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The Role of Art Making in the Recovery from a Physical Disability due to Trauma

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The Role of Art Making in the Recovery from a Physical Disability due to Trauma

By

Erika Y Schreefel

A research paper presented to the

Faculty of the Department of
Marital and Family Therapy
Loyola Marymount University

In partial fulfillment of the
Requirements for the Degree
Masters of Arts in Marital and Family Therapy

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Abstract

This qualitative research study presents an examination of the role that art making fulfills in the recovery efforts following the development of a physical disability due to a trauma. Preexisting literature informed the current study on art making's ability to manage psychological and physical stressors that can accompany the development of a physical disability due to a trauma experience. The current study utilized a focus group to gain a better understanding of art making's benefits by obtaining firsthand accounts from individuals with experience incorporating art making in their own recovery process. Data collected during the focus group suggests that the art making process is beneficial as part of the recovery efforts. Data showed that art making possesses the ability to aid with the processing of psychological and physical stressors encountered during recovery, and functions as an integrative process that helps individuals to accommodate their new identities. Such findings suggest that the inclusion of art therapy, of which art making is the core foundation, can be a beneficial component to incorporate into recovery efforts.

Disclaimer

This paper does not reflect the views of Loyola Marymount University nor the Department of Marital and Family Therapy.

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Introduction

Study Topic

The purpose of this research is to explore the therapeutic qualities of the art making process in relation to the mental health aspects associated with physical disabilities. The inquiry process will illuminate the ways in which the art assists in the recovery process and integration of the altered physical ability. When considering this research topic the researcher questioned what the experience of art making was like for a person with a physical disability? If the experience helped to process any negative and/or positive thoughts and feelings in relation to having an acquired physical disability? And, if making art helped create a more positive self-image and positive outlook on life?

Significance of the Study

This study is significant as individuals who become disabled following a trauma not only face the challenges of adapting to new physical capabilities, but as they face mental health stressors following the change in their physical status as well. With advances in medical technology individuals are surviving more severe injuries and traumas more often than seen in previous years increasing the population of those developing and living with physical disabilities. The process of making art has been shown to be beneficial for improving mental health with individuals dealing with long-term illnesses such as cancer, and as beneficial for generating creative approaches to exercises within occupational therapy and physical therapy, but research on the effect that art making has on mental health aspects related to developed physical disabilities is limited. Due to this lack in research the continued examination of how the process of making art may benefit individuals with developed disabilities following a trauma is warranted.

This study is important to me because I have an aunt who developed physical disabilities and limitations following a traumatic car accident. Having broken her back in three places my aunt lost the

ability to walk and utilize most of the functions in her arms and hands. Art had always been a pastime that my aunt engaged in before her accident, and she found it to remain a pleasurable engagement even though her new physical limitations required her to change the mediums she used and projects she undertook. Though my aunt never received formal art therapy services, she engaged in art making while still in her early stages of recovery as her children brought scrapbooking materials and simple projects for her to do from her hospital bed, and as she later participated in a program at her rehabilitation clinic where she glazed premade pots. Such activities provided her with joy and satisfaction as she “really enjoyed seeing the end (finished product)...what you accomplished.” Witnessing how beneficial art making has been for my aunt following her accident, and considering this aspect of her recovery through the art therapy lens I have developed from the Marital and Family Therapy Program at Loyola Marymount University, it appears that the process of making art does have an impact on mental health aspects related to the development of physical disabilities following a trauma. Such a realization has caused a desire in me to better understand what such effects may be so as to be able to increase the knowledge base of, awareness of, and application of art therapy approaches within recovery efforts following the development of a physical disability due to a trauma experience.

With the conclusion of this research, I anticipate the finding that the art making process is effective with positively influencing the mental health aspects related to the development of a physical disability following a trauma experience. It is the intent of this research to better understand the experiences of individuals utilizing the art making process as part of their recovery efforts.

Background of the Study Topic

When thinking of worldwide issues the war on terrorism, global warming, and perhaps even worldwide hunger are the items that may come to mind, but one issue that does not appear as often in the news is the prevalence of disabilities affecting individuals and families in all countries of the world. There are in fact over a billion people in the world living with impairments such as paralysis, partial or complete amputation of limb(s), mobility deficiencies, sensory disabilities such as blindness, and psychological trauma (World Health Organization, 2015b). Physical disabilities are defined as the “condition where a person experiences significant deviation or loss in their body function or structure that results in physical limitations in their physical activity that may affect their perception in life, depending on the context within which they live” (Taleporos & McCabe, 2005, p.638). In some cases individuals are born with a physical disability and, in others, acquire such a condition following an illness or traumatic incident in which they experienced alterations to their physical status. Acquired physical disabilities have been found to be more difficult to adjust to than congenital physical disabilities as individuals often experience severe psychological trauma due to the changes and losses related to the life they previously held (Li & Moore, 1998). Such psychological stressors have been found to include depression (Gayman, Brown, & Cui, 2011; Gayman, Turner, & Cui, 2008; Nosek et al., 2008; Turner & Noh, 1988), unemployment (Kerra, Dattilo, & O’Sullivan, 2012; Turner & Turner, 2004), symptoms of grief and loss (Li & Moore, 1998; Niemeier, Kennedy, McKinley, & Cifu, 2004), stress (Nosek et al., 2008), anxiety (Niemeier, Kennedy, McKinley, & Cifu, 2004),) sleep problems (Nosek et al., 2008), fatigue (Nosek et al., 2008), and increased risks of suicidal ideation (Russell, Turner, & Joiner, 2009).

Following the development of a physical disability common treatment efforts focus on the managing of physical abilities via physical rehabilitation (PR) and occupational therapy programs. Such programs aim to support an individual's ability to live within the community, to live independently, and to be able to partake in education opportunities, the labor market, and civic life (World Health Organizations, 2015a, para. 1). While PR assists with improving an individual's physical capabilities it does little to address the psychological aspects an individual is dealing with following the acquisition of a physical disability. At times, PR has been found to even leave an individual unsatisfied despite physical gains made as feelings of inadequate levels of self-efficacy and self-management skills remain (Frain, Tschopp, & Bishop, 2009).

While PR is a common treatment for the physical aspects related to acquired physical disabilities, Cognitive Behavioral Intervention (CBI) is a treatment approach often used to aid the psychological aspects related to a traumatic experience. CBI approaches focus on identifying and altering dysfunctional thought patterns that exist in an individual's frame of mind. When utilized with individuals with acquired physical disabilities, CBI interventions often focus on identifying and altering thought patterns that minimize and catastrophize the remaining abilities that an individual has. By altering such negative thought patterns the intention within CBI interventions is to positively influence feelings of self-worth and subjective well-being in the individual to improve their state of functioning (Smedema et al., 2010).

Art therapy (AT), noted as "a mental health profession in which clients...use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem." (American Art Therapy Association, 2015), has been shown to be a therapy modality capable of paralleling techniques

within CBI (Sarid & Huss, 2010) helping to improve individuals' state of psychological and emotional well-being. AT has been found to help improve well-being by providing opportunities for individuals to express various feelings such as frustration, anger, sadness, and joy (Russell, 1995), by approaching difficult issues in indirect manners via metaphorical expressions and nonverbal interactions seen to be less threatening than traditional talk-therapy techniques (McGraw, 1995), by assisting with the development of concrete solutions to specific struggles being faced (Czamanski-Cohen et al., 2014), and by providing positive group experiences that decrease feelings of loneliness through peer support and increased socialization (Drapeau & Kronish, 2007; Heenan, 2006, McGraw, 1995). Studies on AT have also demonstrated it to possess the ability to influence the well-being of individuals facing struggles related to acquired physical disabilities as the art making process has been shown to help individuals in PR accomplish their PR goals, fill their time with meaningful endeavors, increase their sense of enjoyment, regain positive levels of confidence, and increase engagement in future activities following PR completion (Symons, Clark, Williams, Hansen, & Orpin, 2011). AT techniques used in PR were further found to assist with improving individuals' physical conditions by helping to engage and practice bilateral sensorimotor skills (Yaretzky & Levinson, 1996), gross motor skills (Alyami, 2009), and fine motor skills (Barker & Brunk, 1991) through the use of art materials.

When researching articles on AT and physical disabilities related to trauma, a majority of articles found concentrated on disabilities in relation to chronic illnesses such as cancer (Reynolds & Prior, 2003; Svensk et al., 2009) and multiple sclerosis (Reynolds & Prior (2003) and not physical disabilities caused by incidences of trauma. While such studies do not speak directly to AT's potential impact on the recovery process of a trauma related physical disability,

their findings do demonstrate AT's ability to assist with the psychological aspects and acceptance of physical changes and/or a loss in abilities caused by circumstances outside of one's control. With relatable research indicating AT's effectiveness in combating psychological stressors, its ability to assist in facilitating positive outcomes in PR programs, and its ability to improve the well-being of those facing changes in their physical status due to chronic illness, AT may posit itself as an effective treatment approach for individuals with acquired physical disabilities related to a trauma as it has the ability to impact both physical and psychological symptoms.

Literature Review

There are over a billion people in the world living with a disability with a significant percentage of cases stemming from incidences of traffic accidents, falls, burns, and violent acts of abuse and war. Impairments that can result from such incidences range from physical and/or cognitive limitations due to neurotrauma, paralysis due to spinal cord trauma, a partial or complete amputation of limb(s), mobility deficiencies due to limb deformation, sensory disabilities such as blindness, and psychological trauma (World Health Organization, 2015b). According to Emory University School of Medicine, the term disability defines “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (Sheena, 2015, para. 4).

In accordance with the focus of this paper, physical disability is then the “condition where a person experiences significant deviation or loss in their body function or structure that results in physical limitations in their physical activity that may affect their perception in life, depending on the context within which they live” (Taleporos & McCabe, 2005, p.638). Li and Moore (1998) reported that physical disabilities acquired later in life, as compared to congenital disabilities one is born with, are more difficult for individuals to adjust to as one often experiences severe psychological trauma due to the changes and losses related to the life previously held. Research has shown that the development of a physical disability is often accompanied by not only physical pain (Nosek, Hughes, & Robinson-Whelen, 2008) and the adaptation to new physical limitations and abilities (Li & Moore, 1998) but by secondary and psychological states such as depression (Gayman, Brown, & Cui, 2011; Gayman, Turner, & Cui, 2008; Nosek et al., 2008; Turner & Noh, 1988), unemployment (Kerra, Dattilo, & O’Sullivan, 2012; Turner & Turner, 2004), grief and loss (Li & Moore, 1998; Niemeier, Kennedy,

McKinley, & Cifu, 2004), stress (Nosek et al., 2008), anxiety (Niemeier, Kennedy, McKinley, & Cifu, 2004),) sleep problems (Nosek et al., 2008), fatigue (Nosek et al., 2008), and increased risks of suicidal ideation (Russell, Turner, & Joiner, 2009) as well.

The first part of this literature review examines the psychological aspects related to acquired physical disabilities including depression, body-esteem, and self-esteem. It also looks at the role that social factors, disability identity and disability culture, and the psychological aspects of physical rehabilitation play in the lives of individuals with acquired physical disabilities. The second part of this literature review focuses on art therapy's ability to influence an individual's experience of psychological stressors, such as depression and struggles with identity, as well as its ability to enhance Cognitive Behavioral Intervention techniques and the role it plays in navigating aspects related to physical rehabilitation and chronic illnesses.

