

ATHABASCA UNIVERSITY

ART THERAPY AS AN ADJUNCT TREATMENT IN CHRONIC PAIN MANAGEMENT

BY

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DEDICATION

This paper is dedicated to anybody who has ever found him or herself in a situation in which conventional solutions did not apply and to those who have defied all odds to live their dreams. With a dream and creative will, anything is possible.



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ABSTRACT

Chronic pain is a multi-factorial, idiosyncratic experience that has been the subject of human study for centuries. Chronic pain is responsible for hundreds of millions of dollars in lost work and compensation. Art therapy is recognized as a helpful treatment in a number of reported cases, yet the use of art therapy in chronic pain treatment remains under-studied and unevaluated. To promote understanding of how art therapy can be used in chronic pain treatment, an overview of chronic pain and art therapy was carried out, followed by a theoretical rationale for using art therapy in chronic pain management and its ethical considerations. Finally, a review of the current literature was conducted in order to evaluate what gaps exist between theory and practice.

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CHAPTER I: INTRODUCTION

Chronic pain is a mysterious, multi-factorial, and idiosyncratic experience which has been the subject of human study for centuries. In contemporary society, chronic pain is responsible for hundreds of millions of dollars in lost work and compensation (Harstall & Ospina, 2003). On a personal level, the psychosocial impact can be considerable. Chronic pain has the ability to rob an individual of his or her identity, occupation, healthy relationships, mental health, and general quality of life (Collen, 2005). As a consequence of the far-reaching impacts of chronic pain, researchers from a variety of disciplines such as medicine, physiotherapy, occupational therapy, psychology, social work, nursing, and creative arts therapy have examined the cause, course, treatment, and impact of chronic pain in an attempt to ameliorate the immense personal, social, and economic cost it incurs.

Rationale

From the decades of research carried out on chronic pain one thing is certain: there is no cure for chronic pain. While some interventions and treatments work for some people, they fail for others leaving many people living with chronic pain roaming from one doctor to the next in search of relief. Some individuals even seek complementary and alternative forms of treatment when all mainstream medical interventions have failed (Collen, 2005; Koenig, 2003). As such there is a great deal of research being carried out on complementary and alternative (CAM) approaches which include traditional medicine, relaxation, meditation, and art therapy. According to the National Center for Complementary and Alternative Medicine (NCCAM), some CAM interventions such as cognitive behavioral therapy have even been accepted as mainstream interventions due to sufficient research proving their efficacy (NCCAM, 2007). Art therapy is an example of a CAM treatment. Currently art

therapy is recognized as a helpful treatment in a variety of settings such as mental health and some areas of the medical system (Malchiodi, 2007). A variety of professions make claim on art therapy such as psychology, social work, occupational therapy, nursing, and recreation therapy (Malchiodi, 1999). While there is interest toward this evolving profession, art therapy in relation to chronic pain remains highly unevaluated due to the sparse literature.

With all the treatment options that are put forth for chronic pain sufferers, it is important that healthcare professionals are informed about how chronic pain works and the various approaches for treatment (Butler & Moseley, 2008). Furthermore, it is important to understand that chronic pain is a composite of symptoms which have the potential to affect one another. As a result it is up to individuals living with chronic pain to manage their symptoms with respect to their lifestyle. In fact, the most accepted approach to chronic pain is self-management (Asmundson, Vlaeyen, & Norton, 2004; Butler & Moseley, 2008; Caudill, 2002; Landgarten, 1981; Phillips, 2008).

Professionals working within the field of chronic pain must have a firm understanding of the impacts, treatments, and characteristics of this condition combined with the emphasis on patient self-management. The primary focus of this paper is to examine the psychological treatment of chronic pain from an art therapy perspective. Specifically an attempt will be made to clarify how art therapy is used in the treatment of chronic pain, to identify both strengths and weakness in the current literature, and to propose possible avenues for further development.

Method

In the attempt to clarify how art therapy is currently used in chronic pain, four major topics will be reviewed: (a) chronic pain; (b) art therapy; (c) theoretical impetus for

incorporating art therapy in chronic pain treatment; and (d) the state of the literature with respect to how art therapy is used in treating chronic pain. The first chapters will be devoted to providing basic knowledge for chronic pain and art therapy both of which are highly specialized areas of practise. Because the study of chronic pain tends to be more medical in nature and art therapy more psychological, the terms used to describe the recipients of treatment vary between “patients” and “clients” respectively. To reflect this difference in terminology, the terms “patient” and “client” will be used interchangeably throughout this paper to reflect the context being discussed. The third section will examine the theoretical impetus for incorporating art therapy as an adjunct treatment for chronic pain. Finally, a thorough review of the literature will serve as a means of evaluating what advances have yet to be made in terms of practice and research. Keywords applied in the literature review search included: chronic pain, art therapy, and pain management. Search words such as cancer and AIDS were omitted because the articles found only addressed the disease process as opposed to specifically addressing pain.

CHAPTER II: WHAT IS CHRONIC PAIN?

Working in the field of chronic pain requires professionals to have a basic knowledge of chronic pain. To answer the question “What is chronic pain?” the following topics will be reviewed in this chapter: (a) the history of pain theory and treatment; (b) current definitions and classifications; (c) psychological perspectives of chronic pain; and (d) the effects of chronic pain.

History of Pain Theory and Treatment

Humankind has investigated pain and how to relieve it since prehistoric times (Todd, 1999). Throughout history and across cultures, many theories were created in accordance with existing beliefs and knowledge of the human body at specific moments in history. In the following section a brief history of the study of pain will be described in order to establish a foundation of basic pain theory and management. There are two areas which are specifically relevant to this paper. An overview will include a description of shifting paradigms on pain throughout history and how these shifts affected the current concepts of pain.

Pre-history

As pain is a product of the human nervous system (Butler & Moseley, 2008), it is safe to assume that the very first humans who walked the earth experienced pain. Supporting this assumption, physical evidence has been found in prehistoric human skeletons indicating the presence of painful disease conditions (Bonica & Loeser, 2001). Also pain with no visible cause was attributed to supernatural causes (Bonica & Loeser, 2001; Todd, 1999).

Ancient Civilizations: The Effect of Culture on Pain Study

Later on in ancient civilizations, a variety of approaches to treating pain developed. Ancient civilizations such as Egypt, India, and Greece conceived that pain was felt through

the heart as this was the only organ that seemed to connect all parts of the human organism (Todd, 1999). In particular Aristotle was known for conceptualizing pain as an affective quality which could only be felt through the heart because the heart was supposedly the centre for affective sensibilities (IASP, 1997). Aristotle's theories would survive until the end of the Renaissance despite evidence against them. Galen, one of Aristotle's predecessors, was among those philosophers who conceptualized the brain at the center pain perception. Other philosophies regarding the perception of pain varied with respect to cultural beliefs. According to Todd (1999), the Buddhists in India conceived pain an ailment of the body while the Chinese placed greater emphasis on the principle of balance. Thus imbalance between the organs was thought to cause pain. On the other hand in Mesopotamia, in addition to cultural beliefs, the treatment and study of pain was influenced by the prevailing legal system at the time. While pain was regarded culturally as a punishment, the advance of medical interventions was hampered by heavy legal consequences in the case of medical mistakes. Again a different perspective on pain could be observed in Babylon where theology and science was combined, and physicians were also priests (Bonica & Loeser, 2001). Diversity in the way ancient civilizations conceived of pain is well documented in the literature. The understanding of pain ranges from physiological to philosophical beliefs and a combination of the two.

