of the new” (Tenbaaf, 1998). Duchamp described the creative process that underlines his readymade art as total indifference to aesthetics: “a true readymade: no beauty, no ugliness, nothing particularly aesthetic about it” (Schwarz, 2000, p. 643).

This aspect, *freedom from aesthetic tradition*, drawn from the evolution of readymade, is a valuable feature of the therapeutic context. This may ease the task for clients, in contrast to creating conventional art like drawing and sculpting that might elicit self-criticism and judgment (Magides, Shalev, Trismann, Koren, & Piven, 2009). Creating readymade art may encourage clients to be freely engaged with the found object materials and to express their subjective experience. In addition, it may enable the freedom to act in the face of some conventions. In other words, readymade can be a powerful private protest in the face of self and relational constraints in the therapeutic setting.

The second aspect of found object/readymade’s therapeutic potential is its *use of real objects as the raw material for artwork*. The artist actually transfigures these real objects into works of art by changing their location, which implies that we see them out of their context, thus changing our attitude toward them (Graham, 2005). Conceptualized psychoanalytically, readymade brings the real into the potential space (Winnicott, 1971) and the real into the status of a symbol (Ogden, 1993). The use of real objects as symbols might reduce the distance between the art and the real, or in Ogden’s conceptualization, between the symbol and the symbolized. This could have two implications. On the one hand, it could offer a closer representation of the individual’s experience

that retains its vivacity (Hollway, 2009), communicating authentic psychic realms. For example, the artist Doris Salcedo (born in 1958 in Colombia) addressed the traumatic recent history of her country in her art works. Many of her works transmute intimate belongings (such as worn shoes) of missing people in the context of political violence. These real intimate objects serve as metonymic displacement for the absent body (Wong, 2007) and may evoke the sense of loss. On the other hand, artworks that include real objects imply a possibility of evoking the lived experience of the trauma and might be perceived as “perceptually identical” (Oliner, 2012, p. 22) with the traumatic event. The real objects’ similarity to the traumatic event might trigger painful emotions and/or symptoms. In these cases, extra caution should be taken by the art therapist, who must offer much closer support and containment.

The third central aspect of found object/readymade’s therapeutic potential has to do with *integrating objects/materials*, some seemingly unrelated and some integrated by coincidence. The artist Richard Wentworth (born in 1947 in London), for example, deals in his readymades with bizarre coincidences as well as with the juxtaposition of materials and found objects that do not belong together. Man Ray (born in 1890 in Philadelphia) stated that the creative act rests on the coupling of different features to produce an artwork (Waldman, 1992). Duchamp saw coincidence as the basis of readymade, the only way to avoid the control of the rational, a real expression of the subconscious (Tomkins, 2013).

The integration of mental aspects that had been split as a consequence of traumatic events, and thus became “unrelated,” is a therapeutic endeavor in the treatment of trauma through art therapy (Avrahami, 2005). In regards to coincidence, many events of trauma and loss have an accidental element, demonstrating our inability to control our fate. Posttraumatic and bereaved individuals inevitably deal with the accidental in life and thus may find in the process of creating readymade a medium that resonates this aspect, but this time offering choice and control.

Finally, the last therapeutic aspect of found object/readymade is *playfulness and the humor* it may invite. Some found objects/readymade artists have expressed playfulness and humor while creating readymades (Tomkins, 2013). According to Erikson (1950), play can be seen as “the most natural self-healing measure childhood affords” (p. 222) and as “the royal road to the understanding of the . . . ego’s efforts at synthesis” (p. 209). Because synthesis and integration are essential in the treatment of trauma and loss, play, as embedded within the readymade medium, may have a vital therapeutic role.

In the context of the therapeutic relationship, when the readymade evokes humor, it may constitute a shared, intersubjective experience that is known for its significant therapeutic benefit (Lemma, 2000). Therefore, “Creativity and humor should not be considered mere peripheral or defensive activities because they allow us to appreciate the ridiculous and absurd in life all the while embracing the most important of human conditions” (Knafo, 2004, p. 540).

To summarize, we identified four central aspects of found objects/readymade art that might be enacted in the process of creating:

- (a) the freedom from aesthetic conventions,

(b) the approximation of reality in the space of art through re-location of real objects,

(c) the integration of objects (some unrelated; some by accident), and

(d) playfulness and humor.

These aspects may be especially relevant to the treatment of trauma and loss; in particular, dialects and dialogs between the controlled and the accidental, between the split/fragmented and the integrated, between the reality and the symbolic space, and finally between uncontrolled fate and the playful space. These contrasts, or opposites, which at times may collide, could evolve into dialectical coexistence within the possibility of playing with reality in the therapeutic context. The following vignette demonstrates these characteristics. It is taken from a workshop during a graduate program course in art therapy.

Michal, an art therapy student who forgot to bring objects to a found objects/ readymade workshop focusing on trauma and loss, found a sketchbook in her bag that had belonged to her beloved grandmother, who had died one month previously. Her grandmother had been a woman of all trades (she sewed, knit, cooked, and more) and a Holocaust survivor who suffered a stroke in her later years. As a very active woman, she coped courageously with the consequences of the stroke. She drew in her sketchbook, despite her physical limitations, in an attempt to strengthen her motoric capabilities. The drawings depicted her childhood memories – common European scenes and landscapes. Michal, her granddaughter, is an artist, but is not as proficient an embroiderer as her grandmother had been. She took one of her grandmother's drawings from the sketchbook and embroidered on it, her hand trembling much like her grandmother's. During this phase, she remembered her grandmother with deep longing; by holding her drawing and embroidering some of its contours she felt close to her (see Figure 1). Michal's personal reflection:

I chose to deal with the loss of my grandmother, which had taken place less than a month ago. . . . I began to embroider. I was never good in those precise crafts. The embroidery thread is so delicate and I surrendered to the movement upon it meditatively. I embroidered . . . and I thought – what a pity I'm not good at it – and then I started to feel the connection, the same accuracy that had been lost to my grandmother and had become a quiver. I feel my quivering, uncertain hand that tries to trace her drawing, to trace after her . . . There are many holes that made dots on her drawing because I missed with the needle. Suddenly they seem to be as important as my attempts to find the exact spot, the place, the memory. I think about the world my grandmother came from, a world that had been lost to a harsh childhood. . . . While writing, I remembered that grandma and grandpa met in a sewing factory after the war.

This example exemplifies the *accidental* aspect, together with the *freedom to create* with a personal object, a *real object* that once belonged to a beloved person. The drawing paper became a space for *integrating* the grandmother's lines with her granddaughter's thread and dots. Through *playfulness*, Michal followed her grandmother's drawing lines with embroidery thread, opening a space in which to re-member through movement and touch that



Figure 1. Michal's artwork.

were similar to her grandmother's during a time of adjustment to a crisis. A process of mourning and remembering is apparent through the kinesthetic and touch channels. The sensual and kinesthetic modes of experience will be further discussed in the next section.

Michal's final artwork documents her and her grandmother's marks of coping with private loss. The readymade demonstrates how traumatic events can still be traced after three generations, with each generation holding and transmitting memories in unique ways.

PHASES IN THE FOUND OBJECTS/READYMADE CREATING PROCESS

The process of creating found object/readymade comprises three central phases:

1. Scanning and collecting objects/part objects from the environment;
2. Transfiguring the found objects through various methods of connecting;
3. Naming or titling, or telling a story about the readymade work.

These phases in the creative process have the potential to engage the creator within the therapeutic working-through and meaning-making, especially relating to trauma and loss memories.

Scanning and Collecting Objects (Including Part Objects and Damaged Objects)

Availability of broken/damaged/out of context objects and their therapeutic message. Many art therapy studios have a container with various broken and useless objects as raw materials for creating art. The word trauma derives from the Greek word meaning "wounding" and "penetration" (Renn, 2012, p. 19); thus, collecting broken/faulty objects may evoke identification with their wounded aspects among clients. As a result of trauma and/or loss, the individual literally experiences themselves as damaged, wounded. On a metaphoric level, it can be said that these broken

objects may give voice to the injured and painful parts in us that were caused by the trauma. In the realm of mental functioning, they also serve as representations of these elements, which the traumatized person tends to dissociate, repress, and/or mute.

The encounter with the damaged is akin to Segal's (1957) description of art as a reparation activity in the course of psychic development. "The wish to restore and re-create (the damaged object) is thus the basis of later sublimation and creativity" (Segal, 1957, p. 197). Artistic activity allows a reparative process toward the damages we feel we have inflicted on the loved object (Abella, 2010). Segal's (1957) insight is that "creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self" (p. 199). This reparative process may support a work of mourning, in which, as it continues, the ego is enriched, re-integrated, and enlivened (Abella, 2010).

A unique implication in this respect concerns the exchange that normally takes place between external reality (daily life) and phantasy life (Klein, 1948). A traumatic event might cause a cessation or split between the two realms that will eventually cause unassimilated experiences in the individual (Britton, 1998). Here too, a related phenomena is the risk of being divided, or worse, not connected. Thus, the broken or the deconstructed object may resonate with these traumatic consequences in the mental realm. However, along with the meeting with the damage, there is an opportunity to discover its potential as a constructive element in the new form (Shapiro, 2005). This dialectic between recognition of the broken, the damaged, and/or the missing on the one hand, and of the reconstruction, on the other, is an essential goal in the treatment of trauma and loss.

According to Shapiro (2005), there is an inherent message in offering clients these broken/useless/ruined objects as raw materials for creative work. Specifically, it communicates non-verbally that deconstruction holds a potential to create the new.

Availability of variant objects. An additional aspect is the availability of widely divergent objects, ranging from very soft (fabric, cotton, sponge, etc.) to very hard (nails, steel, iron, etc.); from children's (toys, baby rattle etc.) to adult objects (subway ticket, key, etc.); from transparent to opaque; as well as prototypic gender objects (hair ribbons, razor, etc.).