Physical Disability and Secondary Psychiatric Risk Factors

In a study by Turner, Lloyd, and Taylor (2006) it was found that a physical disability functions as a basis of stress that increases one's risk of the onset or reoccurrence of a psychiatric disorder and/or a substance disorder. The view that disability is a form of chronic stress that primes individuals for the development of or relapse of a psychiatric disorder supports previous studies viewing chronic stress as a predictor for psychological distress (Turner, Wheaton, & Lloyd, 1995). In Turner et al.'s (2006) study 37% of participants with disabilities met criteria for a psychiatric or substance disorder at least once in their lifetime, as compared to participants without disabilities who reported at a rate of 22.3%, suggesting that the population of individuals with physical disabilities may greatly benefit from mental health programs aimed at preventing both the onset and reoccurrence of psychiatric disorders.

Depression. Many studies show that individuals with physical disabilities are at an increased risk of developing symptoms of depression (Gayman et al., 2008; Gayman et al., 2011; Niemeier et al., 2004; Nosek et al., 2008; Turner & Noh, 1988;). Niemeier et al. (2004) for example, found that individuals who experience a decrease in functioning due to a physical disability experience a form of loss and depression similar to that felt during grief over the death of a loved one. Such individuals were found to experience the same symptoms of shock, disbelief, longing, and intrusive cognitions, as well as sadness and anxiety as those who experienced a loss due to death. Murray and Fox (2002) discovered that individuals who were better able to cope with their loss in functioning experienced less phantom limb pain; with phantom limb referring to the “experience of feeling as though the amputated appendage is still there and intact” (Murray & Fox, 2002, p.926). The phenomenon of such perceived sensations can be experienced, among other things, as sharp knife like pains and/or feelings of pressure and burning (Jensen, Krebs, Nielsen, and Rasmussen, 1983), all of which have been found to affect not only an individual’s overall sense of well-being, but levels of depression as well as individuals struggle to find an explanation for and resolution to the reoccurring sensations.

Another way in which depression is thought to occur in relation to physical disability regards the way in which it can cause periods of prolonged unemployment due to the restrictions that it places on an individual. Such periods are seen to disrupt one’s sense of identity as feelings of loneliness, helplessness, bitterness, and despondency affect self-respect and one’s sense of identity. In addition, unemployment has also been found to create family and marital stress, decrease social support outlets, and increase financial strain and stigmatization (Kerra et al., 2012; Turner & Turner, 2004). Unemployment is seen to have such effects as being employed functions as an activator of the ego through the experience of feeling fulfilled and

accomplished in having performed a task and/or provided for others; thus at the other end of the spectrum, being unemployed allows for a lack in feeling fulfilled and accomplished, diminishing one's sense of worth (de Guzman et al., 2011).

The state of unemployment is also seen to increase depression levels as it creates a situation of dual stigma as an individual faces social attitudes for being both disabled and unemployed (Kerra et al., 2012). Effects of dual stigma on depression have also been found to exist when an individual with a disability is also female, as Nosek et al. (2008) found that women with disabilities had a higher occurrence rate of depression compared to women without. Nosek et al. (2008) further noted that many depressed women with disabilities are depressed without meeting criteria for a clinical diagnosis, believing depression criteria of fatigue and sleep disturbances to be often overlooked and assumed to be caused by the physical disability and not a true state of depression. Such under-detected and untreated depressive symptoms were found to lead to increases in hypertension, stress, smoking, and weight gain all of which can compound the preexisting struggles of the originating disability and depression (Nosek et al., 2008).

Depression and physical disability have also been linked in previous research via body-esteem ratings as lower levels of body-esteem have been associated with higher levels of depression for men with physical disabilities (Taleporos & McCabe, 2005). Body-esteem is seen as "the overall positive or negative evaluations of the body" and is thought to be "affective" as it "denotes the satisfaction people experience with their bodies" (Mayer & Eisenberg, 1988, p. 156). In Taleporos and McCabe's (2005) study, men were found to have higher levels of positive body-esteem when they experienced decreased needs of assistance, higher levels of self-esteem and sexual-esteem, and lower levels of depression. Women, on the other hand, were seen as

having higher rates of positive body-esteem when they experienced higher sexual-esteem and higher self-esteem with no influence being found in relation to levels of depression. Levels of body-esteem were found to vary not only between genders but between severities of disability as well, as Taleporos and McCabe's (2005) study also found that individuals who experienced more severe physical disabilities experienced decreased levels of body-esteem when compared to individuals with less severe disabilities. Taleporos and McCabe's (2005) finding that more severe disabilities amounted to lower levels of body-esteem mirrors Nosek et al.'s (2008) finding that individuals with disabilities who experience greater limitations in functional capabilities experience decreased levels of self-esteem. Adding to this, Mazur (2008) found that whereas the number of limitations caused by an acquired physical disability did not affect an individual's self-efficacy, the extra amount of time it took for such individuals to complete household tasks and parenting tasks did. Alongside the frustration of taking more time to complete household and parenting tasks, Mazur (2008) discovered that individuals with physical disabilities were also frustrated by the inability to partake in family activities and the inability to prepare meals independently. This lack in ability to participate and act autonomously reflects Taleporos and McCabe's (2005) finding that men with disabilities who require increased needs of assistance tend to have lower levels of positive body-esteem in relation to their disability.

Equating body-esteem to one's physical self-concept, Shapiro and Martin (2010) found that physical self-concept accounted for only half of individuals with disabilities overall self-esteem, with aspects of academic, emotional, and social self-concepts accounting for other portions. Li and Moore (1998) define self-esteem as "the summation of positive self-attitudes and competencies" (p. 22) and add that "the emphasis of competencies over limitations and of abilities over disabilities leads to conscious, positive attitudes of self" (p. 22). In a study by

Brown (2014), women with disabilities who had lower levels of self-esteem also experienced higher levels of depression as they relied on others emotionally. Brown (2014) suggests that the perception of having personal control, seen as the ability to direct and regulate circumstances in one's life, is impactful on self-worth and psychological wellbeing for individuals with disabilities. Thus, with increased reliance on others for emotional strength, the women in Brown's (2014) study lacked self-esteem as they were unable to function independently of others relinquishing a sense of control over their own lives. Nosek et al. (2008) found similar results in demonstrating that the perception of life being unpredictable and uncontrollable was related to higher stress scores and lower self-esteem. In experiencing less control over their lives individuals in Nosek et al.'s (2008) study were seen to also experience increased levels of physical pain and fatigue and decreased levels of social support.

Social factors and physical disability. Social factors, such as social support as mentioned by Nosek et al. (2008), have been found to play a significant role in quality of life (QOL) ratings for individuals with disabilities, with QOL being recognized as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (Study protocol for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL), 1993, para. 1). For example, perceived social stigma and perceived social support, both of which play a role in the experience of community integration, which have been found to impact QOL (Amundson (2010), were seen to be significant predictors of depression (Jensen et al., 2014; Rybarczyk, Nyenhuis, Nicholas, Cash, & Kaiser, 1995) and positive psychological health (Jensen et al., 2014). In a relatable study, Li and Moore (1998) found that social and family support greatly influenced one's adjustment to the development of a physical disability. Li and

Moore (1998) found that in general both social and family support positively influenced an individual's adjustment to an acquired physical disability, whereas Jensen et al. (2014) found that the type of social support was influential as support from friends related to lower levels of depression compared to levels reported in relation to support received from significant others and/or family members.

Jensen et al.'s (2014) finding that support from friends was more beneficial than support from family members reinforces research showing that current interpersonal relationships are an influential factor of an individual's self-concept (Nelson, & Gruver, 1978). Demonstrating the importance of peer relationships research has shown that support groups, in which an individual spends time in proximity and/or communication with peers, have the ability to positively affect one's self-concept and self-confidence (Mejias, Gill, & Shpigelman, 2014). Mejias et al. (2014) found that women with disabilities who participated in a group with other women with disabilities experienced positive increases in their sense of belonging, both in the group and in settings outside of the group, due to an increase in their self-confidence and pride in having a disability. Such gains were seen to occur due to the social and emotional support experienced with the sharing of personal stories which functioned as opportunities to receive and/or give advice and role model for others. Through such a group experience the women were found to be able to develop a more positive disability identity as they were able to incorporate their disability into their identity as a shared positive experience rather than as a shameful one. This finding is consistent with social identity theory which proposes that membership in a group helps to create a positive self-concept that is internalized as a sense of group affiliation that can be used to resist experiences of isolation in settings outside of the original group (Mejias et al., 2014). Such an internalized sense of belonging can be seen as being a crucial defense for stemming off the social

stressors that have been found to be the strongest predictors of suicidal ideation for individuals with disabilities. With rates of suicidal ideation found to occur twice as high for individuals with disabilities than for those without (Russell et al., 2009), a sense of group affiliation presents itself as being imperative for those with physical disabilities.

Disability identity and disability culture. Extending the notion of group to the context of a culture within a larger population, disability culture refers to the shared experience of oppression that is accompanied by the art, humor, history, evolving language and beliefs, as well as the values and strategies for surviving and thriving for those with disabilities (Dupré, 2012). Disability culture aims to focus on the maximizing of psychological independence and control over one's life in spite of how severe a disability may be and how much physical and/or economic assistance is required by an individual with a disability (Conyers, 2003). Just as support group affiliation was seen to enhance self-concept, self-confidence, and pride (Mejias et al., 2014), disability culture has been found to nurture positive identity as it provides symbols, rituals, and values to strengthen personal and group identity, as it unites individuals towards support and group action, and as it refutes the negative images of disability common in mainstream society (Robertson, 1994).

Portrayals of individuals with physical disabilities in media, and the perception of individuals with disabilities by those who do not have a physical disability, have been found to interpret the having of a physical disability as an inherent negative quality (Zhang & Haller, 2013) that lowers one's QOL (Amundson, 2010). In Amundson's (2010) reporting, the notion that having a physical disability equates to a substantially lower QOL was dispelled as individuals with disabilities were seen to self-report only marginally lower QOL ratings in comparison to individuals without disabilities. Findings also showed that associations between

physical disability and QOL were paralleled not by the severity of one's disability but by social factors pertaining to employment status and community integration. Such findings not only support research showing that a lack of employment leads to higher depression levels for individuals with disabilities (de Guzman et al., 2011; Kerra et al., 2012; Nosek et al., 2008; Turner & Turner, 2004), but also counters the medical model view of disability which emphasizes disabilities as biological defects that require medical interventions, having no connections to societal physical or attitudinal barriers, and in which the goal is to make levels of functioning conform to society in an attempt to assimilate (Longmore, as cited in Robertson, 1994).