The Middle Ages

In addition to being affected by local and historical perceptions, the study of the human body was also affected by widespread economic collapses and social unrest during the Middle Ages. Such change resulted in the abandonment of science and to the adoption of strong religious dogma (Todd, 1999). Despite the apparent step back in medical advances,

medical knowledge continued to grow elsewhere as intellectuals fleeing from Europe found refuge in Persia where they were able to continue studying the human body (Todd).

According to Bonica and Loeser (2001) during this time, European scholars were able to draw on the theories of Persian scholars such as Avicenna who was also known as the “prince of physicians” (p.6). This led to further discoveries about the human physiology and subsequently contributed to greater knowledge of pain. Scholars were able to return to Europe during the more stable times of the Renaissance and reintroduced knowledge that had continued to develop in the Middle East. Regardless of the support of scientific advances during the Renaissance, the lack of technology in the Middle Ages and the Renaissance period led to few advances in the treatment of pain. Ancient remedies such as opium and somnolent sponge were still being used.

Galen vs. Aristotle: Pain Theory Makes a Permanent Move to the Brain

The 17th and 18th century was an interesting time with respect to developments in pain theory. While many theories continued to be based on the Galenic concept that the brain was the center of sensory perception, there were still theorists such as William Harvey who continued adhering to the Aristotelian doctrine that named the heart the base of sensory perception (Bonica & Loeser, 2001). However, Descartes put forth a theory that would change the face of medical practice for centuries to come when he proposed that human afflictions could be split into somatic and psychological ailments (Bonica & Loeser). This theory is extremely important because today’s medical model, which distinguishes between physical and psychological problems, is heavily based on the Descartes model (Hardin, 2004). Descartes theorized pain to be a somatic phenomenon described in terms of cause and effect. If a part of the body sustained injury, a message would be sent to the brain via nerves

that enervate the injured area (Bonica & Loeser, 2001).

Modern Theories of Pain

During the 19th century, two major theories in pain evolved from Descartes' theory proposing that there were pathways linking the brain to the periphery of the body (IASP, 1997). These theories were known as the Specificity Theory and the Summation Theory. The Specificity Theory held that pain is a sensation different from all other sensations and proposed a stimulus-response theory in which the amount of pain experienced by an individual is directly related to the degree of tissue damaged incurred to the human body (Hardin, 2004). Conversely the Summation Theory supposed pain to be the result of when the touch sensation was felt in great intensity (IASP, 1997). Both of the above theories are fundamentally physiologically based and do not take into account individual's perception of the pain experience (IASP). Because the psychology of pain was absent from these theories, phenomena such as pain in the absence of tissue damage and the variation between individual reactions to the same degree of tissue damage remained unexplained. This greatly influenced the treatment of pain in the 20th century in which the general approach was to fix pain through drugs or surgery (Hardin, 2004).

By the mid twentieth century both the Summation and Specificity Theory had evolved. In fact, each theory had developed strong followings, which led to a problem regarding methodological rigor with respect to pain studies. Research was being conducted with the bias of proving either of the theories in question (Bonica & Loeser, 2001). The biased methodology of researching pain mechanisms left many questions unanswered when it came to pain conditions occurring in the absence of seemingly inappropriate stimulus (Melzack & Wall, 1965). As such, Melzack and Wall developed the Gate Control theory

(GCT) which combined aspects of previous theories. The GCT is based on the idea that pain sensations are modulated by the spinal cord. The gate, in the dorsal horn of the spinal cord, modulates pain in two ways: the gate is controlled by ascending signals from the peripheral nervous system, and from descending signals from the brain which are influenced by cognition and emotion which either open the gate and increase the pain sensation or close it in which case the pain eventually subsides (Hardin, 2004). According to Robinson and Riley (1976), in spite of amendments made to the GCT over the years with the advance of technology, the major tenants of the theory remain the same.

The implication of a gating system controlled by impulses from both ascending and descending nerve fibers suggests that how pain is processed in the cerebral cortex plays a part in the phenomenology of the pain experience (Melzack & Wall, 1965). The phenomenology of pain or how one experiences pain is dependent on a variety of biopsychosocial factors and is unique to each individual. How pain is experienced can be modulated by external factors (Koenig, 2003) including daily stressors, tension from injury, taking analgesics, the cessation of physical activity, and a variety of other factors (IASP, 1997). In this way GCT was the first theory on pain to acknowledge that both the mind and body played a simultaneous role in the pain experience as opposed to previous theories that positioned the mind against the body (Camic, 1999; IASP, 1997). The GCT was revolutionary because it provided a new way to conceptualize pain thus broadening pain management interventions encouraging “the investigation of the nature of pain-associated disability and led to the development of biopsychosocial models which have attempted a wide integration of physical, psychological and social perspectives” (IASP, 1997, p. 2).

Pain Definitions and Classifications

Modern definitions of pain reflect the shift from differentiating between psychological and physiological aspects of pain. The IASP (2008) defines pain as an “unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Pain section, ¶ 21). While the study of pain is considerably more complex than the above definition, it integrates both the sensory and psychological experiences of pain, which is quite possibly the most important component in understanding the pain experience.

Pain itself can be subdivided into two major categories: acute pain and chronic pain. Acute pain refers to the immediate pain resulting from tissue damage which is accompanied by the release of stress hormones in the body warning the individual that they are in danger (Hardin, 2004). On the other hand, the definition of chronic pain is not as concrete. Many sources describe chronic pain as pain lasting longer than three to six months from the date of injury (Hardin, 2004; Harstall & Ospina, 2007; Koenig, 2003;). However, Niv and Devor (1999) note that attaching a time frame to chronic pain is arbitrary and more emphasis should be put on the increased complexity of chronic pain syndromes instead. Butler and Moseley (2008) propose yet a different approach in asserting that “all pain experiences are a normal response to what you brain thinks is a threat” (p.26) and part of treating the pain is finding out why the brain is sounding off the alarm system. Another way of understanding chronic pain and why it is signaling danger is through the subdivision of chronic pain into malignant and benign categories. Malignant chronic pain refers to pain that originates from the progression of a life threatening illness whereas benign pain refers to pain occurring without significant physical cause (Hardin).

Despite the categories of pain that have been formulated as a result of extensive research on the topic, chronic pain remains shrouded in mystery as there is an apparent discrepancy in how different theorists comprehend pain. While many theorists differentiate between acute and chronic pain, others like the IASP does not (Turk & Okifuji, 2001). In acknowledgement of this, Turk and Okifuji proposed the necessity to distinguish between the different kinds of chronic pain. While they do not use the malignant and benign terms adopted by Hardin (2004), they draw attention to cancer pain (akin to malignant pain) and recurrent pain. Turk and Okifuji propose that cancer pain can be both a result of disease progression as well as the permanent neurological effects of treatment. Thus cancer pain can be a combination of both acute and chronic. On the other hand, recurrent pain, such as some headaches are not considered to be chronic because pain occurs in these conditions as a result of an underlying pathology. Consequently the major differences between acute and chronic pain are duration and complexity. In a later section the factors which contribute to complications in chronic pain will be discussed.