The opening of the readymade box (see Figure 2) with a rich spectrum of objects can resonate the opening of a toy box in childhood, and thus may invite the individual into a playful activity. In a deeper sense, it may resonate play in childhood as a way to assimilate the world, to make sense of an experience in order to make it part of themselves (McMahon, 1992). The diversity of the objects is important in another way: it could represent more precisely the clients' inner representations, their contrasts, subtleties, time dimensions, and contexts. This can help promote their psychic integration in a therapeutic supporting framework (Hazut, 2000).

Scanning and collecting. Scanning and/or collecting the found object/s and/or part-object/s engage the individual in sensory, kinesthetic, and perceptual exploring activities (Landgarten, 1981; Wadson, 2000). Sensory activity can be seen here as the basic foundation of mental activity (Marshall & Magon, 1998),



Figure 2. Found objects and readymade box.

touching reality as part of the functioning of the ego. Since this phase is mainly sensorial, it is important to bear in mind that trauma narratives are more dominated by sensorial and perceptual aspects, as compared with daily life experiences (Crespo & Fernández-Lansac, 2015). This is consistent with the idea that verbal encoding deficits and involuntary memories are rich in sensory and emotional content (Ehlers & Clark, 2000).

Some emotional responses as well as specific memories (some of which may be painful) might be evoked during this phase. Emotional flooding might take place as this stage introduces the creator with real objects, some of which are very close to the traumatic experience or to the deceased. An example could be medical tools available in art therapy for children hospitalized in oncology departments. Caution should be taken not to retraumatize the individual with stimulating exposure stimuli (Courtois & Ford, 2013; Steele, 2003). The therapist has to be particularly alert and sensitive of this possibility and assist in containing these emotions (Magides et al., 2009) or even postpone this art medium.

By choosing the objects, the individual may experience her/his control capability through making choices. This phase is basically offering choice, which is known to be a therapeutic aspect of art therapy (Nicholas & Lister, 1999). This aspect can be seen as counter-traumatic since the traumatic state is one of psychic helplessness (Freud, 1926).

Placing the collected objects before attaching them. Before starting to act on the collected objects, the client places them in a group. During this phase, the client usually may think about how to join the objects, what methods and techniques to use, and into what form (two- or three-dimensional). In Bion's (1962) concepts, the collected objects may function as building blocks to be transformed into an image. They may reflect beta elements in such a way that they are still in the form of raw materials (disconnected and unprocessed), however, present and waiting to be connected in the here-and-now, to be transformed into alpha elements. This process of alpha-function may be regarded as an achievement equivalent to the ability to dream (Bion, 1962).

The presence of real objects as raw materials may reduce

anxiety for some individuals (Landgarten, 1993) in comparison to starting anew on an empty canvas. In addition, these collected objects, as building blocks of art-making, are actually based in child's play, thus echoing early development.

The Reconstruction, Transfiguration Phase

This phase is the actual creation of the found object/readymade artwork and requires the reconstruction of the objects/part objects through various methods such as connecting, gluing, assimilating, or manipulating the objects. The main process in this phase is connecting and integrating objects into one construct.

Trauma impacts the self by impairing the integrative capacities of the mind, which might be revealed in nonintegrated memory processes and impaired self-regulation (Solomon & Siegel, 2003). Traumatic events affect systems of attachment and meaning, leaving the individual feeling abandoned and disconnected (Herman, 2001). By actually connecting the objects, which are loaded with emotional content, the medium might enable mending broken connections in the inner world, especially in case of trauma and loss. Haeseler (2002), conducting group art therapy with American veterans after September 11, 2001, described the therapeutic effect of the reconstruction phase:

The physical process of constructing something from nothing, and of bringing lost and broken pieces together in a work of art, felt like a powerful antidote to the powerlessness I experienced when witnessing the shattering of buildings and sorting through the broken pieces looking for human life. I felt as though together we were rebuilding and creating beauty from the rubble. (p. 123)

From our clinical experience, many children of divorced parents have found object/readymade to be the preferred medium with which to build containing images such as rooms, houses, refrigerators, and bags. Some used excessive amounts of glue. Along with this therapeutic feature of integrating, many clients will be facing a novel task and might experience anxiety about their ability to handle the media. Art therapists should be familiar with these media properties in order to assist clients in their expressive process (Hinz, 2009).

The following clinical vignette will exemplify the phenomenological dimensions of the process of creating found object/readymade art in the treatment of trauma:

Dan was a seven-year-old boy who had been undergoing chemotherapy treatments for about a year. He was brought to art therapy because he suffered from many fears (mainly from thieves) and had angry outbursts. During this period of intensive chemotherapy his motor abilities were poor and drawing was a frustrating activity for him. Dan scanned the readymade box and found a few candles. He also found a large seashell and first tried to listen to the sound of the sea by placing the shell near his ear. He finally decided to use the seashell as a container and melted the candles into it until it was full (see Figure 3). In the beginning, he was afraid of lighting the matches but gradually gained more control and proficiency. He found this activity exciting and filled many seashells with wax from variously colored candles. During the repetitive activity with fire, a number of issues were raised such as the dialectic between danger and caution/safety, the

permanence versus the finality of things. Holding a lighted candle and melting it into a container served as a here-and-now experience that was bound to issues of life in terms of control and lack of control, transformation, and finality.

The repetitive melting might also symbolize Dan's subjec-



Figure 3. Dan's artwork.

tive experience in his relationships with the close adults around him. Many of them had difficulties setting him limits because he was suffering from his illness. It was as if they were melting in their encounter with him. On the face of it, Dan's working with fire in the therapeutic setting demanded the art therapist set clear guidelines and limits for his safety. Thus, through the relational aspect, Dan could also gain a relational experience that was lacking for him at that time. This experience around the readymade may be seen as co-construction of a new way of experiencing self and other (Fonagy, 1999).

Dan's readymades hold a meaningful symbolic aspect – the seashell's presence outside its natural context, or in other words, its re-location. At that time, Dan felt himself re-located for long periods while in the hospital and not allowed to attend school because of his compromised immune system. He longed for his friends, his previous normal routine. The seemingly accidental choice of a seashell could be seen here as a preconception, in Bion's terms (1962), that was transformed into a conception. The connection to his own wishes and to what was deprived during that time can be perceived as "a lost and found experience" for him.

This vignette shows how creating readymade enabled Dan to express himself in an authentic way. By selecting objects that he encountered in the room by chance and re-locating and incorporating them into his artwork, he actually communicated his inner world (non-verbally and verbally) and gained a sense of autonomy.

This example also illustrates the repetition characterizing many readymade processes. The repeated movements in the melting process exemplified this; in other clients we can see repeated

gluing of pieces, sewing, hammering nails, and many more activities common in the readymade process. This aspect may be experienced as meditative or as a space in which subjective association might be elicited. Because there is an obligatory tendency towards repetition of the trauma in thought, feeling, and behavior in PTSD symptoms (Blum, 2004), the process of making readymade can be a safe place for the individual to work-through aspects of traumatic memories to a better conscious awareness.

This phase inherently consists of attaching objects/part objects into a whole and might be seen metaphorically as the opposite of the psychological splitting and fragmentation that are well-known reactions to trauma (Fonagy, 1991).

Like the previous phase, this one requires the client be active in creating the final art form, which is the opposite of being helpless or frozen in the context of traumatic experience. Transforming passive into active is a therapeutic goal in psychotherapy with traumatized individuals, specifically assisting them to change from perceiving themselves as victims into active survivors who take actions to control their destiny (Knafo, 2004).

Naming or Titling the Readymade

This phase may entail the client's meaning-making process. By giving the new art image a title or even by verbalizing it, the client bridges the nonverbal representations that usually characterize traumatic memories (van der Kolk, 1997) with words. This phase is essential to mastering the trauma. Since it is not unique to readymade but present in all art mediums, we will only mention the specific challenge of verbalizing readymade that is usually composed of various objects, materials, contexts of time and places, techniques of connecting, and more. Highly loaded and complex visual objects, on the one hand, and verbal language, on the other, may represent a wide gap for the client that the therapist will sometimes have to cross as well. Finding the right words for describing the subjective meaning in the readymade art may thus be a real therapeutic challenge and achievement for the client, similar to finding meaning in their suffering as the only thing that helps them bear it (Knafo, 2004).

The question, "What do you see?" (Betensky, 1995) may particularly assist the client and therapist to carefully observe the multifaceted readymade object in respect to form, color, material features, images, and many more visual aspects that are intrinsic to readymade products. Observing the final product from a few vantage points may serve as "binocular vision" (Bion, 1962) that explores the different views of the same object. This is particularly important because in trauma and loss we tend to perceive the traumatic event in a single rigid way.

A short vignette from a workshop with veterans suffering from PTSD exemplifies this. The workshop was a collaboration between the famous Israeli assemblage portrait artist Hanoeh Piven and a group of art therapists. In these therapeutic workshops, the clients were asked to build a self-portrait by readymade, or in other words a "drawing with objects" (Magides et al., 2009). David, a former Israeli prisoner-of-war (captive in Syria for eight months), created an assemblage with the verbal title "Release is Not a Freedom" (see Figure 4). He said:

What I did reflects the period that I have been through. The



Figure 4. David's artwork.

watch is the time. Eight circles, rings, are the eight months I was in captivity. From Sunday noon until I was released, it was exactly eight months. But even though I was released, release is not freedom. The butterfly is not free. It symbolizes me. What I have been through.