More evidence against the medical model point of view is seen in Li and Moore's (1998) study which demonstrated that the more an individual with a disability felt devalued and discriminated against by society, the more likely they were to not accept their disability as part of their identity. In a study by Dunn and Burcaw (2013), disability identity was recognized to be an influential component of one's self-concept as it allows for expressions of individuality in personal characteristics and roles and as it accounts for group affiliations. Zhang and Haller (2013) further repudiate the medical model reporting that as negative messages pertaining to having a disability are experienced individuals with disabilities begin to feel inferior to those without leading to lower levels of self-esteem and self-identity and, in contrast, experience a more positive and confident self-identity when positive messages are experienced. Such findings showcase that the experience of having a physical disability is not free of influence from societal attitudes as the medical model so proposes, as views and acts depicted by society were shown to affect an individual's acceptance of and identification with their physical disability.

In relation, Zhang and Haller (2013) also mention that even unrealistic portrayals of “supercrips,” which Quinlan and Bates (2008) define as “a person who has superhuman capabilities because they have a disability” (p. 75), were experienced as positive messages that individuals found comfort and hope in seeing another individual with a disability succeed. Though other studies have demonstrated that portrayals of “supercrips” lead to feelings of inadequacy as they create false expectations and unobtainable goals for individuals with disabilities (Quinlan & Bates, 2008), such contrasting findings still demonstrate that societal attitudes towards physical disabilities have an impact on an individual’s self-concept and identity as individuals with disabilities compare themselves to images created by and celebrated by society. The occurrence of mixed messages in media and society, in regards to how life with a disability should be experienced, highlights the importance that a sense of disability culture and the experience of peer group interactions can have as they have the potential to provide opportunities to experience positive interactions and support (Mejias et al., 2014; Robertson, 1994).

Physical rehabilitation and psychological implications. Following the development of a physical disability focused efforts within medical treatment are centered within the realms of physical rehabilitation (PR) and occupational therapy (OT). The World Health Organization (2015) denotes rehabilitation as being integral in enabling those with physical disabilities to obtain and/or maintain a life within the community, to live independently, and to be able to partake in education opportunities, the labor market, and civic life (World Health Organization, 2015a, para. 1). PR focuses on assisting individuals with doing such things as it aims to improve the ability to move, to reduce pain, and to restore function and prevent further disability (Malchiodi, 2013, p. 21). While PR assists with improving an individual’s physical capabilities it

does little to address the psychological aspects an individual is dealing with following the acquisition of a physical disability. PR has been shown to actually increase psychological stressors as it increases family strain and family functioning (Allan & Ungar, 2012) and leads to the development of raised levels of anger (Bruns & Disorbio, 2000). Bruns and Disorbio (2000) found that some components of PR contain an inherent element of stress as they require an individual to execute painful exercises, and as PR legal aspects associated with health care systems create pressures, frustrations, and delays in receiving treatment, all of which raise an individual's level of anger as they endure such situations. These raised levels of anger and strains on family dynamics can be seen as secondary stressors that compound the effects already felt from the originating disability, similar to how under-detected and untreated depressive symptoms compounded upon the preexisting struggles of an originating disability in Nosek et al.'s (2008) study.

Despite physical gains from the participation in PR, Senra, Oliveira, Leal, and Vieira (2012) found that many individuals continued to report problems with their overall well-being following the completion of a PR program. This finding was believed to be due to the lack of psychological health components included in PR programs as individuals were not aided in their psychological adjustment with such things as a loss of limb(s) due to amputation. It was further discovered, in a study by Frain, Tschopp, and Bishop (2009), that improvements in self-efficacy and self-management skills were increasingly correlated with positive PR perceptions rather than improvements with physical functioning. Empowerment gained via the increases in self-efficacy and self-management skills was related to increased satisfaction with QOL and adjustment to disability, and was noted to having no significant ties to the actual physical outcomes following the completion of PR. Such findings support other arguments against the medical model of

disability as the significant variable in recovery was not seen as improvements in physical capabilities nearing or equating that of individuals without disabilities, but as improvement in psychological aspects that allow a person to feel more in control of their lives.

Art Therapy

While there is a lack of research published regarding art therapy (AT) and its implications on the recovery process associated with acquired physical disabilities, AT posits itself as an avenue that can aid in such a process as it has been found to improve mental health aspects commonly experienced with acquired physical disabilities including depression (Gayman, Brown, & Cui, 2011; Gayman, Turner, & Cui, 2008; Nosek et al., 2008; Turner & Noh, 1988), grief and loss (Niemeier, et al., 2004), and struggles with identity (Quinlan & Bates, 2008; Zhang & Haller, 2013). AT is noted as “a mental health profession in which clients...use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.” (American Art Therapy Association, 2015). There are two approaches to AT consisting of the clinical model and the studio model. The clinical model of AT is seen to utilize a relatively fast paced process of making art that typically incorporates a specific task and/or theme to be explored, and includes a discussion of the finished product in which feedback is obtained from an art therapist. In contrast, the studio model encourages a more free approach to art making as it lacks explicit directives and requirements for ensuing discussion, providing an increased amount of time to work and become more deeply enveloped in the process (Malchiodi, 1995). While the two models approach improving mental health in different ways both have been found to be beneficial for psychological health.

Art therapy and psychological factors. In looking at the studio approach of AT, McGraw (1995) summarized ten main ways in which the art making process was seen as beneficial for individuals facing psychological stressors. One such way was in the art making processes' ability to approach difficult issues in an indirect manner through metaphorical expressions and nonverbal interactions. This indirect approach was deemed as being less threatening than traditional talk-therapy techniques making it easier for individuals to engage in. McGraw's (1995) second and third points both reference art making's ability to grant an individual control over the pace and decision making made in sessions. In having such control the pressure to perform is seen to be lessened allowing the individual to proceed at a rate in accordance with their needs. Art making was also seen by McGraw (1995) to be a way to overcome the feelings of loss as art products exist as tangible objects external to the individual that can exist beyond the present moment, in essence, creating a sense of permanency. McGraw (1995) further notes that art making provides an alternative form of self-actualizing expression in comparison to verbal expression; provides the opportunity for self-reflection both through the process and products of art making; provides a shared experience between group members that combats feelings of loneliness; provides the ability to accommodate to disabilities and issues with gradual confrontation and acceptance; avoids the pressures of and defenses against feared and/or undesired traditional psychiatric modalities of therapy; and possesses the ability to create multiple experiences of adapting to a situation through both the manipulation of materials and the learning of appropriate techniques with various mediums.

McGraw's (1995) ten stipulations have been reflected in other bodies of research, such as Russell's 1995 study, which found that AT provided the opportunity to express the various feelings of frustration, anger, sadness, and joy. Russell (1995) also noted that AT assisted with

the setting of new personal goals as art engagement aided with the coming to terms with the losses and gains experienced due to having new physical limitations. Participants in Russell's (1995) study viewed art making as a relaxing distraction from their physical pain that provided both predictability and control, and was further seen to function as a source of pride as it offered tangible products that validated their accomplishments. Such experiences were seen to assist in the reintegration of individuals' body-image as they adjusted to their new functioning capabilities while also creating a permanent record of their thoughts and feelings. Czamanski-Cohen et al. (2014) explain that tangible art products are beneficial for recovery because they provide a physical incarnation of thoughts and feelings that are easier to utilize than thoughts left loosely imagined in one's head. Due to their physical nature, art products provide a way in which to examine and manipulate mental imagery in an effort to change maladaptive beliefs and their associated behaviors as they provide new insights and ways of coping. In Czamanski-Cohen et al.'s (2014) study, participants found that the process of making art assisted them with defining and focusing on what they were specifically struggling with and with developing concrete solutions to such issues. As such solutions were played-out through the engagement with art, moments of success were experienced encouraging attempts of implementing such new strategies in real life leading to decreases in distress and increases in well-being.

Research also exists specifically in support of McGraw's (1995) postulation that AT creates a positive shared group experience as Heenan (2006) and Drapeau and Kronish (2007) reported that group AT sessions decreased feelings of loneliness through peer support and increased socialization. Brooke (1995) and Ponteri (2001) add to this that group AT interactions improve general and social aspects of self-esteem which have been shown to be constructs that positively influence the incorporation of a positive disability identity (Mejias et al., 2014; Li &

Moore, 1998). Chandraiah, Ainlay, and Avent (2012) further add to the benefits of group AT by reporting that participants in a brief AT outpatient group saw significant decreases in depression that coincided with increases in interpersonal communication and assertiveness.

Drapeau and Kronish's (2007) study further supports McGraw's (1995) findings of AT providing an easier style of engagement than more traditional verbal therapy approaches, as they discovered art engagement to allow for personal reflection that decreased stress and suicidal ideation. Such changes were seen to occur as art engagement allowed for reality testing of personal capabilities alongside safer feelings of self-expression. Heenan (2006) adds to the notion of AT allowing for a safe space for personal reflection by reporting that AT fosters empowerment, confidence, and self-esteem in individuals while decreasing their sense of vulnerability.

Many studies regarding the specific use of clay in AT have also worked to support McGraw's (1995) postulations as they demonstrate parallels in art making's ability to affect psychological aspects related to physical disabilities. De Morais et al. (2014), for example, found that the manipulation of clay decreased levels of both depression and anxiety while improving scores of relaxation. Physical engagement with the clay was viewed as facilitating experiences of adapting to situations as participants learned how to better work with the clay in order to create a finished product. Such experiences functioned as opportunities to learn and integrate new abilities into one's life much like Czamanski-Cohen et al.'s (2014) finding that the practicing of new coping strategies via art engagement led to increased probabilities of using such solutions in real life. Clay was further determined to be a beneficial modality as Yaretzky and Levinson (1996) found that participants in an AT clay group experienced high levels of enjoyment and socialization reflecting Brooke (1995), Drapeau and Kronish (2007), Heenan (2006), and

Ponteri's (2001) studies that demonstrated group AT experiences as positively increasing social engagement.

Art therapy and cognitive behavioral intervention. Connecting back to AT's ability to provide an easier style of engagement than more traditional verbal therapy (Drapeau & Kronish, 2007; McGraw, 1995), AT has been shown to also be capable of paralleling techniques within Cognitive Behavioral Intervention (CBI), a treatment approach shown to aid in the psychological recovery following a traumatic experience (Sarid & Huss, 2010). Smedema, Catalano, and Ebener (2010) report that when individuals become focused on the negative effects that an acquired disability creates they minimize the positive abilities they remain to have. In focusing on what they can no longer do, individuals devalue their lives preventing themselves from accepting and adapting to their new physical state. It is these and other dysfunctional thought patterns that CBI interventions aim to identify and alter in order to develop more positive coping strategies. By focusing on the reduction of negative responses related to acquired physical disabilities, such as stress, catastrophizing thoughts, and dysfunctional attitudes, CBI aims to positively influence feelings of self-worth and subjective well-being (Smedema et al., 2010).

Within CBI, reframing is a technique employed to alter the dysfunctional and maladaptive thought patterns that an individual has regarding their state of being (Smedema et al., 2010), and is a technique that Sarid and Huss (2010) found AT capable of facilitating. Whereas reframing conducted in more traditional verbal therapy approaches requires an individual to mentally recall and mentally adjust a disturbing thought and/or image, AT allows for the creation of a tangible representation of such thoughts and/or images that can be examined and physically adjusted through manipulation with art materials. Such interactive contact with one's thoughts echoes the findings of Czamanski-Cohen et al. (2014) which described the active

manipulation of art pieces as a way to develop and practice new coping skills to increase one's well-being.