Pain on its own regardless of classification is a phenomenological experience and aside from duration, the major difference between acute and chronic pain is that chronic pain is more likely to have a greater psychological component (Niv & Devor, 1999). This statement is not meant to devalue the very real physiological sensations involved in acute pain; rather it is meant to emphasize that chronic pain experience is a multi-factorial experience, which also consists of more psychosocial components (Harstall & Ospina, 2003; Koenig, 2003; Robinson & Riley, 1999).

Growth of Psychological Perspectives

Thus far this chapter has reviewed the general acceptance of chronic pain as a mind-

body phenomenon. The assertion of chronic pain as a mind-body affliction motivated the multidisciplinary approach to treatment with specialized training standards for each professional working within it. As the primary goal of this paper is to explore how art therapy is being used in chronic pain treatment, it is important to discuss the psychological perspective involved in this condition. Discussion of psychological perspectives in chronic pain will include the following topics: (a) psychoanalytical roots of psychology in chronic pain; (b) psychologically-based models of explaining pain; and (c) transitions from acute to chronic pain.

Psychoanalytical Roots of Psychology and Chronic Pain

While Melzack and Wall (1965) identified that physiology and psychology simultaneously played a role in the pain experience, they were not the first to suggest that psychology was involved in pain. In fact Freud was one of the first to suggest that psychological mechanisms played a role in the pain experience. However, Freud placed a greater emphasis on psychological conflict as a cause of pain in his psychodynamic approach, as opposed to balance between psychological and physiological systems (Robinson & Riley, 1999). The IASP (1997) notes that this idea grew in the 1930's and 1940's as interest in the psychology of physical illness increased with the study of pain in patients suffering from mental illnesses. It was thought that pain could be a function of mental illness. Unfortunately these discoveries lead to the dichotomizing of pain into pain due to physical causes and pain caused by psychological states (IASP). While other theorists built upon this model, the psychodynamic model is not well established in research (Robinson & Riley, 1999).

In addition to the psychoanalytical roots of pain studies other models also sought to

explain the human pain experience. Currently there is not one particular theory that offers a consistent framework for addressing chronic pain (Butler & Moseley, 2008; Turk & McCarberg, 2005).

Approaches Based in Behaviour, Cognition, and Learning

The behavioural approach depends on the distinction between nociception, the mechanical neural event that transmits the message of tissue damage from the peripheral nervous system (PNS) to the central nervous system (CNS) (Turk & Okifuji, 2001), and pain behaviours. As such, the pain experience is conceptualized in terms of behaviours, and the way people respond to it is learned (Robinson & Riley, 1999). In other words, similar to the GCT, the behavioural model characterizes pain behaviours as a response to painful stimulus, external psychosocial factors, or operant conditioning (IASP, 1997).

The behavioural model provided a foundation upon which the cognitive behavioural approach was developed. The cognitive behavioural approach links individual response to external stimulus with internal cognitive processes. In this way thoughts and emotions also play a role in conditioning behaviour. Modifying thoughts can translate to modifying behaviour. This is done by identifying automatic thoughts, assumptions, and core beliefs of an individual and systematically testing them in reality (Beck & Weishaar, 2005). With respect to pain, there are five underlying assumptions to the cognitive behavioural model: (a) people are constantly making meaning of incoming information based on previous experience; (b) thoughts can influence emotions and physiology; (c) both the individual and environment are agents of conditioning; (d) treatments should target maladaptive learning which all humans are prone to; and (e) patients play a role in the development and maintenance of their conditions (Turk & Rudy, 1989 cited in Robinson and Riley, 1999)

Given these assumptions, cognition can affect behaviour in two ways. First, as soon as maladaptive thought processes have been identified through reality testing, the resulting new patterns of thinking interrupt old relationships between stimulus and response. Finally, an individual's cognitive processes can have an effect on physiological responses by activating or deactivating the flight or fight response (Robinson & Riley, 1999).

The cognitive behavioural model is not only well grounded in the literature but it has been touted as being the intervention that improves adherence to pain management programs. It has highlighted active and passive coping mechanisms and their role in rehabilitation (Robinson & Riley, 1999). In fact, many guides for coping with chronic pain such as, Caudill's (2002) *Manage Pain Before it Manages You* use cognitive behavioural theories to help people living with chronic pain conceptualize, understand, and effectively cope with their condition.

Another theory which builds upon cognitive behavioural theory is the fear and avoidance model which focuses on the role of the flight or fight response in pain experience (Asmundson, Vlaeyen, & Norton, 2004; Butler & Moseley, 2008). According to Asmundson, Vlaeyen, and Norton this model is divided into three components: a cognitive component, a physiological component, and a behavioural component. Cognitive functions include automatic thoughts such as those thoughts that allow the individual to focus on the threat and act as motivators for subsequent defensive action. If the automatic thought perceived danger, the sympathetic nervous system would be activated the initiating the flight or fight response. This response includes increased levels of epinephrine, norepinephrine, and sugars in the blood stream accompanied by increased blood flow to major muscle groups that could aid the organism in defeating the perceived threat. Finally, a behaviour will be produced that

matches the initial automatic response. One key distinction made by Asmundson, Norton, and Vlaeyen is that between fear and anxiety. While fear is characterized as adaptive and necessary for survival, anxiety is a result of learning and is defined as a preparative behaviour which activates an avoidance behaviour.

Fear and avoidance models are in some ways similar to evolutionary models which also emphasize the adaptive nature of the pain and associated behaviours. The evolutionary model however, emphasizes that pain behaviours are hard wired for the specific purpose of saving the human body from danger, thus maintaining the ability to procreate (Butler & Moseley, 2008).

Psycho-physiological Model

Robinson and Riley (1999) describe that the psycho-physiological model is based on the idea that the body responds to internal and external stress. These stresses play a part in activating the autonomic nervous systems as well as some muscle efferents which can lead to the malfunction of muscle and organs consequently leading to pain. The research on this model has been inconsistent. Although this theory is supported in some pain conditions it is not supported in others.

The Biopsychosocial Model

McCarberg and Turk (2005) noted that there are no treatments which consistently and predictably alleviate chronic pain. This seems fairly logical to ascertain especially when brain-imaging findings have shown that no two pain experiences are the same even within the same individual (Butler & Moseley, 2008). As such, a biopsychosocial model incorporates all of the above theories such as: psychoanalytical, behavioural, learning, and physiological. The biopsychosocial model provides a broader, more comprehensive approach

to chronic pain symptoms (Robinson & Riley, 1999). All professions involved in treating chronic pain can employ this approach. For instance Caudill (2001) provides a framework upon which doctors in the primary care setting can implement the biopsychosocial model. This type of integration allows for a greater understanding of the multidimensional quality of chronic pain, thus allowing doctors to make more informed and holistic treatment recommendations and referrals. Despite the wide approach housed in the biopsychosocial model, there are still parts of this model such as the psychosocial aspects which are still relatively new and require more research (IASP, 1997).