This example shows how the naming and verbalizing of the readymade/assemblage can act as a gradual encounter with the memories, as well as with the dissociative aspects (memories and their emotions), in the work of assisting the reconstruction of the individual's autobiography (Avrahami, 2005). This client represented the period of captivity in a very concrete way, but also represented the concept of freedom by gluing a butterfly image, a universal symbol of freedom. It could be inferred that he had made a very communicative image in an effort to be seen and understood by others. The paradox of no longer being a prisoner but still feeling himself in mental captivity is a very strong message to the self as well as to others. This assemblage may also act as a protest against war and its lasting wounds.

THE ART THERAPIST'S ROLE IN THE READYMADE PROCESS

Readymade processes are clearly challenging for the art therapist because of their complexity and their nonverbal nature. Although readymade invites the individual into a playful space, it simultaneously asks for integrative endeavors of painful memories. The final products are commonly complex with various forms, colors, materials, textures, shapes, etc., and are indeed very idiosyncratic and personal. In a way, they remind us of how psychoanalysis works with dreams, which are characterized by condensed aspects and multifaceted layers that may reveal in clarity the individual's unconscious (Greenson, 1970). In the context of trauma treatment, the therapist is requested to be a witness to the client's nonverbal and verbal narratives as they evolve during the readymade process. Careful phenomenological observation (Betensky, 1995) may assist, according to Bion's (1962) concepts, first in detecting the beta elements – those raw, unprocessed, and unrepresented elements – and second in containing and trans-

forming the client's nonverbal communication of implicit memories into alpha elements.

However, in many readymade processes the therapist cannot always remain in the witness role, but is also requested to actually participate in the readymade process. The uniqueness of the client and the art therapist relating around the readymade process can be seen here as an analytic field (Baranger & Baranger, 2009; Baranger, Baranger, & Mom, 1983), specifically as the emotional dimension created by the unconscious affective interaction of patient and therapist in the context of the therapeutic process. This aspect of the client-therapist relationship is also in line with relational neuroscience, in which the mind emerges from the interactions between intrapersonal and interpersonal mind-body exchanges (Siegel, 2006, 2012). The clinical vignette featuring Dan illustrates this point.

The uniqueness inherent in readymade processes challenges our efforts to connect things that were apart, that are made of very diverse materials. This challenge requires creativity and novelty from client and therapist alike. The therapist is thus asked to direct her/his attention to the relational immediate, emerging experience during the process of creating readymade art. Finally, interpreting the readymade object in the last phase requires open, floating attention to the image as seen from different angles. It may be helpful for the art therapist to encourage the client to describe what s/he seeing as well as bodily feelings and free associations.

CONCLUSION

The inherent qualities of readymade art as they were reviewed in this article may especially lend themselves to the treatment of trauma and loss. Found object/readymade art that deals with trauma, ruptures, and loss can be seen en masse in art galleries and museums. The art object may attempt to restore broken connections between the traumatized individual and social structures and people by imposing "form onto the destruction if only by representing it within new structure: the structure of art" (Knafo 2004, p. 539).

In the therapeutic setting, this process of creating found object/readymade art encompasses looking for lost memories, some of them fragmented, split, and dissociative; placing them as present objects; and finally, connecting them and re-locating them into a narrative. Recovery from trauma and loss requires the reconstruction of meaning, the rebuilding of hope and sense of agency. These may be embodied in the found object/readymade creating process, which in cases of trauma and loss incorporate the real and the imagined, the controlled and the accidental, the fragmented and the integrated, the lost and the found.

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Visual Sexualities: Exploring an Integration of Art and Sex Therapies

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This research explores the potential of integrating art and sex therapies. Three interviews were conducted: two with certified art therapists and one with a certified sex therapist, in order to understand how each of these professionals approaches issues of sexuality and creative expression within his or her practice. The resulting data were compared within and between each interviewee, resulting in three overarching themes through which the challenges regarding this integration can be understood. It was found that there is great potential for an integration of the two therapies, provided clinicians have access to appropriate training, as well as a deeper understanding of individual attitudes toward sexuality as provided by cultural experience.

Keywords: art therapy, sex therapy, sexuality, sexual exploration, sexual identity exploration, sexual dysfunction

The relationship between art and sexuality is undeniable: examining art from any stage of history will show that sexuality, sensuality, and the human body have been, and continue to be, an abundant source of inspiration across cultures (Bahrani, 1996; Cooper, 1994). The correlation between creativity and sexuality, however, goes much deeper than inspiration – each is an essential, core part of us (Ellis, 2007; Goodwach, 2005). Much like creativity, sex is fluid, controlled and uncontrollable, individual, cultural, and often intimidating. Each requires both self-awareness and the ability to lose oneself in the moment, to understand the mechanics of how something works, and to let go just enough to create something powerful and unique.

Art therapists know that art is a versatile and thorough method of reflection and exploration. It affords access to memories, emotions, and experiences that our limited language often cannot express (Ellis, 2007; Jones, 1994). Creativity is exercise for the brain; it is an essential part of remaining emotionally active and in touch with oneself (Wadson, 2010). Somehow, though, we have missed the opportunity to explore our own and our client's complex relationships with our sexual selves. In our culture of shame and repression, we forget that sexuality is a vital part of relationship and life satisfaction (Birnie-Porter & Hunt, 2015). It is often an identity, a part of us that we can learn from, use to express ourselves, and that is too often used to inappropriately judge our character and abilities (Pelton-Sweet & Sherry, 2008).

The relationship between art and sexuality is one that can open the door to self-exploration at every level, from the practice of mindfulness (Brotto & Heiman, 2007; McCarthy & Wald, 2013; Monti et al., 2013) to the exploration of gender (Cho, 2013; Hogan & Cornish, 2014), sexual identity (Pelton-Sweet & Sherry,

2008), shame (Saltzman, Matic, & Marsden, 2013), and desire (Wakefield, 2014). The marked lack of research regarding the use of art as a method of sexual self-exploration leaves an enormous hole in our ability to attend to our client's needs. In one of the few articles on the integration of art therapy and sex therapy, Ellis (2007) agrees, lamenting the lack of empirical research, largely because the two lend so naturally to one another.

In the field of sex therapy, there is a similar lack of research regarding the use of creativity in sex therapy. Based on a traditional medical model, much of sex therapy is solution focused, using specific methods to fix the problem (Lieblum, 2007). This is a very limited approach considering that most sexual dysfunctions are rooted in psychosocial factors such as anxiety, stress, and relationship struggles (McCabe & Connaughton, 2014). Perhaps, as Ellis (2007) suggests, it is this clinicalization of sexuality that has contributed to the divide between art and sex therapies since art offers a much more individualistic and less linear approach.

This old approach is slowly changing, however, with new methods taking into consideration that desire is complex and can be built through emotional connection and preferred touch (Iasenza, 2010). Furthermore, the challenges of sexuality do not begin and end with sexual dysfunction or differing sex drives. Therapists must also be equipped to discuss an individual's relationship with a sexuality that exists both within the individual and within a larger cultural framework (Jones, da Silva, & Soloski, 2011). According to Meana and Jones (2011), the field of sex therapy is in "a figurative midlife crisis" (p. 58) due to the growing field of sexual medicine and the changing definition of cultural sexual values, a few of which include a heightened importance of eroticism, lifespan concerns, and the acceptance of diversity in

sexual preference. This means that the old medicalized approach is making space for a new holistic approach. As we enter a time of sexual exploration, acceptance, and openness, we no longer need to hide behind pathologies and quick fixes.

In order to better understand the possibility of using art to explore sexuality, an interview was conducted with two art therapists and one sex therapist on each clinician's experience using creativity as a method of sexual self-exploration.

METHOD

Design of Study

This research used a qualitative approach, through the collection of data from the chosen group of art and sex therapists. The researcher compared reported experiences, finding key elements through semi-structured interviews. Purposive sampling was utilized with local clinicians who have worked largely with expressive therapy and/or sexuality, and were known to the researcher and faculty at Loyola Marymount University who were overseeing the research. Participants were chosen based upon professional licensure and experience as sex therapists and/or art therapists.

Participants. Three participants – Dr. Nick Ryan, MFT, Psy-D, ATR-BC; Kate Loree, MFT, ATR; and JR (pseudonym), MFT, DHS - were chosen based upon professional licensure and experience as sex therapists and/or art therapists. It is important to note that each interviewee was provided the option to be associated with this research through the use of his or her professional name, or to provide an alias in order to remain anonymous. One interviewee chose to remain anonymous. There were no age or gender requirements. All interviewees are LMFTs, two have an ATR (Nick and Kate), and two have doctorates (Nick and JR). All three work with LGBTQ populations; two interviewees work with an awareness of kink, poly, sex work and other sexuality-based lifestyles. All three work with sexual trauma as well as emotional intimacy for couples and individuals. Only one interviewee, JR, the non-art therapist, formally specializes in sex therapy, treating sexual dysfunction and providing sexuality education.

Data analysis. Interviews were semi-structured with open-ended questions regarding the participant's professional clinical experience treating sexuality concerns. Interview questions primarily consisted of requests for clinical vignettes in order to better understand the clinician's common clients and approach: *share a vignette of the sexuality concern most commonly presented by your clients; share a vignette describing your most memorable case; share a vignette describing your most challenging case, if different* are a few examples, which were followed by appropriate follow up questions. The goal was to allow the topics of sexuality and art therapy/creativity to come up within answers as appropriate, in order to get a better understanding of the participants' authentic orientation and clinical approach. The participants did, however, understand the topic of this research, which may have led them toward these topics more often than they may have otherwise. Each interview lasted about an hour.

Once data was collected, audiotaped interviews were transcribed and analyzed. Analysis was performed by organizing tran-

scribed data by topic discussed, then comparing and contrasting topics within and between interviews. The amount of variance between topics discussed was part of the analysis since the open-ended nature of the interview provided both high variance and many overlapping topics.