Sarid and Huss (2010) further postulate that having tangible incarnations of one's thoughts works to benefit the CBI process of correcting and connecting the fragmented memories that can exist in relation to a traumatic experience. AT can aid with such a process as the incarnations of segments of memories can be altered and physically rearranged to create a more accurate representation and timeline of the event. Sarid and Huss (2010) then suggest that tangible incarnations can aid with the CBI process of imaginal exposure as the creating and exploring of the physical art pieces increases the number of senses involved in the process creating a fuller sensory experience. Such increased incorporation of the senses works to not only engage more areas of the brain than traditional verbal therapy, but to also provide a regulating process in which excitatory reactions can be channeled to prevent excessive arousal caused by the stimulating thoughts and memories (Sarid & Huss, 2010) creating a better sense of control over such reactions (Bitonte & De Santo, 2014).

Art therapy and physical rehabilitation. Despite the minimal research on AT's specific role in the treatment of psychological issues related to acquired physical disabilities, research does exist on AT's role within PR. In a study conducted by Symons, Clark, Williams, Hansen, and Orpin (2011), for example, five themes were discovered within the role that AT played in participants' overall experience in PR: meeting PR goals, using time, enjoyment, regaining confidence, and engagement in future activities. The theme of "meeting PR goals" was seen to pertain to improvements noted in cognitive, social, psychological, and physical skills; which art making was seen to benefit as participants experienced opportunities to improve physical functioning and rebuild stamina through creative, repetitive, task-specific movements. Findings

in other studies have mirrored such outcomes: Yaretzky and Levinson (1996) found that the use of clay engaged bilateral sensorimotor skills; Alyami (2009) found that the making of collages and paintings improved gross motor skills for individuals with Multiple Sclerosis and quadriplegia; Barker and Brunk (1991) found the use of tools such as scissors and glue sticks to improve fine motor skills; Reynolds (2012) found the physical engagement with materials to increase the limited use of stroke-affected limbs.

While PR itself primarily deals with improving the physical abilities of individuals, AT was seen to positively affect both the physical and psychological experiences of individuals in PR. Symons et al. (2011) found art making to also improve social, cognitive, and psychological skills through the meeting of new people and engagement in non-illness related conversations. Such findings mirrored reports by Drapeau and Kronish (2007), Heenan (2006), and Russell (1995) as they discussed art's positive effects on socialization. Symons et al.'s work further highlighted such earlier studies in also pointing out art making's ability to improve the practicing of sustained attention and concentration, the experiencing of emotional release, and the practicing of frustration and failure tolerance when working with materials. Symons et al.'s (2011) second theme of "using time" further suggests AT having benefits on the psychological aspects involved in PR as the making of art was viewed as a self-directed task found rewarding through its spending of time in a meaningful manner. Such time was found to be made easier to recognize and relish as meaningful art products functioned as tangible markers of such spent time, and as individuals experienced approval from friends and family in having art pieces to present and share.

Symons et al.'s third theme of "enjoyment" yet again supports other research (Griffiths, 2008; Spandler, Secker, Kent, Hacking, & Shenton, 2007) as art making in PR was found to

provide experiences of success through the exceeding of expectations of oneself, experiences of pride and satisfaction in the ability to produce art pieces, and as it provided opportunities for creativity and distraction from the mundane and negative aspects of life with a physical disability. Symons et al.'s (2011) final two themes of "regaining confidence" and "engagement in future activities" work to sum art making's ability to improve self-esteem and encourage participation in other activities, reflecting Li and Moore's (1998) finding that self-esteem is crucial in recovery following the acquisition of a physical disability. In all, Symons et al.'s (2011) five themes demonstrate art making within PR to be a positive experience that can aid in the exploration of self-identity following an acquired physical disability, as an experience that maintains focus on what individuals can do instead of on the deficits they now face, and as an experience that helps drive improvements in both psychological health and physical capabilities.

Art therapy and chronic illness. When searching for articles on AT and physical disabilities related to trauma, a majority of articles located focused on disabilities in relation to chronic illnesses such as cancer (Reynolds & Prior, 2003; Svensk et al., 2009) and multiple sclerosis (Reynolds & Prior (2003). While such studies do not speak directly to how AT can impact the recovery process of a trauma related physical disability, their findings are relatable and worth mentioning as they demonstrate AT assisting in the acceptance of a loss in abilities and the physical changes caused by circumstances outside of one's control, and as they demonstrate AT's ability to modulate psychological aspects related to such changes.

In a study by Reynolds and Prior (2003), for example, interviewed participants affected by conditions such as multiple sclerosis, arthritis, chronic fatigue syndrome, and cancer, reported that AT improved their health and overall well-being as it helped to fill occupational voids, created a distraction from thoughts focused on illness, allowed for the expression of grief,

promoted the experience of flow and spontaneity, helped to maintain a positive sense of identity, and increased available social networks. Svensk et al. (2009) add to the benefits of AT in relation to cancer as they found that individual AT sessions with women with breast cancer experienced significant improvements in their QOL as their anxiety, depression, and stress decreased while their social functioning and coping resources increased. Art making was seen to help maintain a positive identity for the women as it facilitated the processing of pain by providing an opportunity to reflect on and legitimize personal experiences through image making. The ability to allow individuals with cancer to express themselves outside of a group context was further evidenced by Bar-Sela, Atid, Danos, Gabay, and Epelbaum (2007) who reported that individuals with cancer who did not enjoy a group setting still benefited from the art making process in individual settings. Such engagements produced decreased levels of depression, emotional distress, and levels of fatigue when coping with the strains of chemotherapy.

Specific to the studio approach of AT, Hunt, Nikopoulou-Smyrni, and Reynolds (2014) found that art making provided individuals with multiple sclerosis experiences of positive feedback and feelings of self-worth through the experiencing of achievement in having created tangible products. Finished products functioned as affirmations that the individuals were still capable of meaningful endeavors in a life with physical restrictions, not unlike Symons et al.'s (2011) finding that time spent making art was time spent meaningfully with art products signifying accomplishments made. Hunt et al.'s (2014) study further parallels research on recovery following changes to an individual's physical status (Drapeau & Kronish, 2007; Heenan, 2006; McGraw, 1995; Russell, 1995; Spandler et al., 2007; Symons et al., 2011) as they went on to state that art making was found to provide individuals with an avenue to interact

socially, develop new skills, establish a new identity, and fill otherwise vacant periods of time that existed due to the loss in ability to perform previous endeavors.

Such outcomes in relation to AT and chronic illnesses speak to AT's ability to aid those adapting to an acquired physical disability as such individuals have also been shown to experience similar situations of occupational voids (Kerra, Dattilo, & O'Sullivan, 2012; Turner & Turner, 2004), threats to a positive identity (Quinlan & Bates, 2008; Zhang & Haller, 2013), grief over lost abilities and opportunities (Niemeier et al., 2004), and limited social networks (Nelson, & Gruver, 1978). As AT has been found to aid chronically ill individuals' processes and improve such conditions despite physical symptoms and limitations, it can be suggested that AT then has the ability to assist individuals with physical disabilities with these same tasks as well.

Conclusion

The acquisition of a physical disability following a traumatic event is an experience that not only effects an individual's physical capabilities, but their psychological well-being as well as they are faced with identity issues (Mejias et al., 2014; Zhang & Haller, 2013), depression (Gayman et al., 2008; Gayman et al., 2011; Nosek et al., 2008; Turner & Noh, 1988), and anxiety (Niemeier, et al., 2004) amongst many other potential stressors. Despite a lack in published research speaking directly to the potential benefits of AT on the recovery efforts following an acquired physical disability due to trauma, relatable research on AT's ability to positively affect mental health stressors commonly associated with acquired physical disabilities (Gayman et al., 2008; Gayman et al., 2011; Niemeier, et al., 2004; Nosek et al., 2008; Turner & Noh, 1988) demonstrates the possible positive influence AT may have on one's recovery efforts. Research has shown AT to be capable of mirroring and enhancing CBI interventions commonly employed to treat trauma related issues (Sarid & Huss, 2010), and has shown AT to be capable

of improving physical and psychological issues faced by individuals with chronic illnesses (Hunt, et al., 2014; Reynolds & Prior, 2003) and by individuals participating in PR programs (Symons, et al., 2011; Yaretzky & Levinson, 1996). Because of these findings it may be suggested that AT could be a an effective component in post acquired physical disability recovery efforts as it has the potential to address both physical and mental health stressors being faced by individuals.

Research Approach

A qualitative research approach was utilized in this study as it allows for the exploration and understanding of a social or human problem from the level of the individual and/or group (Creswell, 2009, p. 4). Qualitative methods provide insight into an individual's or group's unique experience, allowing for the exploration and adaptation of the studied intervention in an attempt to increase its effectiveness with clients in the future (French, Reynolds, & Swain, 2001, p. 11). The explorative nature of qualitative research also allows for the possibility of discovering unexpected findings, potentially showcasing unforeseen benefits and/or problems with the intervention being studied (French et al, 2001, p. 11), adding to the understanding of the intervention's limitations and effectiveness.

One qualitative method that allows for obtaining information on a topic from multiple participants at one time is the focus group. Focus groups facilitate the discussion of a topic amongst multiple individuals permitting the validation and challenging of fellow participants' comments, the clarification of others' comments via the asking for explanations of stated opinions, the comparison of experiences between individuals, and the exchanging of information through the seeking and giving of advice (Lambert & Loisel, 2008). The researcher chose to utilize a focus group in gathering data to gain a better understanding of the topic from individuals who have firsthand experience incorporating the art making process in their recovery efforts.

Method

Introduction to Methods

A qualitative research approach was utilized to collect the data used in this study. Specifically, a focus group was used to obtain information and personal testimonials referencing the role of the art making process in the recovery process of individuals who had developed a physical disability following a traumatic experience. The following section defines terms that may apply to this research study. The second section outlines the design of the study including information regarding the sampling, gathering of data, and analysis of data.

Definition of Terms

Body-esteem: “the overall positive or negative evaluations of the body” that is thought to be “affective” as it “denotes the satisfaction people experience with their bodies.” (Mayer & Eisenberg, 1988).

Disability: “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.”

(<http://www.pediatrics.emory.edu/divisions/neonatology/dpc/Impairment%20MX.html>)

Disability Culture: refers to the shared experience of oppression that is accompanied by the art, humor, history, evolving language and beliefs, and values and strategies for surviving and thriving of those with disabilities (Dupré, 2012).

Disability Identity: one’s conception of themselves, allows for expressions of individuality in personal characteristics and roles, accounts for group affiliations (Dunn, & Burcaw, 2013)

Focus group: qualitative method that allows for obtaining information on a topic from multiple participants at one time (Lambert & Loiselle, 2008)

Medical model: emphasizes disabilities as biological defects that require medical interventions, that have no connections to societal physical or attitudinal barriers; the goal is to make levels of functioning conform to society in an attempt to assimilate (Longmore, as cited in Robertson, 1994).

Physical disability: “condition where a person experiences significant deviation or loss in their body function or structure that results in physical limitations in their physical activity that may affect their perception in life, depending on the context within which they live.” (Taleporos & McCabe, 2005, p.638).

Physical rehabilitation: aims to improve the ability to move, to reduce pain, and to restore function and prevent further disability (Malchiodo, 2013, p. 21).