The Transition from Acute to Chronic pain

The transition from acute to chronic pain provides another dimension to the psychology of pain. Initially when an individual is injured, pain is most likely due to tissue damage. It is when pain persists beyond the time it takes for the tissue damage to heal that problems start to occur. In the attempt to explain these problems stemming from prolonged unexplained pain, some authors have tried to examine what happens in the transition from acute to chronic pain. Gatchel (1996), Keefe (1982), and Niv and Devor (1999) all discuss the transition from acute pain to chronic pain in terms of stages.

The first model by Keefe (1982) consists of three stages: acute, pre-chronic, and chronic. Basically the acute and chronic stages are consistent with the definitions I have already provided. However, the pre-chronic stage is identified as the point in the pain experience when the individual may lose hope that the pain will ever go away. In this stage Keefe posits the pre-chronic stage is the most opportune moment to initiate psychological interventions.

The second model by Gatchel (1996) shows the relationship between the physical and

psychological de-conditioning that may contribute to the above loss of hope. With the incidence of an injury there exists a natural period of recovery and healing. This may involve some inactivity due to the bodies need to heal and subsequently graded physical activity. During this stage of reduced physical capacity the body is subject to some degree of physical de-conditioning. As the injured individual begins resuming physical activity de-conditioned muscles are prone to soreness as a result of exercise. This resulting pain can be mistaken for pain associated with re-injury. During this normal stage the patient can either work through the physical de-conditioning or succumb to mental de-conditioning, which is comprised of three stages. The first stage consists of fear and anxiety resulting from additional pain involved in recovery. The second stage involves the exacerbation of psychological problems such as depression from disability, substance abuse, anger and others. Finally, the third stage is the acceptance of the sick role and the display of abnormal illness of pain behaviours.

Finally, Niv and Devor (1999) propose a more physiologically based theory regarding the transition from acute to chronic pain. They emphasize two crucial transitions as opposed to the actual stages (acute pain, sub-acute pain, and chronic pain). In the transition between acute and sub-acute pain, Niv and Devor propose that there are two neurological functions activated by the incidence of tissue damage or acute pain. First, the peripheral nervous system is activated by means of nociception. The second function is called central sensitization. This occurs as a result of the peripheral messages sent to the spinal cord. In essence central sensitization turns up the volume on the information received from the nociceptors. During this stage where the patients experience physical incapacitation as a result of the body trying to heal. As a result, there will be pain from moving joints, a feeling of fatigue along with other symptoms that can be characterized as illness. This is thought to

be an adaptive function, which is thought to be conducive to healing. However it is the behavioural reactions in addition to surrounding social structure, which play a role in the transition to sub-acute pain. It is quite understandable that individuals coping at this stage of their recovery experience apprehension towards their treatment and whether they will regain their former functional capacity. However, this apprehension in some individuals can lead to maladaptive pain behaviours such as modified postures and which can lead to other physically painful conditions.

Niv and Devor (1999) note that the transition from sub-acute to chronic pain as result of an array of factors. These factors include: (a) the age and physical status of the individual, (b) the individuals reaction to pain and whether they develop maladaptive pain behaviours, and (c) the interaction with friends and family.

Each of the authors utilized different terms and provided different explanations for what underlies their theories of pain transition. Despite these differences each of the transition models appear to adhere to the aforementioned definitions of pain in that acute pain is attributed to tissue damage and chronic pain is associated with psychological problems or the maintenance of maladaptive behaviours (Hardin, 2004). While all the authors made some attempt to mediate between psychological and physical aspects of pain, none of the authors present a concrete model, which reliably predicts the onset of chronic pain. In particular Niv and Devor (1999) note that more research must be carried out regarding the transitions involved in developing chronic pain so preventive treatments can be initiated earlier.

Given the advances listed above in both medical and psychological fields, pain continues to be under-treated (Bonica & Loeser, 2001). Bonica and Loeser propose that there are three major reasons for this such as: (a) the huge gap in the literature regarding pain, (b)

inadequate application of current knowledge, and (c) poor communication between researchers and clinicians involved in pain management studies. All of these shortcomings are symptoms of a field that is growing and evolving as more disciplines explore the psychology and physiology of chronic pain.

Effects of Chronic Pain

In the discussion of different pain models and the transition from acute to chronic pain, it is easy to recognize some of the biopsychosocial factors, which might contribute to the development of chronic pain. Not only can chronic pain erode an individual's ability to cope with external factors, there is also an increased gap between his or her personal pain experience and what is evident to the outside world, thus intensifying the pain experience (Niv & Devor, 1999). Additionally, the uniqueness of each pain experience requires a discussion regarding the far-reaching impact of chronic pain and how to apply this information to treatment.

Impact of Pain

Although the exact mechanisms involved in the transition from acute to chronic pain remain a mystery, the impact that chronic pain has on individuals is clear. With advances in pain studies the understanding of how pain impacts individuals has grown beyond mere physiological or psychopathological dichotomies. A number of sources cite a wide array of consequences with respect to the chronic pain experience. The most commonly cited consequences of chronic pain include increased reports of depression, anxiety, and anger (Camic, 1999; Harstall & Ospina, 2003; Hardin, 2004; Garguilo, McCaffrey, & Frock, 2003; Leo, 2003; Caudill, 2001). Chronic pain can also impact family life (Harstall & Ospina; Koenig, 2003; Otis, Cardella, & Kerns, 2004), affect self-image, contribute to decreased

activity, mental deconditioning (Hardin; Koenig), social stigma (Collen, 2005), feelings of loss, (LeResche, 2001; Smith & Osborn, 2007), social isolation (Garguilo, McCaffrey, & Frock), memory deficiency, and suicidal ideation (Hardin). Furthermore, the long-term incapacities resulting from chronic pain also create economic strain thereby adding yet another stressor (Collen).

Because chronic pain affects all aspects of people's lives (Otis, Cardella, & Kerns, 2004) and the chronic pain experience varies widely from one person to the next, professionals specializing in chronic pain are presented with some unique treatment challenges (Butler & Moseley, 2008; Garguilo, McCaffrey, & Frock, 2003). To address this issue, the factors exacerbating the pain experience must be discussed with respect to the phenomenology of pain.

Phenomenology of Pain

Pain is widely accepted to be a phenomenological experience (Butler & Moseley, 2008; Camic, 1999; Garguilo, McCaffrey, & Frock, 2003; Hardin, 2004; Koenig, 2003). The discussion on pain phenomenology begins with the presentation of two individual experiences of chronic pain consisting of a personal commentary and a clinical case study.

In this commentary, Collen (2005) describes his ongoing experience with chronic pain. He describes how he expected his back injury to heal with medical treatment, however, the ordeal turned into an odyssey to escape from the clutches of chronic pain. As part of his experience he notes the frustration resulting from moving from one doctor to the next, being chronically under-medicated, and being afraid of asking for more drugs for fear of being perceived as a drug addict by his doctors. Collen experienced further stigma from his insurance companies who did not believe the extent of his symptoms and cut off his benefits.