To ensure validity and control for bias, the analyses were reviewed both by graduate student peers and the writer's research mentor. The final transcriptions and analyses were also provided to each interviewee for approval.

RESULTS

Each of the following categories presents multiple similarities and differences, which are organized by interview question along with overarching themes.

Presentation of Sexuality in Clinical Work

Sexuality presents in clinical work for all interviewees at least some of the time. Two basic presentations were discussed: sexuality through verbalization and sexuality in artistic expression. Nick showed verbal expression "almost always," JR "always, Kate "sometimes." While artistic expression in general occurs more often for Nick and Kate, the expression of sexuality through art occurs most often for JR and Kate, particularly in reference to Kate's hospital practice. For hospitalized clients, the conversation about sexuality occurs naturally based upon sexual trauma, often negating the need for specific directives about sexuality, making the comparison challenging. Perhaps a more accurate way to describe this finding is to state that JR gives more sexuality directives than the art therapists.

Common Interventions

In this section, some visual examples have been provided, but clients were not asked for written permission to show actual art created in session. Therefore, the writer has recreated each example based on descriptions of interventions by the interviewee.

All interviewees use expressive techniques with at least some clients, varying from visualizations, to dream work, to sexuality based directives or expressions. For Nick, art is often related to dreams, with the client creating art while Nick journals the dream narrative. Kate often uses art in a similar way, with visualizations, providing the client with a starting point, then providing materials for the client to further explore the visualization. In these visualizations, Kate will often set the scene for the client, and then provide space for the client's subconscious to fill in the details. She describes these visualizations:

[They are] an art product in their head. [The process is] a journey. I am creating the art expression through the visualization and they're painting it in ... They'll take these things that come up from their subconscious, which are their resources, then, many times, put them in the art ... The visualization allows them to access the best part of their subconscious, and that part of their subconscious gives them gifts that they are able to grab and put in the art, allowing it to become richer and bigger.

While Kate did not have permission to provide specific

examples of her visualizations, some possibilities were discussed. Each visualization can be tailored to the specific needs of the client, for example:

- A calming visualization to help the client release anxiety. This could take the form of a safe space the client has described, a favorite vacation spot, or place created specifically for this purpose.
- Memory visualization to explore either positive or challenging memories. An example of this may be to explore the origin of sexual shame or fear. Starting with primary sexual memories, clients can describe the scene, and then be taken through a visualization to uncover hidden feelings and experiences. With this, art can be used as an aid for the therapist, creating a map for exploration. This can be incredibly challenging work, however, particularly in the case of sexual trauma and should not be taken lightly.

While Kate's descriptions of visualizations ended here, one can imagine the possibilities of creative visualization explorations. These might include exploration of fantasy, sexual scenario, feelings/experiences regarding sexual dysfunction, etc. While the limits of this paper do not allow further discussion of the possibilities of these visualizations, this does open up a possibility for future research.

JR often uses exposure therapy such as directing a client to visit a sex shop, and then asking the client to journal about what made him or her uncomfortable and how he or she was able to break through that discomfort. Other techniques used often by JR include psychoeducation, externalization, and various physical exercises such as masturbation and peaking techniques.

In terms of sexuality art and/or expressive interventions specifically, Kate uses some sexuality based art directives with her hospital clients such as placing sexually suggestive images in the collage box (see Figure 1) to encourage discussion within her clinical groups although she is most likely to see sexuality in the art of clients who have been victims of sexual trauma. By providing her clients with a more open "art expression," Kate states, "Inevitably these things come up in the art, particularly when discussing the trauma narrative." She recognizes common images representing sexual abuse, particularly of closed in, blocked off images such as dark X's over mouths (see Figure 2), depictions of being boxed in or alone in a dark room. "It becomes a double bind for them . . . that struggle of 'The box keeps me safe, but the box is killing me.'" Through therapy and healing, Kate shares that the images and the client's body language slowly become more expansive "literally connecting them to their resources" with the art changing to more organic images and brighter colors such as aqua and yellows (see Figure 3).

JR uses art expressions with some clients such as coloring in parts of the body and mirror genital exams, which includes drawing genitals as well as other expressive techniques such as letter writing: "Some common techniques that I will use, let's say, for example, a person has anxiety, or erection difficulties, or vaginismus, or painful sex, I'll have them write a letter to the body part that they're struggling with, or I'll have them write a letter to the anxiety they're experiencing. What I'm trying to do is have them express some of the frustration, some of the pain, some of the

guilt, some of the shame, some of the difficulties, but at the same time separate them from that, because a lot of people have fused their identity with their sexual concern and have a difficult time seeing themselves as separate from what they're struggling with."

All three interviewees use visualization and mind/body connection in some form: both Nick and JR use breath work. Accord-



Figure 1. Collage featuring sexually explicit/suggestive imagery.



Figure 2. Boxed in/unable to speak, an example of the red X and dark figures common for victims of sexual trauma.

ing to Nick, “We talk about a feeling and at the same time monitor what is going on for them subjectively based on their breathing or how fast their heart is beating.”

In addition to these exercises, Nick uses a sand tray and various other items throughout his office in order to help the client remain connected to his or her body. “It’s all about tactile and sensory experiences and how to integrate the mind and the body, which is a perfect way to think about sexuality and intimacy because that is, from my perspective, what sex is about: the mind and the body integrating together.” According to Labovitz Boik and Goodwin (2000), a sand tray “provides the client access to his/her innermost core or psyche By making concrete what the inner voice is expressing, the client brings into external reality her/his own relationship with her/himself and allows unconscious material to be revealed” (pp. 3-4). The authors go on to state that while the sand can ground the client, it also allows a regression to the self that needs emotional attention. By using this earthy element combined with kinesthetic movement, clients are connected to the self more fully and can lose themselves in the process, or access difficult memories.



Figure 3. The organic shapes and brightened colors often indicative of healing.

Training/Theoretical Orientation

All interviewees reported using “mindfulness” or “body/mind connection” techniques and relational or attachment approaches. Nick and Kate were trained as art therapists through a program focusing in marriage and family therapy with psychodynamic undertones, which encourages a less directive approach. It is important to note that neither has been trained to use art specifically for the purpose of expressing/understanding sexuality. In contrast, JR is trained in sex therapy, which focuses on the more directive approaches of cognitive behavioral and narrative techniques in addition to some psychodynamic techniques.

Common Presenting Concerns and Client Challenges

All interviewees mentioned anxiety and relationship/intimacy issues as primary concerns for clients, both with regards to sexuality and life issues. In terms of challenges specific to sexuality, all interviewees mentioned shame as a major challenge, often resulting in the client being unable to fully discuss sexual challenges and/or desires. Sexual transference was another challenging factor mentioned by all interviewees although all three support the healing potential of sexual transference when approached appropriately.

Common Therapist Challenges

Nick and Kate both expressed difficulty providing art directives, particularly regarding sexuality, due to feeling as if they were “forcing an agenda” or were being “too directive.” Kate shared that she preferred the term “art expressions [because] art directives sounds too directive; it sounds almost authoritarian.” These clinicians also stressed the importance of meeting a client “where they are at,” highlighting another challenge of therapist agenda versus client agenda. JR, on the other hand, relies heavily on specific directives. He states, “We have to be the ones who ask the tough questions. We have to be comfortable with that because if we aren’t, they may not come out and share with us.”

DISCUSSION

Three themes emerged in the research, helping to define the specific challenges that came up for each clinician, as well as the possibilities, and providing insight into the existing barriers that have thus far kept the two therapies separate: (a) the importance of theoretical training and scope of practice in unlocking sexuality, (b) inviting the client to explore sex and sexuality using creative expression, and (c) concerns and challenges for the clinician using artistic expression with sexuality. Each theme presents its own set of challenges and clues regarding the solution to those challenges based upon a comparison between and within interviewees.

The first theme, *the importance of theoretical training and scope of practice in unlocking sexuality*, is inextricably interwoven throughout the other challenges. It is in the training and approach of the therapist that confidence and comfort are developed. For the art therapists, limitation exists in the combination of a relatively unstructured, non-directive approach and a lack of sexuality training leaving both clinicians unwilling to push a topic

that many clients will not discuss without encouragement. For the sex therapist, the limitation lies in a lack of training regarding recognizing and understanding metaphor and symbolism present in the art, losing an opportunity to gain deeper, meta-verbal understanding of the underlying challenges for the client. For all three clinicians, there is a basic understanding of one another's approaches developed through professional exposure.

While Kate Loree and Nick Ryan are comfortable with sexuality and open to bringing it into their practices, psychodynamic training keeps them from leading the conversation in that direction. This presents a challenge with the nature of our cultural approach to sexuality being one of shame and secrecy. Perhaps this data is suggesting that in many cases clients may need to be strongly encouraged to discuss sexuality in order to provide the safety and containment necessary for the conversation to occur.

It is interesting to note that Nick Ryan is more likely (as an art therapist) to intentionally bring sexuality into the clinical conversation, perhaps due to his psychoanalytic training, which directly names the essential relationship between sexuality and the psyche.

The second theme, *inviting the client to explore sex and sexuality in clinical work using creative expression*, rests on the previous challenge. In order for the door to open, the clinician must first have taken this journey and must be prepared to lead the client through. It is important to remember, however, that some clients simply do not want to walk through this door. For the art therapist, the question becomes: how important is it that clients be encouraged to explore this aspect of themselves? If the question is one of sexual trauma, this undeniably becomes a vital piece. For others, the answer seems less clear.

If the issue were one of attachment, each of these three therapists might assess and reflect back to early attachment experiences, providing an understanding the client's current state through that lens. If sexuality is a core piece of our experience, as Goodwach (2005) suggests, it can be argued that this is equally as vital as attachment. How then can art be used to assist in opening this door? An excellent example of this is Kate Loree's work with victims of sexual trauma. Her reports of the client's artistic progression mirroring the personal healing process show that art can lead to understanding without requiring verbalization, a potentially safer way for many clients to begin the conversation. Kate did not need her client to talk about the pain; she could see it in the dark, closed off images that were created. Through these images, she was able to experience the emotions with the client, providing a safe space to begin the conversation.