Quality of Life (QOL): “an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (<http://www.ncbi.nlm.nih.gov/pubmed/8518769>)

Rehabilitation: aims to enable those with physical disabilities to obtain and/or maintain a life within the community, to live independently, and to be able to partake in education opportunities, the labor market, and civic life (World Health Organizations, 2015a, para. 1).

Self-esteem: “the summation of positive self-attitudes and competencies” (Li & Moore, 1998)

Supercrip: “a person who has superhuman capabilities because they have a disability” (Quinlan & Bates, 2008, p. 75)

Design of Study

Sampling. 5 adult subjects were selected from a pool of current participants at Artists for Trauma (AFT) having met the criteria of having a physical disability due to a trauma experience. AFT is a non-profit organization that pairs trauma survivors with an artist from an art discipline of

interest to the survivor who provides support through the art making process and an ongoing relationship. AFT proposes that the art making process is a means to expedite recovery through artistic expression and human connection that helps the trauma survivor process complex emotions, regain confidence, and build self-acceptance following a traumatic experience. Upon first providing the primary investigator (PI) with written permission to recruit participants through AFT, the organization's representative/Founder/Board President/Executive Director referred qualifying candidates to the researcher. During the focus group one participant revealed that they did not create art (i.e. paint, draw, collage, etc.) during their recovery, identifying their form of art as "acting" and "singing." The participant was permitted to maintain participation during the focus group, and was included in the data analysis for the current study, due to the participant's influential role in the focus group and their ability to connect with and reflect on the art making process engaged in during the focus group.

Possible biases may exist in that the PI is a volunteer at AFT which may have influenced the organization's representative/Founder/Board President/Executive Director to refer candidates whom she felt might provide the PI with positive reviews of the art making process in an attempt to provide the PI with positive findings. The organization's representative/Founder/Board President/Executive Director may also have referred candidates whom she felt might provide positive feedback as a way to create positive support regarding her program at AFT. The participants' engagement in a structured art program through AFT may also create bias, as participants were provided access to art supplies and work spaces, as well as with assistance in how to use supplies and adapt to their physical limitations during art making. Such services may have influenced more positive feedback regarding the art making process as participants experienced increased support, both with available materials and with adapting to limitations, when engaging in art making as compared to other disabled

individuals who may have lacked such amenities and opportunities in their recovery efforts and/or engagement with art.

Gathering of data. Data was gathered in a focus group facilitated by the research mentor (Dr. Paige Asawa, PhD, MFT, ATR-BC) and observed by the PI. Participants gathered at the LMU Marital and Family Department Art Studio for 1.5 hours on a Saturday and were provided free parking. LMU's campus and parking, as well as the Art Studio used, are ADA (Americans with Disabilities Act) accessible. The focus group started late due to 1 participant's complications with transportation. Participants were provided consent forms prior to focus group activities starting. Following the signing of consent forms, participants were asked to create a piece of artwork reflecting on the role that art making has played in their recovery process of their altered physical status due to a traumatic experience. Participants were provided with the following art materials as options for creating their piece: oil pastels, slick sticks, collage images, found objects, paper of various sizes and colors, masonite boards, paints and brushes, markers, pencils, glue, tape, scissors, clay. Participants were asked to bring and brought the assistive equipment necessary for them to engage in art making. Upon completing their art pieces participants discussed the piece made and the impact that art making has had in their processing of their altered physical status due to the traumatic event experienced. The research data consists of the artwork and transcript of the discussion during the focus group.

Analysis of data. PI debriefed with research mentor to make note of key themes/aspects/statements/feelings following completion of the focus group. PI submerged self in transcription process and looked for themes and key aspects from focus group discussion. PI divided the text into segments of information, labeled the segments of information with codes, reduced overlap and redundancy of codes, and collapsed codes into themes. PI independently reviewed artwork made during focus group then reviewed art work with research mentor/group to confirm and

broaden observed themes and key aspects. PI correlated observations made from focus group discussion and focus group artwork.

Results

Presentation of Data

The focus group was facilitated by Dr. Paige Asawa, PhD, MFT, ATR-BC, who has extensive experience providing art therapy and facilitating research focus groups. The facilitator, the researcher, and five participants were present in the focus group and four support family members and friends gathered socially in a nearby area. Due to one participant's late arrival, caused by transportation difficulties, the researcher had the added opportunity to spend time engaging in casual conversation with three of the participants while waiting in the studio. During this roughly 20 minute period, the researcher listened while three participants shared stories regarding their personal experiences with facing societal challenges due to their physical disabilities, as well as stories about people and friends the participants knew who also faced struggles due to physical disabilities. All three participants were extremely candid and open during the conversation. Lots of laughter was shared amongst the participants and the researcher as descriptions of "ridiculous" encounters with and comments from able-bodied individuals were shared pointing to the "awkward" and insensitive perceptions that some individuals have towards those who have physical disabilities.

The 4th participant who had also arrived on time chose to spend the time in-waiting conversing with a friend in a separate location within the Art Therapy Suite, and did not engage in the pre-focus group conversation with the researcher and three other on-time participants. The 4th participant and his friend knew each other through their relationship through the Artists for Trauma (AFT) program, but had not arrived together at the focus group location.

Once the 5th participant arrived introductions were made by all participants which included the telling of each individual's story regarding the incident that led to their development

of a physical disability. The researcher then introduced herself and explained the personal relevance that the research topic had by sharing her family's experience with having a family member who developed a physical disability due to a traumatic car accident. The researcher also shared how she had observed this family member maintaining and benefiting from her engagement with the art making process. The facilitator then spoke and shared her own personal connection to the topic by sharing the story of having grown up with an older brother who was a quadriplegic due to a car accident that he was involved in when she was very young.

Upon introductions being completed, consent forms were distributed and explained. During this time one participant (F) shared that his form of art was "acting and singing" and not any of the qualifying forms of art making such as painting, drawing, or sculpting. The participant (F) was allowed to continue his involvement in the focus group, and was included in the data analysis, due to his influential role in the focus group and his ability to connect with and reflect on the art making process engaged in during the focus group. Upon collecting the signed consent forms and providing each individual with a copy of the Experimental Subjects Bill of Rights, the facilitator guided participants through two mindfulness exercises. The first exercise sought to have individuals reflect on what it meant to develop a physical disability following a traumatic experience, while the second sought to have individuals reflect on the role that the art making process had in their individual recovery efforts.

During the next stage of the focus group, participants were asked to create an art piece that represented the overall impact that art had had in their recovery efforts. Participants were informed that they could focus on a single thing (i.e. something art making helped them to understand better) or anything they wanted to share about the role art had in their recovery. An array of materials was made available including but not limited to oil pastels, slick sticks, collage

images, found objects, paper of various size and color, masonite boards, paints and brushes, markers, pencils, glue, tape, scissors, and clay. Once they had completed their pieces participants went around the table one at a time sharing their piece and its significance. Participants were encouraged to make comments and ask questions of each other once the individual had finished explaining their piece. During the art making process all 5 participants engaged in ongoing conversation with brief moments of silence.

Participant #1 (J) used pencil, markers, and a sheet of 12"x18" white drawing paper to illustrate a timeline of his life since the development of his disability (Figure 1). Pencil was used to illustrate six images that each represented a different stage in the participant's life post disability. Markers were used to represent the transitions between such stages, as represented by mathematical equal signs, as well as the final stage which appeared as written words versus an illustrated image. The images were presented in a sidewise "U" formation and were read left to right starting with the bottom row, and then right to left across the top row.

When describing his piece J chose to pass his paper around the group while he spoke. J stated that the image of a camera represented his taking up photography as a hobby to get himself out into social situations more frequently. Photography was also reported to be the catalyst that caused J to return to school leading to other opportunities and experiences which lead to J becoming an ADA (Americans with Disabilities Act) advocate.

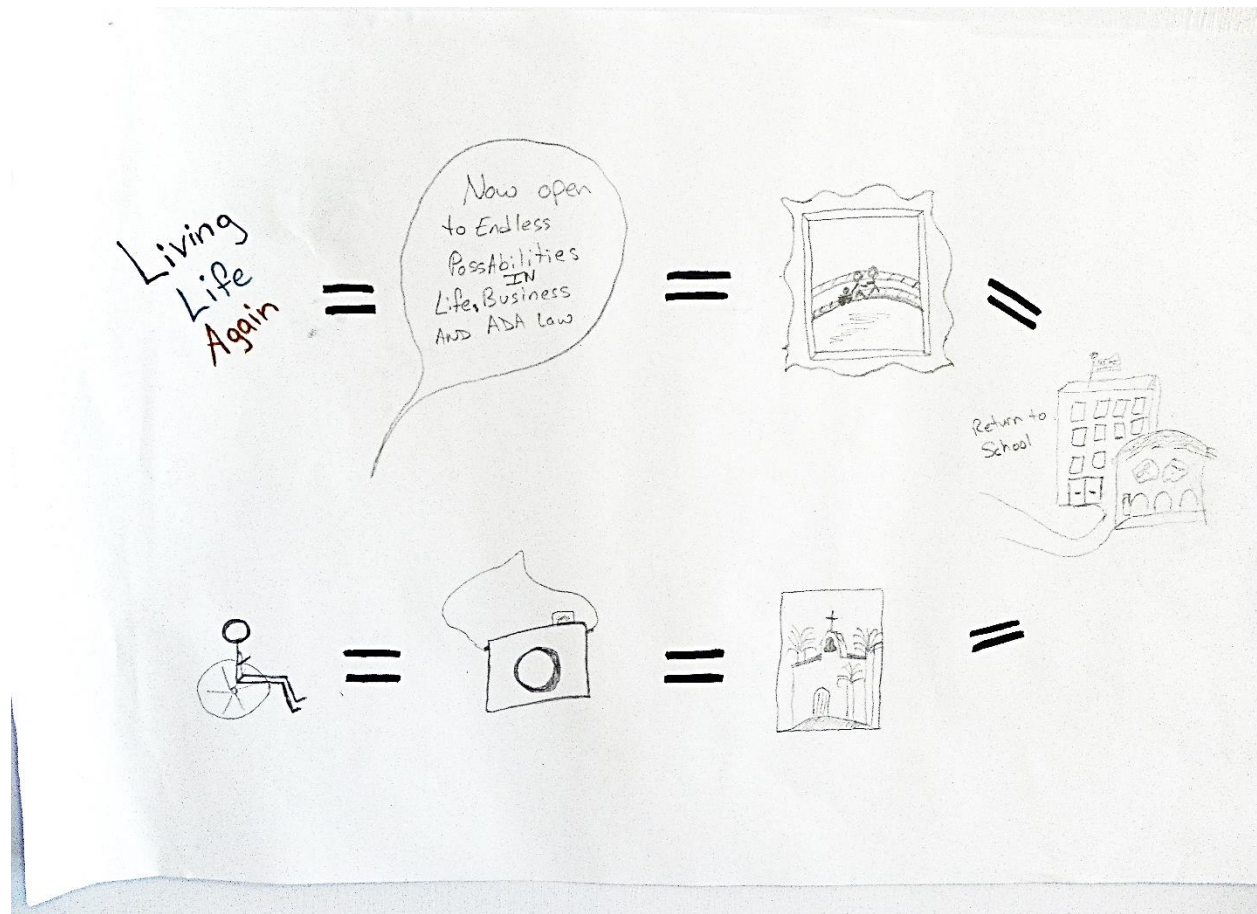


Figure 1. J

Participant #2 (C) chose to use a 12"x16" masonite board and oil pastels to create an image of a tree amongst a multicolored sky and multicolored ground/base (Figure 2). The tree is nearly centered, slightly placed to the left of the median, and is accompanied by the image of a red-orange crown residing on the ground near the right edge of the board. Upon first hearing the directive, C had joked that she was done before making any marks on the board stating that "it's blank" because "it (art making) makes me forget" about having a disability. After drawing her entire image with oil pastels C requested something to smudge the pastels with, so as to blend the marks to make them appear smoother, and was provided with paintbrushes and water.