Collen had to quit his job and was no longer able to work, his marriage eventually dissolved, and anxiety and depression dominated his life. It was not until Collen met his current pain doctor and started dealing with the fallout of chronic pain through psychotherapy that he was able to recognize that the chronic pain was not going away and that he could have some control over his pain with mechanisms other than medication. Art helped him cope with the pain, but he still struggles with sleepless nights as a result of the continued pain.

Hardin (2004) on the other hand presents a case study of a woman who had developed signs and symptoms of depression and anxiety as a result of her pain. Like Collen (2005), for fear of addiction she was taken off of narcotic drugs. When she was referred to a pain centre, the client underwent psychotherapy, attended psycho-educational groups in conjunction to multidisciplinary treatment and discovered some maladaptive pain habits likely a result of a history of childhood abuse. A major part of her psychotherapy was addressing with past psychological trauma and learning to set boundaries for herself. While the pain did not go away completely, in addressing some underlying issues which exacerbated the pain, she was able to gain greater understanding for her overall condition, and engage new coping skills. She has learned to live with the pain and how to enjoy life despite of it.

Both of these descriptions of the pain experience are very different. Yet, there are a number of common themes corresponding with the previously mentioned impacts of chronic pain. Externally, there was the fear from doctors that patients would become addicted to narcotic drugs. Internally, the patient experienced fear, depression, loss of hope, and anxiety resulting from the chronic pain. These aforementioned accounts of the pain experience serve to underscore how chronic pain can vary from one person to the next and be influenced by

factors both external and internal. While each individual described above shared some commonalities they did not have identical pain experiences. In addition to the fact that individual perceptions of any event are idiosyncratic, additional factors which may impact how pain is experienced has to do with culture and gender (Butler & Moseley, 2008).

With respect to culture, the perception of what is painful can be closely tied to the cultural meaning assigned to certain events (Otis, Cardella, & Kerns, 2004). For example in cultural practices such as volunteer crucifixions in the Philippines individuals report experiencing little or no pain (Butler & Moseley, 2008). According to Butler and Moseley (2008) as far as the brain is concerned pain is initiated when danger is perceived. Consequently, because the goal of volunteer crucifixions is to become closer to God, it is not entirely surprising that participants of this practice do not report pain since they do not perceive themselves as being in imminent danger (Butler & Moseley).

Gender on the other hand plays a different roll in pain perception. Both societal roles and stereotypes have the potential to influence how chronic pain is treated in men and women. This is especially true when it comes to women. Butler and Moseley (2008) refer to the popular stereotype asserting that women have a lower pain threshold. While there is little scientific evidence to substantiate this claim, women continue to be under-medicated in comparison to their male counter parts. In this way rather than gender influencing the individual pain experience it appears that this construct is more likely to influence the perceptions of those professionals and family who respectively treat and live with the pain sufferer.

Culture and gender are only two pieces in the pain phenomenology puzzle. Other factors that influence phenomenology depend on personal factors such as hope and personal

coping. There are a number of theories arising from qualitative studies attempting to gain insight into how individuals lose hope and move away from active coping skills (Butler & Moseley, 2008; Gatchel, 1996; Keefe, 1982; Smith & Osborn, 2007). Smith and Osborn propose that the inability to cope with the fallout of chronic pain is a result of the enmeshment between the individual's sense of self, the sense of illness, and the pain. Basically Smith and Osborn posit that patients' ability to manage new senses of self as their life changes due to pain plays a critical role in coping ability. The authors propose that further research be conducted to understand how people construct their sense of self. Also, some valuable insight is offered in terms of how people transpose events that happen in their life such as stigma of illness, loss of function, and loss of role, into a direct reflection of what kind of person they are.

It is evident that the pain experience involves both internal individual processes such as cognition and emotion as well external conditions such as family, economic status, and other environmental factors (Butler & Moseley, 2008; Gatchel, 1996; Keefe, 1982; Otis, Cardella, & Kerns, 2004; Smith & Osborn, 2007). While it is convenient to distinguish between internal and external consequences of pain, in reality there is no distinction. There is a constant interplay between internal and external factors. Based on each individual's personal history, personality, and coping style there is a continuous process of making sense of one's life experience. As people perceive the world around them they make meaning of their experience, this in turn stimulates thoughts and emotions, which influences behavior (Beck & Weishaar, 2005). The resulting behavior has the potential to impact how the outer world responds to the person living with chronic pain (Chapman & Turner, 2001). There is a great potential for those who are not familiar with chronic pain to misjudge the person living

with chronic pain and to treat them differently (Otis, Cardella, & Kerns, 2004). Also there is the possibility that family members contribute to enforcing passive coping skills like inappropriate rest (Otis, Cardella, & Kerns). Conversely additional stress can ensue if the chronic pain sufferer does not feel believed in (Collen, 2005). How other people respond to someone living with chronic pain can also reinforce a negative self-image (Smith & Osborn, 2007). Further complicating the individual's interaction with society are different classifications of cognition. Typically cognition is discussed in terms of conscious mental processes. However Chapman and Turner (2001) point out that conscious cognitive activity is based on unconscious processes suggesting that the pain experience is not entirely lived out in the conscious realm.

The many aspects of pain explored in this chapter are by no means exhaustive. However by illuminating the pain experience the complexity of providing adequate and effective pain treatment is also accentuated. Apparent from the research in this chapter is that pain is a highly individualized experience for which there are varying explanations. Furthermore, the pain experience is influenced by psychological, physical, social, and economic factors which impact the way an individual seeks help and lives with his/her pain condition. Individuals can find themselves going from one professional to the next in the pursuit of finding a cure for their pain and in their journey possibly receive multiple diagnoses and little relief (Butler & Moseley, 2008). As such it is important for professionals specializing in chronic pain to implement ongoing assessment to understand as much as possible about each person's pain experience and the factors that serve to exacerbate it (Butler & Moseley; Hardin, 2004).

CHAPTER III: WHAT IS ART THERAPY?

It is common to hear people say that art is a reflection of life. Yet art therapist and artist Shaun McNiff (1992) notes that the opposite is also possible:

Life does imitate art, as evidenced by how we change in response to images. We become what we imagine, as the person obsessed with troubling thoughts knows. It is the artistic imagination, and not the willful mind, that effortlessly transforms the torturing demon into an inspirational daimon. The discipline of changing an image or story, rather than the moralistic commandment to change ourselves, eases the burden. As images change we change with them. (p.38)

This description on the interaction between art and human reality is a building block at the very foundation of art therapy theory and will serve as a starting point for answering the question, what is art therapy?

Art therapy is a conglomerate of a variety of different theories that dictate practice. Among these theories there is also a meeting between the art and psychology. As such, there is a noted confusion regarding the definition of art therapy. Malchiodi (2007) describes how art therapy has been misconceived as being only for artists or being used as a means of solving aesthetic problems for pieces of art that have something wrong with them. Rubin (1999) even describes a debate regarding the therapeutic nature of art and who was best suited for facilitating art programs in hospitals: artists or art therapists. Sibley, Robbins, and Gordon (1976) discuss whether there should be a differentiation between art therapy and psychotherapy and suggest the term “art psychotherapy”.