For sex therapists, the question lies in how art can augment existing approaches. While JR used creative processes to help clients understand sexual struggles and reach treatment goals, these techniques barely reach the surface of art therapy's potential. If he were trained to look more deeply into the art, using the client's symbolic keys to understand and discuss the challenges on a deeper level, clients could then be approached from a more thorough understanding of the presentation of the dysfunction. The art can also simultaneously provide an understanding of the client's feelings about both the dysfunction and sexuality in general. Perhaps if these internal battles could be recognized and chal-

lenged, clients would be more able to see treatment through to completion.

The third and final theme deals with *concerns and challenges for the clinician using artistic expression with sexuality*, which can help in understanding the challenges inherent in treating sexuality issues for all clinicians. While these challenges can be generalized to all forms of therapy and certainly to all three interviewees, it is important to ask if art will help or hinder when approaching these challenges in combination with sexuality. According to Fink and Levick (1973), sexual content is irrepressibly expressed through art making uniquely suited to assist in sexual self-expression and discovery. While more research is needed to answer this question, all three clinicians express a respect for the potential of art to explore the deep complexities of sexuality.

The premise of this research falls on two essential ideas as pointed out in the introduction. First, sexuality is an inextricable piece of our core selves, providing important insight into our experiences and how those experiences intertwine to construct who we are. Second, our world develops visually first, with language giving name and communication to people and objects already existing within that world, with this language of feelings and images often transcending the power of verbalization (Riley, 1990). Based upon these understandings, it follows that an integration of art and sex therapies could lend itself naturally and easily to a deeper understanding of the core self.

Unfortunately, the cultural framework around sexuality creates shame and unease when approaching the topic, often giving it a sense of being both just below the surface and completely unreachable. Both clinician and client may face barriers to exploring sexuality such as family, religion, early sexual experiences, peer experiences, and cultural views of sexuality. This research suggests that through education and developing a clinical awareness of personal barriers, therapists can begin to approach sexuality with an increased understanding and openness.

This research used the experiences of three clinicians who use some combination of art or expression and sexuality in their clinical work. Each clinician was interviewed individually to gain an understanding of his or her personal approach in order to compare and contrast within and between interviews allowing a better understanding of the challenges and successes of the three unique approaches. Two interviewees have training in art therapy in addition to psychodynamically-based training in marriage and family therapy. One of the art therapists also received additional training as a psychoanalyst. The third therapist has training in marriage and family therapy and sex therapy. Each of the shared experiences provided a unique approach, understanding, and level of comfort with both art therapy and sex therapy.

While the aim of this research was to understand the challenges associated with the integration of art and sex therapies, it was found that it is important to first understand why this integration has thus far been discussed only minimally. Both art therapist interviewees have a personal comfort and instinct toward issues of sexuality, but neither feels comfortable insisting that clients explore this topic, with the exception of treating sexual trauma. JR, the sex therapist, lies at the opposite end of the spectrum, making sexuality the topic of almost every clinical conversation

although doing so in a way that seems much more goal oriented and less open to pure self-discovery. If each clinician is using some techniques of both sex and art therapies, the goal becomes understanding how each end of the spectrum can move toward the middle, realizing the opportunity inherent in creativity for a deeper understanding that can contribute to lasting change, as well as what clients may require such as gentle insistence from the clinician in order to create a space safe enough to remove the feeling of exposure when discussing sexuality.

A final important challenge is that of client preference for treatment modality. Not all clients will have an appreciation for art therapy, and not all clients will feel ready to discuss sexuality. Combining the intimacy of sexuality with the depth of art may also feel too vulnerable for some. Based on these findings however, it seems important that clinicians feel prepared to at least initiate and/or invite a dialogue about sex and sexuality, as well as assess the usefulness of expressive techniques and their ability to enhance the effectiveness of the work. It is important to note that these conversations should be approached with encouragement rather than force to avoid a rupture to the therapeutic relationship.

LIMITATIONS

Due in part to the preliminary and limited nature of this research, there are many potential challenges to the validity of this data. Participants were invited to participate in this study based on snowball and purposive sampling. The resulting participant number was very small, with professional training and affiliations that may not be shared by other sexuality and/or art therapy clinicians. This may create results skewed toward sexual openness and/or an appreciation for the benefits of art therapy that is greater than the norm.

SUGGESTIONS FOR FUTURE RESEARCH

This research poses many new questions. While it would require additional training to bring sex therapy into the scope of art therapists and vice versa, these findings suggest that a deeper understanding of one another's treatment modality could be beneficial for clients and therapists alike and may not be exceptionally time consuming if approached through short certificate trainings, perhaps. It is not the intention of this research to suggest that either modality change its foundational methodologies or approaches, but rather to point out the importance of a more integrative understanding of sexuality for all therapists, as well as to point out the usefulness of art for many diverse forms of therapy.

CONCLUSION

This research set out to explore the possibility of an integration of art and sex therapies. Through in depth interviews with three clinicians: two certified art therapists and one certified sex therapist. Overall, the findings illuminated important challenges and benefits and supported the literature review in the possibilities of a beneficial integration.

Through the analysis of the three interviews, several categories emerged and three overarching themes were discussed: (a) the importance of theoretical training and scope of practice in unlocking sexuality, (b) opening the door to sex and sexuality in clinical work using creative expression, and (c) concerns and challenges for the clinician using artistic expression with sexuality. Each theme provided insight into unique challenges and possibilities presented by this integration. The primary problem seems to be that of scope - considering the combination of non-directive psychodynamic training and the lack of sexuality training in most MFT and art therapy programs, there is a clear discomfort when it comes to providing art directives designed to explore sex/sexuality. For sex therapists, creative expression is often used, but with limitations due to a lack of training on the potential symbolic and metaphoric meanings present in the product of the expression. By using art and creativity to open the door to sex and sexuality, clinicians may be providing a non-verbal method to express a core construct that our cultural language may not provide words for. The concerns and challenges inherent in discussing sexuality may be, at least in part, alleviated through the use of art, based upon art's unique ability to decrease defenses and communicate constructs that even the client may not have an awareness of. This benefit may be challenged, however, by the client's resistance to the art itself, resulting in increased difficulty bringing the topic into clinical work.

This research has many limitations, including a small sample size and a reliance on participants known to have an appreciation both for the importance of sexuality and the benefits of art therapy. It does, however, provide a foundation for future research and a potential clinical application of integrative approaches.

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

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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

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, Mokkink, Grootenhuis, 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, Picora, 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 experi-

ences 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 mak-

ing 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.

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

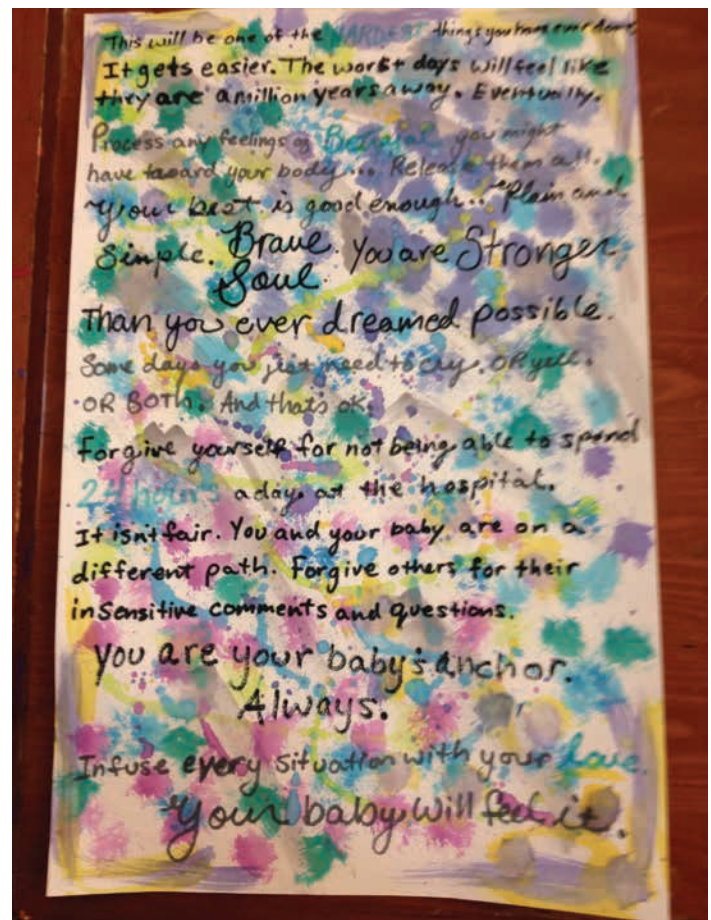


Figure 1. Art serves as a backdrop to a personal letter, holding contradictable feelings.