When discussing her piece C stated that the tree was the "tree of life and death" and that the crown was a symbol of her having held the title of Ms. Wheelchair California. C referred to

the crown as “what lit me on fire,” referring to her title of Ms. Wheelchair California having been the catalyst that started her work as an ADA advocate. C reported that painting is her preferred form of art making and that when she paints she experiences a release as “nothing else matters” while she focuses completely on the act of painting. Such focus was reported as causing everything else, including thoughts and feelings related to pain and other aspects connected to having a physical disability, to fade away from consciousness.

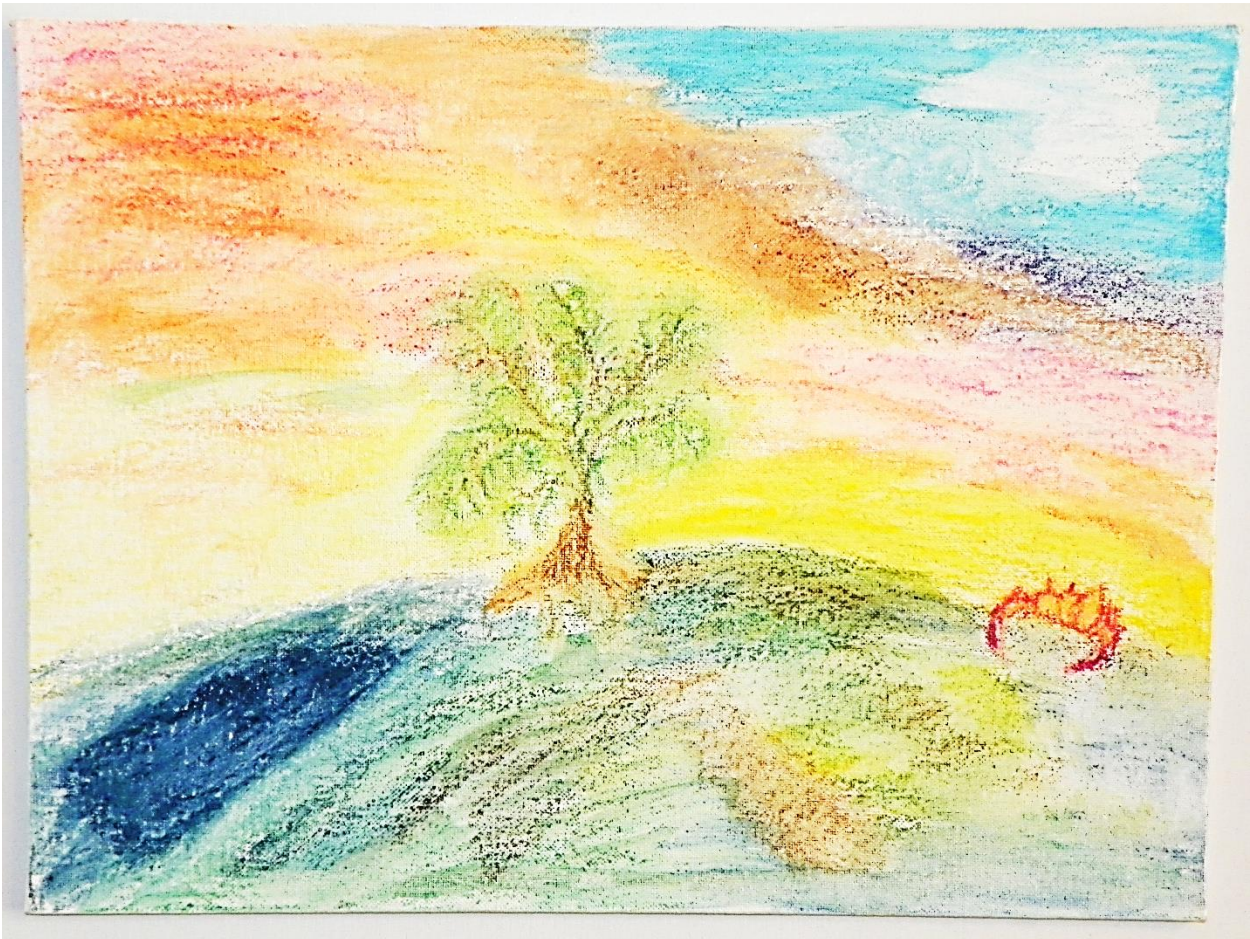


Figure 2. C

Participant #3 (F) used a 12”x18” piece of blue paper, markers, and collage images which he attached with a glue stick (Figure 3). F had hesitated to leave the table and transition to the supply area, and took a markedly longer amount of time to select his art materials being the last to return from the supply area to begin working. F was the most verbal throughout the entire art

making period and continuously engaged the other participants in conversation both sharing personal information and asking questions of them. When working, F first cut out and arranged all of his collage images before gluing them down. He then used markers to add illustrations of hearts in all areas of the page, to add arrows that connected the three separate collage images of people, and to add text to explain the meanings of images (i.e. “inside” was written with an arrow pointing from the text to an image dictating that the image represents how F feels inside; “outside” was written with an arrow pointing from the text to an image dictating that the image represents how F feels on the outside). F was one of only two participants who signed their piece but did so not by signing his own name, but by signing the name of James Dean whom he had mentioned wanting to be like several times during the focus group.

While discussing his piece F stated that the three collage images of people all represented him and that he wasn't sure why he had chosen images of “black people” to represent himself (F is Caucasian). The image that appeared furthest to the left was of a happy child and was described as representing how F feels on the inside as he feels like he is “dancing” on the inside. The figure furthest to the right was described as representing how F feels bound by his disability on the outside, and was the image of a doll's body ensnared in cords. F altered this image by cutting out and attaching the face of a child on top of the doll's original face, however, F did not comment on the meaning of this alteration. The image that appeared in the middle was of a man standing with his back towards the viewer with his arms stretched out one reaching towards each of the other two images. F described the image as a version of himself being “strong (and) pulling it all together,” and described the overall imagery as his attempt to bring together the two realms of his life—his restricted physical abilities and the spirited sense of self he feels on the inside. F commented that the art making process during the focus group had allowed him to

express what was happening for him on the inside, referring to the thoughts and feelings he had regarding his experience of trauma and recovery.



Figure 3. F

Participant #4 (R) chose to use a 12"x16" masonite board and slick sticks to create his piece (Figure 4). R did not hesitate to leave the table to look over the selection of art supplies, and was rather quick in choosing what he wanted to use. R commented on his preference to paint and to use his iPad and stylus when making art at home due to being able to control the stylus extremely well despite the limited functioning in his hands (R is quadriplegic). R also commented that his being late to the focus group probably stemmed from his having been painting earlier in the morning, supporting a prior statement that he actively creates art in his personal life. R was the only participant to sign his piece with his own name and did so by signing on the front of his piece.

R's piece was divided into distinct sections by black lines drawn approximately 1" in from the edge of the board creating a frame within the piece. The frame was then further divided by short black lines drawn from the corners of the board to the corners of the frame, creating four distinct sides and one central rectangular shape. In sharing his piece R stated that the imagery moved from the left side of the board towards the right, and that it represented his "world in an interdimensional space." The notion of interdimensional space was explained as referring to the different dimensions that occur in one's life such as being "in high school," being an "adult," and having a "career." The pane furthest to the left is loosely filled with black lines and was described as R being busy "bustin my butt" while working in his career. Red colored lines that appear on the left side of the central rectangular pane were described as representing the car accident that led to R's development of a physical disability. Also relating to the accident is a mass of curved black and brown lines that fill the central rectangular frame and the left edge of the bottom pane. The top portion of the mass has an enclosed circular shape in which the bottom portion is more saturated with color than the upper portion. Within this shape there is a solid upward angled mass of brown and purple that extends out of the darker bottom up into the less filled space of the top portion. R described this upward angled form as "me reaching or kinda trying to squeeze out into life again which is light." R stated that the top pane and right side of the board were not filled with a design or any color as they represent things in life that have not occurred yet and "other dimensions to explore."