With all these different ideas springing forth from psychology, the fine arts, and art therapy, it is easy to get lost in the theoretical debate regarding what constitutes art therapy.

However the goal of this chapter will be to discuss the major universal qualities that cut across art therapy theory. Once the fundamental and universal processes that drive art therapy are understood, it is possible to integrate those processes with a variety of different psychological theories. Additionally, defining the art therapy process will implicitly distinguish it from art-making for the sake of its inherently therapeutic properties and traditional verbal-based forms of psychotherapy. This is important because art-making for therapeutic purposes seems to have different groups claiming a stake in art therapy such as art therapists, artists, nurses, occupational therapists, psychologists, psychiatrists, and beyond (Stoll, 2005). In this chapter an attempt will be made to clarify the aforementioned issues by presenting: (a) a brief history of how art therapy came into being; (b) discussion regarding how art therapy was defined; and (c) a comparison between art therapy and talk-based therapies.

History of Art Therapy

Art therapy is a field that was born of a number of different disciplines. Among these disciplines are psychology, anthropology, art history, art, and psychiatry (Malchiodi, 2007). Rubin (1999) likens art therapy to a tree rooted in many traditions. The roots of art therapy are vast and far-reaching, but four major roots contributing to art therapy can be traced. These four roots include: (a) art as incorporated in ancient forms of healing; (b) the rise of psychological theories; (c) the study of art created by the mentally ill; and (d) a trend in the fine arts of moving away from representing the external world to expressing the internal emotional world of the artist.

Art and Ancient Forms of Healing

Malchiodi (2007), McNiff (1992), and Rubin (1999) point out that art used for healing

is not a new concept. In fact anthropologists hypothesize that the use of art as a means of protection extends into prehistoric times when healing rituals involved dance, music, rhythm, and visual imagery. Furthermore, anthropologists like Victor Turner (Turner, 2000) have studied the qualities and purpose of ritual in modern day, small scale, traditional societies who do not depend on technology. The primary purpose of ritual activity is to mindfully mark change and growth (Turner, 2000). How ritual theory informs the art therapy process will be discussed in a later section.

Psychological Roots

Many psychological theories contribute to art therapy. One theory was born out of psychodynamic theories developed at the turn of the last century. Sigmund Freud, Carl Jung, and Alfred Adler were the founders who conceptualized some of the most prominent theories.

Freud is known for his many contributions in psychology. One of the most important notions that sets his theories apart from the earlier forms of psychology practised before him was that he was the first to acknowledge that people were not rational beings (Arlow, 2005). Humans were subject to thought processes, emotions, and behaviours that manifested themselves outside of an individual's consciousness (Sibley, Robbins, & Gordon, 1976). This occurred as a result of the interplay between the different levels of consciousness and different aspects of human personality.

According to Freud the personality is comprised of three parts, with the ego at the centre of personality mediating between the primitive compulsions from the id, and the social controls for the superego (Sibley, Robbins, & Gordon, 1976). These aspects of the human personality were thought to operate at different levels of consciousness. Consciousness itself

was divided into three levels: the conscious, the pre-conscious, and the unconscious (Arlow, 2005). Freud conceived that while the ego and the super ego operated at all three levels of consciousness, the id was completely submerged in the unconscious (Liebert & Liebert, 1998).

Of particular interest to Freud was the unconscious and the different ways in which the unconscious mind manifested itself in form of dreams, and slips of the tongue (Robinson & Riley, 1999). Freud even encouraged his clients to describe and explore images they saw in their dreams. The techniques he employed to explore such images included free association to specifically look for symbolic content (Arlow, 2005). While Freud himself never got his clients to depict their images through art, his theories set the groundwork for other theorists to explore the phenomenon of unconscious imagery and its impact on the human psychological experience (Arlow). Essentially, Freud thought that understanding the irrational mind was the key to understanding someone in therapy (Sibley, Robbins, & Gordon, 1976).

Jung on the other hand encouraged his clients to depict their dreams through art-making (Douglas, 2005). In fact, Jung believed that creativity was a healing force and a cornerstone for therapeutic dialogue in a collaborative therapeutic environment in which the ultimate goal was growth as opposed to cure (Sibley, Robbins, & Gordon, 1976). In this therapeutic environment the art pieces acted as testing grounds and an alternate world in which the client could test and experiment with individuation (Sibley, Robbins, & Gordon).

Adler was yet another figure in psychology history that perceived that creativity was an important part of human nature. While Adler did not get his clients to make art, he proposed that people were inherently creative and were constantly creating their own personality

(Mosak, 2005). In his conceptualization of people being inherently creative, he also asserted that humans were neither “good” nor “bad” but rather chose to be either or (Mosak). As such in an art therapy context the most basic of Adler’s theories serve contribute to a subjective environment in which clients can explore the personality they have constructed for themselves and decide how they might want to change it in a creative way.

Based on the psychological theories presented above, three major underlying assumptions that guide the art therapy process are evident. First, the unconscious is a powerful part of the human psyche which stores unresolved conflicts (Arlow, 2005). Second, people are unique, irrational (Arlow), and inherently creative beings (Mosak, 2005). Therefore, engaging in creative activities can be useful in accessing their creativity and utilizing it in therapy to explore and practise different ways of being. Third, art therapy facilitates the integration of internal and external worlds of the individuals (Douglas, 2005; Sibley, Robbins, & Gordon, 1976).

Study of Art Created by the Mentally Ill

In the 1920’s and 1930’s art created by psychiatric patients at a mental institution caught the eye of Hanz Prinzhorn. In the decades Prinzhorn spent collecting the art work of institutionalized mentally ill patients, he theorized that art-making was a natural way of coping with illness (Malchiodi, 2007; McNiff, 1992). However, not everyone was in agreement with Prinzhorn. According to Case and Dalley (1992), Prinzhorn believed that art-making by the mentally ill was merely an attempt to reconnect with reality through the creation of physical objects in the form of prolific art-making. Regardless of why people with mental illness were compelled to create art with materials they managed to salvage from the garbage, the art created by the mentally ill initiated its own movement known as Art Brute or

outsider art (McNiff, 1992).

Shift in the Art World

Much in the same way Prinzhorn recognized art as a means of personal expression, so did artists operating in the art world. Thus, a shift from representational art was observed as artistic movements such as surrealism and expressionism arose, emphasizing the depiction of artist's inner world as opposed to the outer world (McNiff, 1992). McNiff cites a number of examples to illustrate this shift. For instance, similar to art therapy, the philosophy behind surrealism is to use the art as a tool to engage more deeply with life and psyche. Also in terms of artists one expressionist who is often referred to as depicting his emotional turmoil through art is Vincent Van Gogh.