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

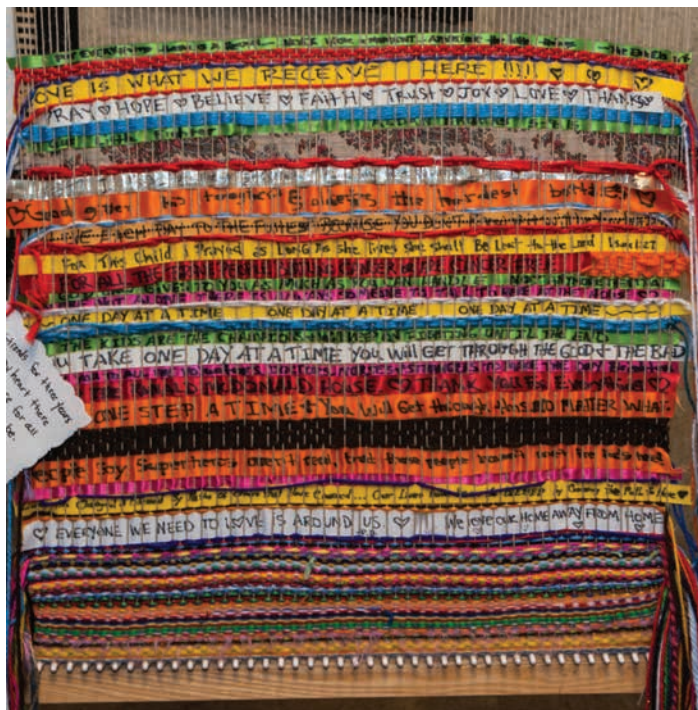


Figure 2. Art serves to maintain privacy while expressing intimate feelings.

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.

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)

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

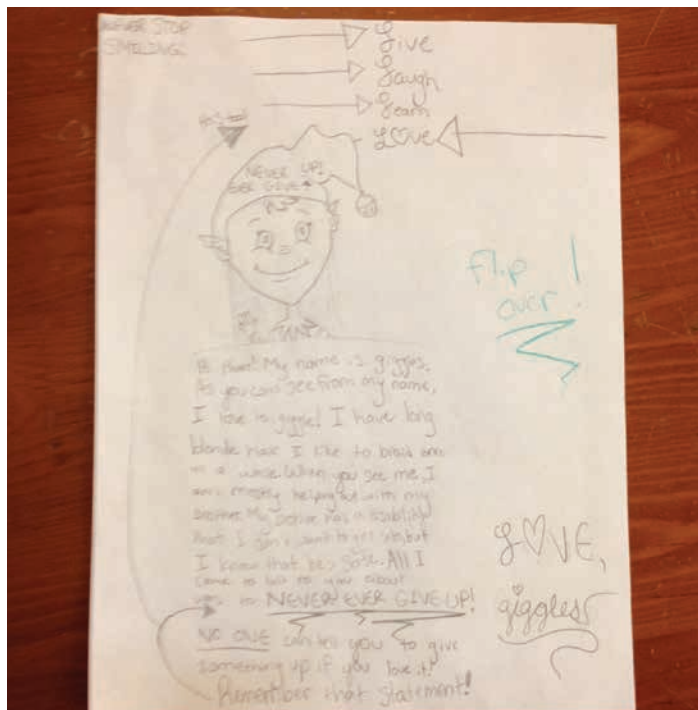


Figure 3. Art serves to communicate what the client is not ready to share verbally.

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 in-patient 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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Implications of National Trends in Digital Media Use for Art Therapy Practice

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This paper presents an overview of national trends in visual art-making and art sharing using digital media, and the authors' reflections on the implications of these findings for art therapy practice. These findings were based on a secondary analysis of the 2012 Survey of Public Participation in the Arts administered by the National Endowment for the Arts. Survey findings indicated that increasing proportions of people in the United States are using digital media for creating, archiving, and sharing their art. Reflections by the authors on these findings include support for increase in use of digital media by art therapists for their own art, and the need for research and education on best practices for use of digital media.

Keywords: digital media, art therapy, survey of public participation in the arts

Art therapists have reported on the prevalence of digital media for creative self-expression (Kapitan, 2007); however, there is limited research in the art therapy community on the implications of using digital and social media for patient care (Kapitan, 2011). A few scholars have recognized that art therapists are increasingly faced with professional and ethical dilemmas in the use of digital and social media (Alders, Beck, Allen, & Mosinski, 2011; Belkofer & McNutt, 2011; Peterson, 2010) and have advocated for research on the topic (Kapitan, 2011; Orr, 2006). Despite evidence of ambivalence among art therapists on integrating digital media in their work (Orr, 2006), there has been increasing recognition of the need to better understand digital media, new technology, and implications for clinical practice (Asawa, 2009; Orr, 2006). This paper expands on this dialogue reflecting on a national survey of the general public's increased use of digital media related to artwork and the implications for the art therapy professional.

LITERATURE REVIEW

In a study on technology use, Orr (2006) found that although 88% of art therapists used technology, they did not use it for therapeutic purposes because technologically-based tools lacked the sensory aspects of traditional art tools (e.g., paints, markers, pencils). Collie, Bottorff, Long, and Conati (2006) reported concerns

from their focus group of art therapists and mental health and telehealth professionals that computer use in art therapy, especially when art therapy is delivered online, could be viewed as isolating, dehumanizing, and impersonal. Using surveys and interviews, Peterson (2010) found that art therapists preferred expressive media that were simple enough for the client to learn how to use effectively. Some of Peterson's participants asserted that digital tools provided them with an opportunity to learn new skills which, in turn, had a positive effect on their clients' self-esteem. Almost all of these participants agreed that if a medium could safely produce a desirable change in a client, then it warranted inclusion in art therapy treatment. The fact that the medium was digital or non-digital was found to be less relevant than the capacity to produce change. However, actual adoption of digital media was related to an individual art therapist's comfort with the media, cost effectiveness, and applicability of the media to clients who might prefer cleaner technology-based artwork, rather than the "messy" options with traditional art media. Potash (2011) argued that electronic media provided rapid delivery and unlimited access to pictures, sounds, and information. Thong (2007) also suggested that computer-generated art was a valid therapeutic modality for empowering clients and fostering the therapeutic alliance.

Digital media in the context of art therapy can also refer to the use of the Internet and social media to archive and share art and related reflections. Aspects of sharing, especially on social

media formats, could contribute to interpersonal connections and social learning through the active participation of these social media members (Belkofur & McNutt, 2011). The digital landscape of social networking has transformed the ways that individuals collaborate, exchange information, and determine what is significant content for their responses and which ones merit their attention while online (Eysenbach, 2008). According to Austin (2009), art therapists are uniquely positioned to understand and leverage social media to help their clients and patients as art therapists work with fantasy, projection, symbol, and metaphor which enables them to provide a unique perspective on the impact of technology on the creative process and on emotional life. Ethical issues that need to be considered include privacy protections in electronic health records, client familiarity and comfort with digital media (Alders et al., 2011; Gussak & Nyce, 1999; Peterson, 2010), and client confidentiality in the therapeutic context (Klorer, 2009). Digital media offer alternate learning avenues and options for sharing artwork compared with traditional modes of art-making and sharing. This in turn could make digital media more relevant to some people than others. For example, there are some people engaged in capturing and sharing photography as an artistic tool using mobile technologies. In addition, digital media potentially offer tools that enable democratic access to art-making, especially for individuals who are unable to work with or are intimidated by artistic expectations of traditional art media.

Little is known, however, about the scope and extent of the use of digital media. One source of data for this is the Survey of Public Participation in the Arts (SPPA). The National Endowment for the Arts (NEA) has conducted this nationwide survey every four to five years in partnership with the United States Census Bureau. This survey is the largest periodic study of arts participation in the United States (US). Although not directly related to art therapy, it can inform us about national trends. The large number of survey respondents—similar in make-up to the total US adult population—permits a statistical snapshot of citizen engagement with the arts by frequency and activity type. The questions on the survey seek to gather information from a representative random sample of the population on participation in arts activities (art, music, performing arts, literary and cultural activities). The survey has taken place five times since 1982, which has allowed researchers to compare trends not only for the total adult population but also for demographic subgroups. The examination of the demographic data included in the SPPA (e.g., age, race, gender, income, education) could help provide further information around digital media usage and access and deepen art therapists' understanding of the diversity prevalent in artmaking and art sharing.

Given that the survey is the only one of its kind that tracks national trends in art participation of the general population, we examined selected findings and considered the implications specifically around art-making, art sharing, and digital media in the context of art therapists' practice. By examining the patterns in art-making and art sharing through the SPPA and reflecting on the implications in research, clinical practice, education, and art-making, we can better understand how these SPPA trends might inform art therapy practice.

METHOD

This study used a multi method design that included (a) a secondary analysis of SPPA data and (b) a summary of reflections on the implications as perceived by art therapists (the authors) for clinical, research and education, and artistic practices. The SPPA in 2012 was conducted over a one year time period from 2011 to 2012 and included responses from a random sample of 37,000 adults from across the US. The survey was conducted in partnership with the US Census Bureau as a supplement to the Census Bureau's Current Population Survey. The 2012 SPPA had 93 questions, 37,266 adult respondents (18 years old and above), and a response rate of 74.8% (NEA, 2013). On both surveys, smaller representative samples of participants responded to different sections of the questionnaire. Although the SPPA has been administered seven times (approximately every four to five years) since 1982, the questions about digital media usage were initiated in 2008 and expanded in 2012. The data from the 2012 SPPA survey are available to the public through a large national database housed at the website of Cultural Policy and the Arts national data archive (<http://www.cpanda.org/cpanda/studies/c00016?view=summary>).

For this study, we focused on the use of digital media for art-making and art sharing. The specific questions used in the secondary analysis of this 2012 SPPA data included those focused on trends in visual art-making and art sharing specifically as they related to digital media. In addition, we also examined distinct patterns by demographics such as age, gender, and income levels. The data were entered into an electronic database and analyzed using the statistical software program SPSS version 20. Descriptive statistics were computed for each question on the survey related to respondents' use of digital media for creating and sharing art, and for participant demographics. Since not all questions were asked of all participants, the findings will be reported here as a percentage of those who were asked a question (rather than the entire sample).

After the data were summarized, in the next part of the study, four art therapists reflected on the findings from the secondary analysis to identify possible implications for researchers, artists, clinicians, and educators. These four art therapists have a combination of over 30 years of personal experience teaching students of art therapy, making their own art, sharing their artwork online (either via blogs or other websites), engaging in clinical practice, and in conducting research. The differences among them lie in the levels of focus in each of the domains listed above. They range in age from 27 to 44 years and racially identify as three White individuals and one Asian American individual. As art therapists, they have used a range of art media including digital tools, crafts, fine arts, and mixed media arts.