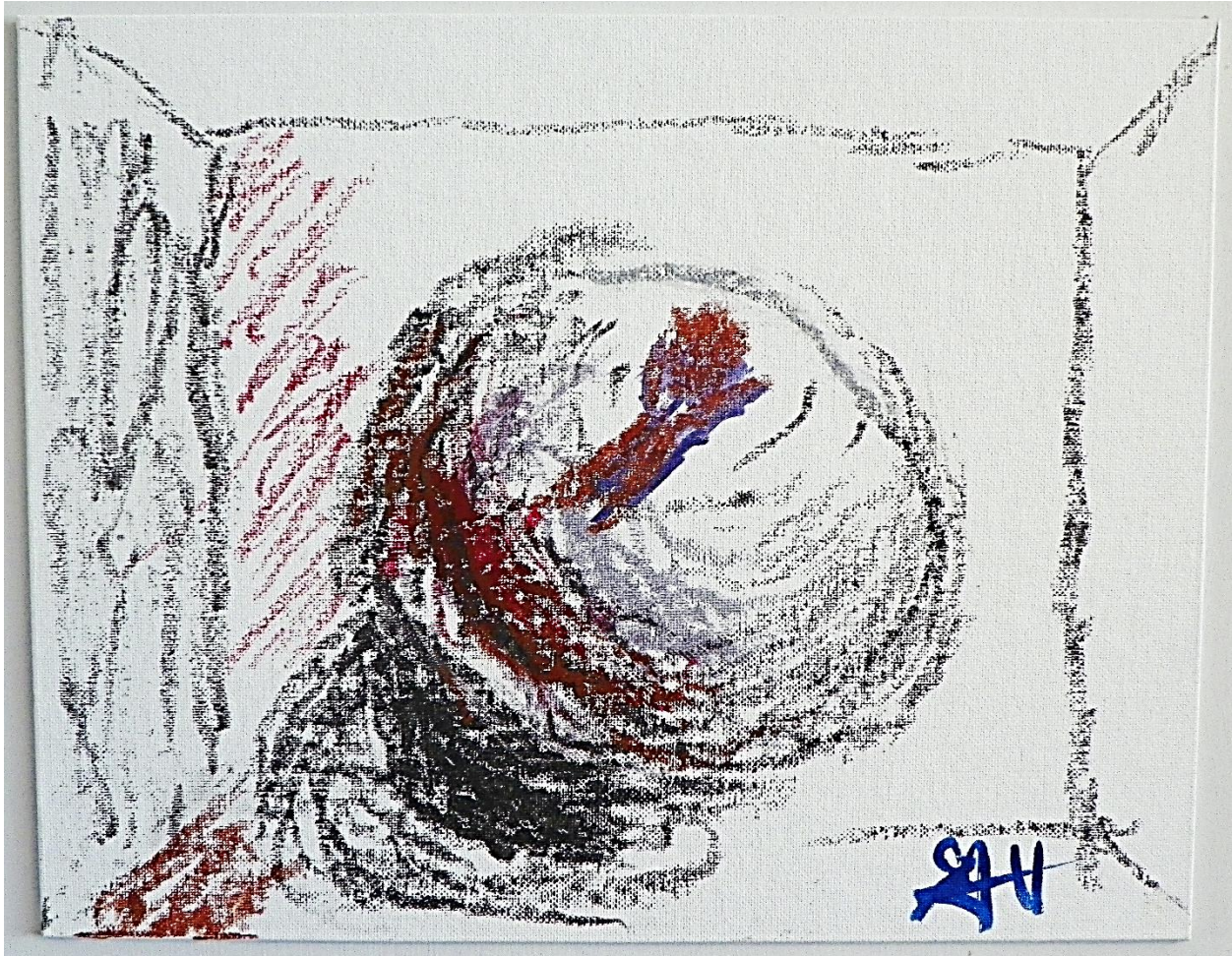


Figure 4. R

Participant #5 (A) used 12"x16" masonite board, slick sticks, collage images, found objects (i.e. sticks, sea shells, small rocks), flat metallic letter beads, a plastic red feather, pre-cut foam shapes, glue stick to attach collage images, and a hot glue gun to attach the more weighted items (Figure 5). A immediately got up from the table and looked over the available supplies taking her time to observe all options before selecting those she wanted. While working A conversed with the other participants periodically, but spent most her time engaged with the facilitator who provided A with assistance due to her physical limitations (A is a quad-amputee and uses prosthetic arms and legs). A was able to use the slick sticks once aided with them being placed at the end of her prosthetic arm/hand. The facilitator assisted A with this task, and with

the gathering of materials. The facilitator also assisted A by cutting out the collage images and arranging and gluing both them and the found objects on the masonite according to A's instructions. While working A began to narrate to the facilitator the meaning behind some of the imagery she was creating.

When sharing her piece A had the facilitator hold it up for the group to see. A stated that the collage image of a woman walking on the left side of the board represented her "life before my new normal." Moving towards the right, the image of a dark colored dog at the bottom of the board was described as representing the darkness and sadness that A felt during her experience. A then described the feeling of "shame and judgment" that felt like "being burnt on a stake" due to "comments" and "insensitiveness" of others. These feelings were portrayed in A's piece by a human shaped figure made from sticks that was standing in a fire formed by the rocks, shells, and red feather A had amassed in the bottom right corner of the board. In her piece, A utilized 2 styles of clouds of which those pertaining to her life before developing a physical disability were drawn with slick sticks. These clouds were explained as representing the happiness she felt in her life (overall blue shape) which contained elements of darkness (black spots within the blue) that she had not recognized as existing prior to her trauma experience. The clouds that pertained to her life after developing a physical disability were created by gluing brightly colored precut foam hearts on top of black and white striped patterned paper that the facilitator had cut into cloud-like shapes. These clouds were explained as being dark overall (black and white patterned paper) as they represent the struggles she now faces. The foam hearts were then explained to signify the many elements of "love" in A's life that diminish the overall dark feeling. A stated that the clouds symbolized the "silver lining" aspect of her current status as she views her trauma experience as being responsible for her becoming cognizant to how much "love" exists in her

life. A added that “those dark clouds have truly made me into this incredible being that will never give up for no reason period,” commenting on her trauma experience also being responsible for the strengthening of her character.



Figure 5. A

Following the sharing of artwork, the facilitator asked participants to look at all of the pieces as they rested on the table and questioned what, if any, common themes and/or imagery the participants noticed. The facilitator also asked if participants had any comments to make about what they had seen and/or heard while listening to the others share about their pieces and individual experiences. The participants identified that all the pieces of artwork had a sense of progression/movement that went from left to right. It was also discussed that “gratitude,” “inspirational,” and “journey” were overarching themes in the artwork. In discussing art’s role in

his recovery, J stated in the discussion that he “was near suicide when I (he) got my (his) camera... When I (he) started taking photos all the thoughts of suicide went away.” J claimed that “art pushed me (him)” to feel more connected to the world and to continue searching for meaningful things to engage in and live for.

Analysis of Data

The data revealed several themes within the focus group participants’ artwork and discussion providing answers to the study questions. A prevailing theme was that of the art making process functioning as a means of self-expression that allows for the managing of stressors related to having an acquired physical disability. A second theme was that of art becoming an integrated component of individuals’ identities making it difficult for them to parse it out from their identity as a whole. Themes of duality and of space being divided and segmented to represent stages and/or different aspects of life were observed across all art pieces. Commonalities in artwork also included movement that progressed left to right, the inclusion of the self within the imagery, and the use of symbolism. A final theme observed by the researcher was that of the participants, some having just met, immediately bonding during the focus group.

Self-expression to manage physical and emotional stressors. During discussion the focus group identified the art making process to function as an outlet for stressors felt in relation to having an acquired physical disability. C was able to explain this function by sharing that the act of painting allows her a “release” from the physical “pain” she feels due to her physical disability. She also reported on painting’s ability to provide relief from the meaning and limitations that both the medical labels placed on her and the adaptive equipment she uses create in her everyday life. C suggested that painting allowed for such “release” as it provided an

enjoyable activity that facilitated increased amounts of focus that allowed all other thoughts and feelings to “fade away from consciousness.”

J provided further insight on the matter as photography was credited as helping him to recover from his suicidal thoughts causing them to eventually stop altogether. Such an impact from the art making process was reported to exist as the act of partaking in “street photography” created increased opportunities for J to actively participate and engage in society preventing his previously engaged in isolative behaviors.

F’s commentary on how strongly he connected to engaging in the art making process during the focus group also supports the notion of art making providing an outlet from stressors related to having an acquired physical disability. In being able to express in his artwork the conflict felt between his inner spirit and desires and the limitations caused by his physical condition, F demonstrated how the exploring of thoughts and feelings through the creation of art allows for an affirming experience in being able to recognize and confront one’s thoughts and feelings.

Whereas F used art making to explore the multiple facets of his identity, A utilized the art making process to express her overall identity both before and after the trauma that led to her development of a physical disability. In doing so A was able to discuss the false sense of happiness that she felt prior to her trauma experience and the true sense of happiness she later came to recognize following her trauma experience. A’s art piece reflected her commentary as the image of her former self was created using a 2-dimensional collage image, while the image of her current self was created using 3-dimensional objects giving it a stronger presence and more prominence in the piece. In being able to reflect on and represent her past and present

identities, A demonstrated how the art making process can assist with the expression of thoughts and feelings related to identity formation as it provided tangible representations to be explored.

Integration of the role of art making into one's identity. During the presentation of artwork J surfaced as the only participant capable of following the directive and represented art making's role in his recovery in his piece. While C did not include a representation of art's role in her piece she, like J, was able to directly discuss the role that it played when sharing about her piece. F, R, and A struggled to focus on art making's role both in the pieces they made and in the discussion of their pieces. This was a difficult observation to sit with as the intention of the focus group was to ascertain the specific role that art making played for the individuals as they navigated their recoveries. Following analysis of the data, however, it became apparent that the individuals were not outright avoiding or dismissing the topic, but had integrated the role of artist so well into their identity as a whole that it was difficult for them to separate it from their sense of self to discuss as a tool that they had utilized. Despite not speaking to its effects on their recovery directly, F, R, and A were able to use the art making process engaged in during the focus group to tell the story of their trauma experience demonstrating art's ability to provide them with a tool for reflection and self-expression.

Duality within and segmentation of artwork. Duality was present in C's description of her "tree of life and death," in F's depiction of the conflicts between his "inside" desires and "outside" physical limitations, and in A's description of her old life and her "new normal" following the development of a physical disability. Segmentation was also present in the imagery that A used to depict her old life and her "new normal" as each facet took up approximately half of her board. Segmentation was also present in J's imagery of a timeline which broke his piece into seven individual images, in F's use of separated collage images to represent the different

components of his identity, and in R's use of five panes to represent different stages held or to be held in life. The use of duality and segmentation speak to the idea of participants having gone through a process of change, growth, and reinvention of the self following the development of a physical disability. Such a process encompasses the participant identified theme of being on a "journey" which one participant stated "art drives." J's timeline exemplifies this notion strongly in his clear depiction of steps taken to better his life circumstances following his engagement with photography.

Commonalities in artwork. The incorporation of movement from the left side of a piece towards the right was noted and supports the notion of a "journey" as the imagery is active versus stagnant. Such an occurrence replicates the process of individuals finding ways to move past the development of a physical disability to continue living meaningful lives and refraining from being held back by their conditions. The inclusion of the self within the imagery was another element utilized in multiple pieces and can be seen as representing individuals embracing their situation and reality. By including themselves in the imagery a connection is made between the individual and the world representing their physical disability. Such a connection strengthens the link between the two increasing the individual's identification with their disability and the role that it has within their overall identity. Symbolism was a third reoccurring element in the imagery and speaks to the ability of the creative process within art making to aid with the expression of thoughts and feelings. Symbolism allowed for a deeper more powerful expression of feelings which enabled individuals to experience a stronger release of such feelings. It also allowed individuals to convey a more true sense of what it was that they had and were experiencing.

Bonding through shared experiences. Though it was not directly discussed during the focus group the researcher observed that the focus group participants were able to form immediate supportive bonds with one another due to the sharing of similar experiences. The bonding and supportive nature of participants' interactions started during the informal pre-focus group discussion. During that time as well as during the focus group participants shared, with what appeared to be without hesitation, personal experiences related to their physical conditions and to instances of being discriminated against. Participants appeared to share anecdotes due to a desire to validate and support each other in an effort to comfort one another by showing they were not alone with their experiences. Such a display of support hints towards the notion of disability culture being a culture within which individuals with common experiences related to having a physical disability are better able to empathize and support one another compared to those who do not share such similar life experiences. This notion was further emphasized by participants mentioning that themes in the artwork include "hope," "motivation," and "inspiration," all terms that indicate participants feeling as though the others in the group were providing encouragement and support.

Study question #1. What is the experience of engaging in the art making process like for a person with a physical disability? Results from the study suggest that engaging in the art making process can be a beneficial experience for individuals with a trauma related physical disability. The art making process was seen to provide an opportunity for self-expression with its ability to assist with exploring the various stressors related to having a physical disability. It was also shown to provide an opportunity for individuals to separate themselves from and feel unburdened by such stressors and the limitations of their physical condition(s). Another benefit found to stem from the art making process was its ability to function as a catalyst for change

leading to improved mental health status and reintegration into the community. A significant result that participants noted was that of the art products functioning as “inspirational” artifacts that provided both themselves and others with encouragement.

Study question 2. Does engaging in the art making process help to process any negative and/or positive thoughts and feelings in relation to having an acquired physical disability?