The combination of art as an ancient form of healing, psychoanalytical theories, the art of the mentally ill, and the shift in the art world which saw the artist express their inner world as opposed to their outer world all influenced the first art therapists in different ways. Naumburg (1987) drew heavily on the psychoanalytical theories of Freud and conceived that art products were in fact a form of symbolic form of communication. More specifically, the communicative aspect of art making was based on the latent ability of all humans to project their inner conflicts through the art-making process. On the other hand, Kramer proposed that art-making initiated specific psychological processes (Malchiodi, 2007). While Kramer agreed that art was a form of communication, she also emphasized that the art-making process itself was therapeutic in that the process of creating art could act as a means of integration, synthesis, and sublimation (Kramer, 2002; Malchiodi, 2007; Rubin, 1999). Both Kramer and Naumburg made important contributions to art therapy. Naumburg posited how art could be used in psychotherapy, while Kramer advocated for the use of art as therapy

itself (Malchiodi). These early differences in how art therapy was defined have persisted as modern art therapists attempt to define a field born of many traditions.

Definition of Art Therapy

Arriving at a universal definition for art therapy has proven an elusive goal when it comes to international and interdisciplinary understanding of art therapy (Stoll, 2005). In part this is because of the different ways art therapy has been conceptualized and incorporated into healthcare systems around the world. According to the Canadian Art Therapy Association (CATA), the American Art Therapy Association (AATA), and the British Association of Art Therapists (BAAT), art therapy is defined as a specific form of psychotherapy that employs art-making as the primary form of communication (AATA, 2008; CATA, 2008; BAAT, 2008). Definitions created by each association cite that the creative process inherent in art-making helps with a variety of different psychological problems. The CATA (2008) describes the art-making process as non-verbal outlet, which could potentially help individuals express thoughts and emotions that would otherwise be difficult to verbalize. The AATA (2008) takes the definition a little further by stating that “the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behaviour, reduce stress, increase self-esteem and self-awareness, and achieve insight” (¶ 1). The BAAT (2008) on the other hand emphasizes art therapy as a means of personal growth.

Other definitions of art therapy can also be found in various art therapy textbooks. McNiff (1992) emphasizes the healing nature of artistic expression as a means of supporting the distressed individual much in congruence with the observations of Prinzhorn. Rubin (1999) offers an art + therapy = art therapy equation in which the sum art therapy equals a

form of psychotherapy that incorporates art as symbolic communication. Following suit Malchiodi's (2007) art + therapy = art therapy formula describes art therapy as a way of expressing oneself imaginatively, authentically, and spontaneously. Other art therapists like Pat Allen (1995) simply regard art therapy as a way of knowing. It is a powerful tool for getting to know oneself through the process of art-based introspection.

In all of the aforementioned definitions of art therapy, while there are minor differences, one feature remains constant across all definitions and that is the conceptualization of art therapy as a form of psychotherapy. This is particularly important for a number of reasons, because it is this psychotherapeutic aspect that differentiates art therapy from therapeutic art or art as therapy that might be a product of recreational art-making. Furthermore the practice of art therapy requires specific specialized training for professionals (Heywood, 2003; Rubin, 1999; Stoll, 2005). While it is quite common for many professionals who perform psychosocial interventions to incorporate art into their practice, this does not mean they are conducting art therapy. As mentioned previously, it is not the mere use of art alone but rather a specific process facilitated by the art therapist that differentiates art therapy from other kinds of talk-centered psychotherapies (Heywood, 2003). Furthermore, art therapy falls into a larger category of therapies known as creative arts therapy. As part of this larger community of creatively-based therapies includes dance, music, drama, and expressive arts therapists that use a combination of all art modalities. Such professionals must undergo their own specialized training despite the common underlying theory of creative process.

Medical Art Therapy

Defining art therapy is meant to clarify some of the confusion that surrounds this growing field. However, ambiguity is a hallmark of development. To get to a place of

knowing anyone or anything, one must move through a period of not knowing (Allen, 1995). At this time while more and more is being written on art therapy, it is still in the formative phases. Consequently, not only are there advances in art therapy theory and practice but specialization are also beginning to surface. One such specialization requiring definition is medical art therapy. According to Malchiodi (1993) medical art therapy can be defined as “the use of art expression and imagery with individuals who are physically ill, experiencing trauma to the body, or who are undergoing invasive medical treatment such as surgery or chemotherapy” (p. 2). Similar to art therapy, medical art therapy can also be used as both assessment and treatment (Malchiodi).

In the same way medical art therapy is a specialization within art therapy, medical art therapy can also be further subdivided into specialties depending on the medical condition experienced by the patient. While it is beyond the scope of this paper to discuss each medical condition addressed by art therapists, it is important to retain that each medical condition comes with its own set of consideration which art therapists must be aware. Such considerations include: how odors from art material can impact the patient’s medical condition (Sexton-Radek & Vick, 2005), or mobility and infection control when working with immune deficient patients (Malchiodi, 1993). Furthermore it is imperative that art therapists have a basic understanding of the medical condition being experienced by the patients they see to ensure that treatment goals are appropriate and achievable (Landgarten, 1981; Long, 2004).

Visual Art Therapy vs. Talk-Based Therapy

Two important factors distinguish creative forms of therapy such as art therapy from talk-based psychotherapy: the triangular working alliance, and the unique art therapy process

(Schaverien, 1992). While the therapeutic relationship embodied in a talk therapy situation occurs within a dyad, the art therapy working alliance takes on the shape of a triangle in which the client, therapist, and art product occupy the respective corners (Knill, 2004; Schaverien, 1992; Schaverien, 2000).

The Working Alliance

Many studies show that the most important factor in effective psychotherapy is the quality of the relationship between the client and therapist (Landgarten, 1981; Bordin, 1979; Horvath & Symonds, 1991). This relationship between the client and therapist is known as the working alliance. In a therapeutic setting the working alliance acts as the vessel, which carries any assessments or any therapeutic interventions (Bordin). In this way the working alliance acts as the interface through which interventions can be applied and practised by casting focus on therapeutic interaction between client and therapist which naturally contain conflict, repetition of unresolved inappropriate behaviour in response to the therapist, and ultimately the observation and resolution of conflict (Bordin; Horvath, 2000; Schaverien, 1992; Sufran & Muran, 2000).

The mechanism driving the therapeutic interaction is known as transference, the transferring of emotions from a previous interaction on to a new situation that involves close human relations (Arlow, 2005). Basically transference is the reliving of behaviour patterns from an unresolved conflict that replay when the therapist does or says something to remind the client the past conflict (Schaverien, 2000). Also because psychotherapy depends on a human interaction, the therapist is also liable to react to the client's transference based on his or her own unresolved issues. This is known as counter-transference and should be dealt with immediately once it arises through supervision (Schaverien, 1992; Gelso & Carter, 1994).

As a result of dialogue and observation of relational dynamics between the client and therapist, talk-based therapies by and large employ what Chutroo (2007) refers to as the mind sense. However, through the art-making process, art therapy engages all of the senses, which in return diversifies the working alliance in the art therapy setting. The three-cornered art therapy working alliance including the client, therapist, and art product creates a unique holding space for themes that arise through the therapeutic process in the form of physical products (Schaverien, 2000; Knill, 2004). In other words, rather than diverting intense emotional material by using the therapist as a symbol of past social interactions, that energy is channeled into the art. According to Knill, it is the physical presence or the “thingly” (p.81) quality of the art piece which allows for a differentiation between reality and imagination. In this way the creative process, regardless of the modality, serves as a container for client issues and an alternate means of communication in which the act of meaning-making can be suspended. As opposed to other creative modalities a special feature that is unique to art therapy is that the art products also provides a visual history of client progress and can be reviewed when necessary to foster greater insight (Landgarten, 1981).