FINDINGS

Findings from the 2012 NEA surveys have indicated an increasing engagement with digital media for arts experiences, sharing, and creating. According to the 2008 NEA report, 40% of adults used the Internet to engage with, access, or post artworks. Of these, about 20% used the Internet to view or download visual

art, and most adults who used the Internet were found to engage with artworks at least once a week. Findings from the 2012 SPPA (NEA, 2013) indicated that there was an overall decline in arts participation in traditional forms such as performing arts events, visits to museums, and attendance at craft fairs. However, there appeared to be large levels of engagement in the arts through digital media. In fact, 71% of adults consumed art through digital media (art forms including music, dance, visual art, drama, and literature). Overall 48% of US adults (113 million people) engaged in art-making and/or art sharing; of these, 40% emailed, shared, or posted their artwork (NEA, 2013) (see Figure 1).

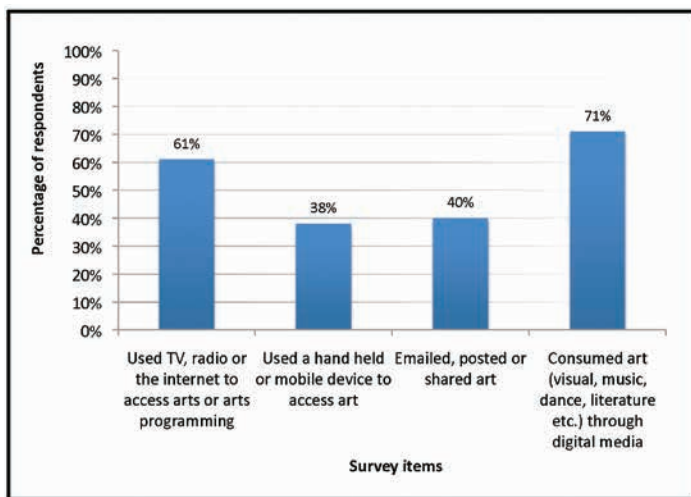


Figure 1. Percentage of the national population that uses digital media to consume or share art.

Source: SPPA 2012 survey (NEA, 2013)

As illustrated in Figure 1, a large proportion of SPPA survey respondents indicated that they consumed art through digital media; however, fewer who created their own art shared this content on-line and/or via hand held devices (NEA, 2013).

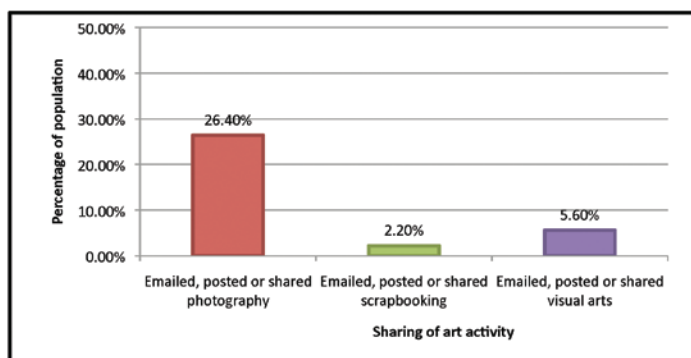


Figure 2. Digital art-making and art sharing activities of one's own art by percentage of US adults who participated in 2012 SPPA survey.

Source: SPPA 2012 survey, n = 9,487

As can be seen from Figure 2, the art form shared the most was photography followed by visual arts and scrapbooking. Figures 3,

4, and 5 present art sharing activities related to gender, age, and family income.

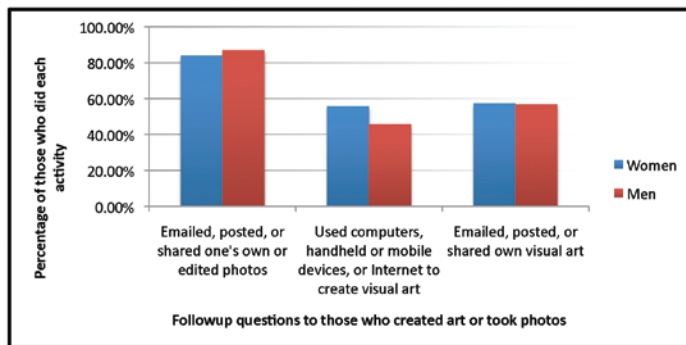


Figure 3. Digital art-making and art sharing activities by gender.

Source: SPPA 2012 survey, n = 1,785

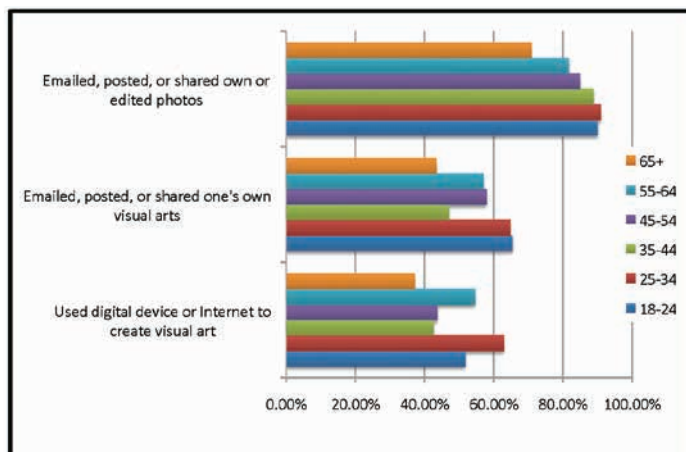


Figure 4. Percentage of those who used digital media or the Internet to create and share art by age groups.

Source: SPPA 2012 survey, n=1785

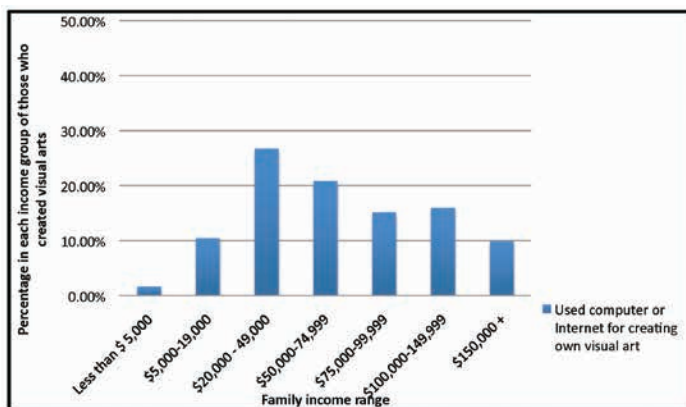


Figure 5. Percentage of individuals who used computers or handheld devices to create visual art by family income levels.

Source: SPPA 2012 survey, n = 555

As shown in Figure 5, larger percentages of those who create art using digital media are those in the \$20,000 to \$75,000

income range. However, it cannot be assumed that higher digital media usage is directly connected to higher income levels. Figure 3 demonstrates that there are no major differences by gender in digital media usage. This indicates that equal proportions of men and women engage in art making and sharing using digital media. Figure 4 indicates that in terms of age ranges and digital media usage, compared with younger age ranges, fewer individuals over 65 years used digital media. Across age ranges, however, photography was shared most commonly. These findings are important to consider, especially in light of how they differ from other art media. We will next explore the implications of all these figures and findings specific to art therapy practice.

DISCUSSION

The SPPA survey provides information on national trends in arts participation. Although not specifically about art therapy, the survey could nevertheless provide useful information for art therapists about the use of digital media tools. The four art therapists, namely authors of this article, reflected on the implications of these SPPA findings for art therapy practice including implications for clinical, research, education, and artistic practice.

CLINICAL PRACTICE IMPLICATIONS

Art therapists need to consider two aspects of digital media: tools for creating digital art and tools for sharing art through the Internet and other types of social media. A major finding from the survey has been recognition of the rising use of digital media for self-expression and art sharing. As shown in Figure 3, digital media usage does not seem to differ by gender or age. Especially with youth who are often familiar with apps and the languages of online tools, digital media might be particularly valuable to build a therapeutic alliance. The following anecdote from one of the participant expert's clinical practice serves as an illustration of including digital tools in therapeutic practice.

One 9 year old boy attended art therapy and disliked drawing. His mind moved faster than his hands could control, and he had the where-with-all to recognize that his fine motor skills were sloppy and did not reflect the image in his head which was a frustrating experience for him. At that time, this young man related everything (metaphorically) to Minecraft – his therapist needed to learn everything about Endermen and the world of Nether. Figure 6 shows an example of the therapist's attempt to understand Minecraft by engaging in her own exploration of the game in an attempt to connect with her patient who used and spoke incessantly about the digital game Minecraft.

While the boy's art therapist did not provide digital or computerized art during his session, she did refer to these characters and assisted the boy in building sets with clay and cardboard to enact different scenarios around survival, coping with pending danger and how to communicate needs effectively; all this was accomplished with the language and 3D avatars comfortable to this child. At one point, this particular client stated, "You know, Minecraft is like life. I



Figure 6. Screenshot image of a garden built in "creative mode" of Minecraft by an art therapist.

Source: Symmetrical Garden, Minecraft Creative Mode, Michele Rattigan

know Minecraft isn't reality, but sometimes it sure explains things better or makes more sense than real life does."

In a different case, this same art therapist found that digital or computerized art-making was a viable tool with a depressed and reluctant adolescent with OCD. The art created through a basic paint program on an old laptop provided a segue into the client's expressive arena and eventually assisted his choosing more expressive, fluid media. It also offered the adolescent control over the expression. The therapist took the role as "student" to his "teaching" her all of the different tricks one could do in the computerized paint program.