Engaging in the art making process may aid with the processing of both negative and positive thoughts and/or feelings related to having an acquired physical disability. By aiding individuals with expressing both the positive and negative aspects related to having an acquired physical disability, the art making process was seen to assist individuals with recognizing successes that they have accomplished and struggles that they face or have faced. The art making process was further seen to aid with pain management, identity formation, and the managing of suicidal thoughts.

Study question #3. Does engaging in the art making process help to create a more positive self-image and positive outlook on life? Engaging in the art making process can assist with creating a more positive self-image and positive outlook on life. Through providing a means of self-expression the art making process was seen to facilitate the recognition of personal abilities and achievements made. It was also found to assist with the recognition of the multiple components within one’s identity, allowing it to aid in the integration of such facets. The art making process was further seen to provide experiences of time spent engaged in an enjoyed activity generating both positive feelings and positive life experiences for individuals. A significant result that surfaced was that of art making’s ability to manage suicidal thoughts, effectively putting a halt to such thoughts as it functioned as a catalyst for finding intention and purpose in life.

Findings

In looking at the data gathered from artwork and group discussion, it appears that there are benefits to incorporating art making into the recovery process following the development of a physical disability due to a traumatic experience. Artwork and discussion revealed art making to have the ability to provide an outlet for self-expression, peer engagement, and the obtaining and providing of emotional support. It was also shown to provide an opportunity to both process and find relief from the emotional and psychological stressors connected to one's trauma experience and physical disability.

All focus group participants agreed that making art has beneficial components to it, and spoke to its ability to support their self-expression of thoughts and feelings related to their trauma experience and ensuing life changes. Previous research supports such an experience as Symons et al. (2011) found that art making provides an opportunity for individuals to express themselves through the experience of emotional release. Russell (1995) adds to the benefits of such an experience in suggesting that expression through the creation of artwork provides a record of one's thoughts and feelings, which Czamanski-Cohen et al. (2014) found to aid an individual with defining and focusing on the specific struggles being faced. F's engagement with the art making process during the focus group functions as an example of this as he was able to confront the struggle of incorporating the two identities that he feels. In having a tangible representation of the struggle he experiences, F was able to articulate his feelings and frustration with having two separate and opposing identities. In capitalizing on the use of metaphor, F's artwork also echoed McGraw's (1995) postulation that the art making process contains in it the ability to approach difficult issues in an indirect manner that is less threatening and easier to engage in than the direct verbalization of such issues. Three other participants were also able to

utilize metaphor in their pieces supporting the notion that art making allows for such an occurrence to take place, and that art making creates a safe space for personal reflection to occur as so suggested by Heenan (2006).

Results from the focus group also demonstrated potential benefits of incorporating art making into the recovery process of trauma induced physical disabilities, as participants named art making's ability to aid with managing psychological stressors related to their trauma experiences and physical disabilities. C's reporting of the act of painting having the ability to provide her with relief from physical pain and relief from the mental stresses associated with her physical disability, reflects findings that art making functions as a relaxing endeavor that distracts from the negative aspects of having a physical disability (Russell, 1995; Symons et al., 2011). In suggesting that painting allows for such "release" by providing her with an enjoyed activity that engages her complete focus, causing all other thoughts and feelings to "fade away from consciousness," C reflected Symons et al.'s (2011) finding that art making functions as a rewarding task through the spending of time engaged in a meaningful manner. J's reporting of his engagement with photography being responsible for the cessation of his suicidal thoughts also supports Symons et al.'s (2011) findings, and goes on to support Drapeau and Kronish's (2007) research which states that engagement in art making facilitates a decrease in suicidal ideation.

Artwork from all participants contained themes of duality and segmentation speaking to the notion of participants having gone through a process of change and identity transformation following the development of a physical disability. Participants acknowledged that art making possesses an ability to generate and facilitate such a process of change in one's identity. Previous research supports such a notion in suggesting that art making can assist with self-reflection

(McGraw, 1995), exploring one's self-identity (Symon et al., 2011), as well as with establishing a new identity all together (Hunt et al., 2014).

Throughout discussion, both prior to and during the sharing of art pieces, participants spent a great deal of time discussing and exchanging anecdotes on their experiences with having a physical disability. Stories shared ranged from incidences of being discriminated against to details of near death experiences and out-of-body experiences. This form of engagement seemed to transform the focus group into a peer support group as participants provided one another with encouragement and reassurance that they were not alone with their life experiences. Though disability culture was not an outright focus of the research project, its presence surfaced frequently pointing to its impactful influence on participants' lives. In sharing details of their personal experiences in a way that demonstrated having shared experiences of oppression and shared understandings of humor, language, values, and strategies for living and deflecting acts of discrimination, participants embodied the essence of disability culture as proposed by Dupré (2012). In demonstrating such commonalities participants appeared to display a self-confidence and pride in having a physical disability. Mejias et al. (2014) explains such an occurrence in reporting that the sharing of personal stories in a group setting with peers creates social and emotional support that encourages the development of a positive disability identity. This is believed to take place as the individual is able to view their disability as a shared positive experience versus a shameful isolated one.

Despite not seeking out the effects of disability culture, this research project highlights the advantages of belonging to such a group, suggesting that access to such peer support is another modality of care that should be incorporated into the recovery process of individuals dealing with a trauma induced physical disability. The benefits of engaging in the art making

process remain applicable within the focus on providing access to disability culture, as art making can provide yet another shared experience between individuals. The benefits of having such a shared experience through art making in a group setting is supported by McGraw's (1995) findings that participation in art therapy groups works to counter feelings of loneliness. Such an engagement is also supported by Drapeau and Kronish (2007) and Heenan's (2006) findings that individuals who engage in art therapy groups experience increased peer support and socialization which lessens feelings of isolation and loneliness.

Conclusions

In looking at the data and findings it can be suggested that art therapy would be a beneficial treatment modality to incorporate into the recovery process for individuals who've developed a physical disability following a traumatic experience. The focus group provided insight on art making's ability to provide relief from stressors related to one's new physical status, to function as a catalyst for change, and to improve one's self-image and outlook on life. Such findings demonstrate art therapy's potential to assist with navigating situations encountered while in the ongoing stage of recovery.

Although the focus group was successful with providing insight on art making's benefits during the recovery process, there were limitations throughout its course and the ensuing data analysis. One limitation was that of participants straying off topic and having difficulty with focusing on art making's role within the recovery process. As participants primarily focused on exchanging anecdotes from their trauma experiences and run-ins with societal acts of discrimination, a significant amount of data was not obtained on the specific role that art making held in participants' recovery efforts. If participants had been better able to stay focused on the presented topic, more information may have been obtained to better speak to what art making has to offer for those in the recovery process.

A second limitation of the study was that of one of the participants not meeting full criteria as he had not previously engaged in the required forms of expressive art making (i.e. painting, sculpting, drawing, etc.; participant's form of art was reported as "acting and singing"). Although the participant was able to connect with and reflect on his engagement with the art making process during the focus group, the participant was unable to provide feedback on the

use of art making during his preexisting recovery process. Because of this, future studies may want to utilize a stricter screening process to ensure that all participants meet full criteria.

Future studies may also benefit from an extended period of time allotted for the focus group, which may better accommodate the length of time that individuals with physical disabilities may require for transportation, necessary breaks while working, as well as the speed at which they can work when engaging in the art making process. Future studies could also benefit from utilizing an individual interview process which may provide a better format for keeping discussion focused on topic. Incorporating individual interviews alongside a group format, such as a focus group, could allow for future studies to combine the benefits of both methods obtaining information from a more controllable 1-1 discussion and a more fluid spontaneous group discussion.

With accidents occurring every day, incidences of trauma leading to the development of physical disabilities will inevitably continue creating not only physical stresses and changes for those involved, but emotional and psychological stresses and changes too. Art therapy, as it functions via the use of the art making process, may present itself as a modality of treatment beneficial for the processing and/or adapting to such physical, emotional, and cognitive stresses and changes.

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Appendix A
Informed Consent Form
Loyola Marymount University

Art's Role in Processing the Development of a Physical Disability

Purpose: The purpose of this research is to explore the therapeutic qualities of the art making process in relation to the mental health aspects associated with physical disabilities.

Your Participation: Participation consists of making an individual piece of art as a reflection on the role that making art has had in the processing of an altered physical status due to a trauma. Individuals will provide feedback on the meaning of their piece and participate in a group discussion of common themes and/or experiences and/or lack thereof, create a second piece as a reflection on participation in focus group discussion, and discuss the meaning of the secondary piece.

Artwork: Photographs will be taken of artwork made during the focus group to be used for research purposes only. Photographs may be used in the researcher's final project but will not include names of the creators to ensure confidentiality.

Benefits and Risks: Potential benefits to participants include heightened self-awareness, increased self-esteem, and self-efficacy, as well as enjoyment of the art making process. Risks include emotional discomfort and anxiety that may emerge with discussing elements related to having physical disabilities.

Confidentiality: Privacy will be ensured through confidentiality. No names or identifying information will be reported in the final project. Participation is voluntary and the participant has the right to discontinue the focus group at any time. A summary of the results will be available to participants upon request.

By signing below, I acknowledge that I have read and understand the above information. I am aware that I can discontinue my participation in the study at any time. Please contact researcher or faculty advisor with any questions or concerns. I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Hardy, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 (310) 258-5465, david.hardy@lmu.edu.

Print name _____

Signature _____ Date _____

Signature of researcher _____ Date _____

Researcher: Erika Schreefel

Faculty Research Advisor: Dr. Paige Asawa

Phone (310) 338-7646 Email: paige.asawa@lmu.edu

Appendix B

LOYOLA MARYMOUNT UNIVERSITY

Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.
2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.
3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.
4. I will be given an explanation of any benefits to be expected from the study, if applicable.
5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.
6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.
7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.
8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.
9. I will be given a copy of the signed and dated written consent form.
10. I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.

Appendix C

Community Sites with available Mental Health Resources

Didi Hirsch Mental Health Services

www.didihirsch.org/adult-services

310-390-8896

Monday-Friday 8:30 a.m.-5:00 p.m.

Mental Health Center Cedars-Sinai Medical Office Towers

www.mentalhealthctr.com/services.html#therapy

310-494-0352

UCLA Health: Adult Psychiatry: Outpatient Trauma Psychiatry

http://www.uclahealth.org/body.cfm?xyzpdqabc=0&id=453&action=detail&limit_department=24&limit_division=1000&limit_program=5226

310-25-9989

USC Medical Center

http://dhs.lacounty.gov/wps/portal/dhs!/ut/p/b1/04_SjzQ0tzAxMrI0MDLXj9CPykssy0xPLMnMz0vMAfGjzOLdDAwM3P2dgo3cLSwMDBwNXHzcPPxdjdw9QBoikRVYmPo5ARWYmPpbeJgYOpsaEKffAAwXK_f1QjdfkwF-PSbmhDQD1RAwP3h-lGoStBDwJSQAgOoAnxhQCgU_Dzyc1P1c6Ny3NzcLD0zA9IVAc_kXjs!/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2X0YwMDBHT0JTMkc4ODAwQTBETEZIT0UyR0o0/

323-409-1000

Monday-Sunday; 24 hours a day