As highlighted in these indirect and direct usage examples, digital art media is currently being explored and used in art therapy. Art therapists might consider the use of computers (Parker-Bell, 1999), Internet and digital media (Orr, 2006), and particularly digital photography and social media applications to engage patients who might be intimidated by expectations around artistic skills and mastery in traditional media choices for painting, drawing, etc. (Moon, 2010). Digital and Internet media could include using digital photography as a collage tool or storytelling apps. This might integrate both digital and handmade formats in art therapy practice to address the sensory needs as well as digital options. Sawyer and Willis (2011) highlighted the use of creative applications like digital storytelling as tools to enhance autonomy and creativity.

In a survey study, Kuleba (2009) found that the therapeutic relationship and the effects of using a computer to create artwork were comparable to the therapeutic outcomes of art therapy using traditional media. Those therapists who were reluctant to use computerized art-making in therapy expressed their lack of training and experience related to the computer hardware and software; they also expressed concern about the unique sensory qualities of a computer to create artwork. Potash (2011) also presented two case studies that illustrated how cyberspace entered into art therapy sessions and how the process of art therapy empowered adolescent clients to transform pop culture images into personally meaningful ones. Thong (2007) presented traditional art-making

methods (e.g., drawing, painting, photography, collage, sculpture) that could be combined or enhanced with photopaint programs and 3D computer modeling and animation software such as Adobe Photoshop, Flying Colors, and People Putty. The author compared the unique tools of various visual graphics and virtual sculpture programs to those of more traditional methods of art-making. Thong (2007) concluded that computer art-making has become an integral part of the process of making art, and is a valid medium for individual self-expression and art therapy.

RESEARCH PRACTICE IMPLICATIONS

The 2012 SPPA survey indicated that digital media are increasingly being used for creating, sharing, and consuming art. In an exploratory qualitative study on digital media and art therapy, Edmunds (2012) found that art therapists combined traditional art-making with digital art-making techniques. Other themes found were that digital art-making supports the defenses of doing and undoing; furthermore, deconstruction and reconstruction were also discussed as part of the defense of doing and undoing (Edmunds, 2012). Further research is needed on the role and applications of non-traditional media including digital media apps, photography and photo usage, and digital art. There is a need to study and better understand the strengths and limitations of digital media as therapeutic tools and how they compare with traditional media (e.g., notion of structure in media).



Figure 7. Scribble drawings by a 3-year-old child on an iPad doodle pro app.

Source: Girija Kaimal

More research is also needed in the role of digital media in the stages of artistic development including if and how digital tools help or hinder the process. For example, Figure 7 presents a scribble drawing created by a 3-year-old child on a doodling application on an iPad. This appears comparable to drawings that might be created using pencils or markers in terms of artistic developmental indicators.

Given the increasing numbers of art therapists who blog and share their work online, research is also needed to examine implications of the online presence of art therapists and art therapy bloggers both for content creators and content viewers. Blogs, according to Kaplan and Haenlein (2010), are the “earliest form of social media” and are comparable to personal websites that “summarizes relevant information in one specific content area” (p. 63). In their perspective paper addressing the implications of social media, Belkofer and McNutt (2011) cautioned that websites and blogs could have unpredictable impacts on the privacy of social relationships and interactions among human beings who contribute to and access the sites. Other researchers have argued that it is essential that art therapy professionals begin to recognize social media as a set of powerful, contemporary tools that can be used for finding meaning in an increasingly uncertain world and for facilitating therapeutic dialogue with patients isolated by distance or illness (Collie & Cubranic, 1999; Malchiodi, 2012).

Belkofer and McNutt (2011) suggested some strategies for successful use of social media including (a) expanding the definition of art to include new media and digital technologies, (b) developing a greater range of expertise to help people deal with the realities of new media, (c) engaging mindfully in the monitoring of online behaviors, and (d) establishing clear policies and procedures to protect clients and the integrity of the therapeutic relationship. One way to learn more about the impact of the art therapy blogging community might be to examine perceptions of those in the field through online comments made on these sites. Many sites also offer web analytics tools which can also be used as a data source to better understand why and how art therapy websites and blogs are accessed and used.

ARTISTIC PRACTICE IMPLICATIONS

All four of the art therapy experts/authors have engaged in artistic practice and have identified as artists. This artistic practice has been used as a form of self-care, a way to share our values, reflections, and beliefs, and a way to better understand our own responses and reactions to the world. This has often been done by creating art and sharing images and narrative reflections via emails or blogs with peers. In fact, three of the four art therapist authors are actively engaged in blogging about their work as artists and art therapists. In relationship to the impact of personal art-making on the creative lives of art therapists, Chilton, Gerity, LaVorgna-Smith, and MacMichael (2009) have suggested the many benefits of using the Internet to engage in online art communities. These include providing the power of support through the relationships that are built within the community, providing a sense of hope and inspiration through the sharing and exchanging of art among community members (on and offline), as well

as empowering creative motivation and accountability (Chilton et al., 2009). Chilton and colleagues have also connected the value of engaging in a virtual creative space to having a positive impact on the work of art therapists through validation and meaningful art-based inspiration rooted in the values of generosity, gratitude, and belonging.

Digital artwork and digital photography can and have been used as essential tools for art therapists who value this connection on the Internet through documenting, collaborating, and sharing their own creative expressions through blogs, online communities, and other social networking sites. With the advent of simple photo capturing and image editing tools now available on mobile devices, creative works in the form of visual art, photo captures, videos, internet memes, and more can be easily created and then connected to social media sites to share with colleagues and peers. These tools have shifted the focus away from skill to ease of self-expression. Baumann (2012), for example, critiqued the popular mobile photo sharing app Instagram as not qualifying as photography which takes talent/skill/education, and instead defined Instagram as “folk photography.” Baumann does suggest that these apps can be seen as therapeutic creation rather than time-consuming technology use and offer the user a means to slow down the fast paced, technology-driven world around them. Baumann finally adds that Instagram’s filtering process (editing) provides an opportunity to spend more time focusing on the process of creating and less on the actual product. With the addition of this technology and its seamless integration into social media, the broadcasting (and viewing) of visual content has become more user friendly and available to the art therapist’s artistic practice and connection online.

EDUCATION PRACTICE IMPLICATIONS

Given that large proportions of the US population use the Internet to consume art and use digital media to create and share art, it is important to incorporate the discussion around digital media into the preparation and ongoing professional development of art therapists. Although digital media might not provide many of the sensory and tactile qualities of traditional art media (Kuleba, 2009; Orr, 2006), digital media are increasingly being used to document and share life events. These include narratives and images shared on social media and other forms of sharing including blogs, emails, and website posts.

Educational implications for professional development for practicing art therapists include education around digital media software, tools, and uses. Students of art therapy need to learn: the ethics of digital data including sharing on social media, copyright restrictions in the use of images in the public domain, privacy and ensuring confidentiality in sharing patient or personal artwork on the Internet, and the strengths and limitations of using digital media as a therapeutic tool. In 2013, the American Art Therapy Association revised the *Ethical Principles for Art Therapists* to include updated content about the “professional use of the Internet, social networking sites, and other electronic or digital technology” (Section 15.0). This content highlights the importance of the need for art therapists to understand the public nature of

information available online, its implications for privacy and confidentiality including HIPAA, the art therapist’s responsibility and awareness of these limitations, as well as the importance of reasonably safeguarding content accessible to their patients/clients.

Art therapy students and continuing education trainees need increased understanding and skills related to the appropriate contexts for inclusion of digital media. This could be accomplished through coursework on different digital devices, preparation on how to use these devices in clinical settings, as well as consideration of related ethical issues. Kuleba (2009) has recommended that computerized art-making should be part of the training curriculum in graduate studies. Including this educational standard supports the findings that if art therapists were knowledgeable and trained with using digital media for art-making, they might be more likely to use this medium as a therapeutic tool in their clinical work as well.

LIMITATIONS

This study presented selected findings from the 2012 SPPA national survey on arts participation. Participation in the arts is not, however, synonymous with art therapy, and the NEA’s SPPA surveys have not included any references to art therapy or art-making in a therapeutic context. It focuses on self-reports of arts engagement. Another feature of the survey is that although the entire study includes over 37,000 respondents, many of the questions were only asked of a small sub-sample, and each follow-up question was based on responses from previous questions and thus had successively smaller numbers of respondents. Consequently, the percentages sometimes mask the wide variations in the actual number of respondents for many of the questions. The questions around sharing and creating art digitally were also limited to questions that encompassed a range of options. The questions did not differentiate between digital devices like smartphones, tablets, desktop computers, or between personal emails and sharing publicly social media sites or blogs. Thus, it is difficult to know the proportions of people who shared and the digital context in which they communicated this information.

Limitations also extend to the clinical, research, artistic, and educational implications offered in this paper. These implications are influenced by the subjective experiences of the authors and might not be applicable to all readers. The authors also used this section to demonstrate potential customizable applications of the findings from the 2012 SPPA survey’s secondary analysis in relationship to the art therapy field. Although thoughtful considerations and discussions took place among the authors about these experience-based implications, these are predominantly anecdotes. More research is needed to understand the deeper implications of how digital media impact the multi-faceted practice and training of art therapists.

CONCLUSION

The purpose of this paper was to reflect on and share findings from the NEA’s 2012 PPA survey which has indicated an increasing prevalence of digital media usage, and to explore how this

increase might relate to art therapy practice. The secondary analysis findings indicated an increasing prevalence and use of digital media for art-making and art sharing. Art therapists are already starting to use digital media as a therapeutic tool and for their own artistic expression. Research on the usefulness and effectiveness of digital media for art therapy practice will be needed to assure integrity of best practices which can then be integrated into education and training for the profession.

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