The Therapeutic Process

The other part of art therapy that sets it apart from talk therapy is the creative process. Like talk therapy, any sort of psychological theory can be applied in order to facilitate client change. However, Knill (2004) describes the process involved in all creative therapies in terms of ritual where clients make a transition from reality to that of imagination and back again. Also, Knill conceptualizes problems that lead individuals to seek therapy such as the result of having come up against a block, the loss of flexibility, creativity or range of play. Such blocks represent the coping limits of an individual as a result of somatic or

psychosomatic illness, mental disorders, affective disorders, personality traits, or any other event that requires an individual to make use of personal coping skills. Consequently the mobilization of the imagination becomes the key factor in releasing individuals from their block in an art therapy context. In order to mobilize the imagination, ritual and the art materials involved in the art-making process are required and will be discussed next.

Ritual and art therapy.

In facilitating the movement between reality and imagination art therapists draw on anthropological knowledge of rituals and rites of passage (Knill, 2004). In traditional societies rituals provide a sensory reality-based event that mark transition. According to Victor Turner (2000), to mark transition from one way of being to another, those engaging in the ritual otherwise known as neophytes, must go through a period in which they are neither what they were or what they will become. This particular phase of ritual is called the liminal period and is marked by being socially undefined. In the liminal stage it is thought that neophytes are brought closer to the supernatural, creator, super human power, the unbound, the limitless, and/or the infinite depending on the cultural context. This leaving of society to temporarily join the supernatural makes up part of the growth process and allows the neophytes to be authentic without having to worry about social constraints of organized culture.

With respect to art therapy, the concept of ritual and liminality are highly applicable. Betensky (2001) and Knill (2004) both utilize the concept of ritual as a means of defining therapeutic space. While each author takes a slightly different approach to art therapy, both of their models contain a liminal period marked by art making. Betensky (2001) presents a four-sequence process which outlines the general steps of the art therapy process. The first

sequence involves engagement with the art materials through experimentation, and the second consists of the art-making itself. The final two phases involve processing what comes from the art, followed by integration. While Betensky's model is specifically phenomenological and is clearly directed at addressing what presents itself in the art, it can easily be generalized to fit all art therapy sessions. In the first stage there is engagement. Knill (2004) refers to this time as a time to talk to the client as opposed to Betensky's experimentation. These are merely different methods of engaging and do not change the nature of the purpose of initial contact at the beginning of the therapy session, which is to prepare and initiate the creative process where pre-existing meaning and convention are irrelevant. The art-making phase contains the liminal phase. In this time the client is free to create whatever and however he or she wishes. This is an opportunity to sublimate, express, and or just merely be. As mentioned previously one of the goals of art therapy is authentic self-expression and personal growth. Adapted to art therapy, the physical act of making the art and exploring the art during the art therapy process is a means to exploring the imagination in a context that is not restricted by convention (Knill, 2004). In this way an individual is able to communicate thoughts and emotions simultaneously without censorship. As such it is in the art-making where people are able to contact their deeper selves (Allen, 1995).

It is during the "out phase" presented by Knill or the last two phases presented by Betensky that the client and the therapist can take a step back from the art work and the client can begin reflecting on the art-making experiencing. This phase is meant to bring the client back from the art-making experience to a place where he or she might be able to process the emotions, sensations, thoughts, or memories that arose during the art-making session and

integrate them. The information from this “out phase” can serve as another entry point to address the original issue that brought the client to therapy or it can be a way for the client to understand patterns that he or she identifies when reviewing art from previous art sessions. The art therapy process is just one aspect of what defines art therapy. The second part of art therapy which works simultaneously with the process is the use of art materials.

Art Materials

Art therapy is an inherently mind-body experience (NCCAM, 2007) due to the constant simultaneous use of all senses in the art therapy process (Cane, 1983). The art materials provide a concrete sensory connection to the external world (Betensky, 2001). This sensory stimulation in conjunction with the art therapy process is what creates the opportunity to bridge the inner and external world of the client (Malchiodi, 2007).

With respect to art materials there are a wide range of approaches in using the art materials (Rubin, 1999). Generally, the art materials used in art therapy are simple and easy to use in order to minimize focus on competence and focus on authentic expression (Allen, 1995; Naumburg, 1987; Rubin, 1999; Rubin, 2003). Providing easy to use art materials creates what Knill (2004) refers to this as a “low skill/ high sensitivity” context (p.97). A commonly noted initial reaction to art therapy is clients reporting that they are not artists or that they do not know how to work with the material. By de-emphasizing the need to know how to use the art materials and shifting focus to how it feels to use different types of art materials, clients can start becoming familiar with how the outside world affects them internally (Knill, 2004).

According to Rubin (1999) there is no standardized way of implementing art materials during art therapy as each art therapist has his or her own preference. Nonetheless, art

materials can be characterized as existing on a continuum. Art materials range from being fluid to resistive (Malchiodi, 2007). The more fluid art materials such as paint are more difficult to control and are conducive to increased energy and self-expression. On the other hand, more resistive materials such as pencil and collage are more appropriate for situations in which control and containment are necessary (Malchiodi). Choosing the appropriate material for each therapeutic situation is a product of client and therapist collaboration. For the most part clients choose what they feel more comfortable using (Allen, 1995). However, in some situations it might be therapeutically important for clients to step outside of their comfort zones by trying a fluid medium, or use more resistive materials to contain overwhelming emotions and energies (Malchiodi).

This chapter has been devoted to providing a definition of art therapy, what differentiates it from talk therapy, and a description of the art therapy process. As the goal of this chapter was to provide a general overview of art therapy, the specific theories that define different approaches to art therapy were not examined. Because the general base of art therapy is reliant on self exploration as opposed to exploring problems (Knill, 2004), a therapeutic environment is created in which clients are able to sublimate, express themselves authentically, discover strengths, and then bridge their learning to their life. In this process, as individuals self explore, the problems they may be experiencing will surface naturally.

CHAPTER IV: THEORETICAL BASE FOR USING ART THERAPY IN CHRONIC PAIN MANAGEMENT

There are many theoretical compatibilities in using art therapy for chronic pain. As described previously, pain is a multi-factorial experience, which combines psychological, social, and biological factors experienced differently by each person (Asmundson, Vlaeyen, & Norton, 2004; Butler & Moseley, 2008; Camic, 1999; Caudill, 2002; Collen, 2005; Hardin, 2004). The idiosyncratic nature of the pain experience makes it difficult to deliver systematic and reliable treatment within the medical model simply because communicating the pain experience cannot be generalized between individuals. While a ten-point numeric pain scale is often used to gain a phenomenological measure of pain intensity, the pain ratings are subjective and serve little diagnostic purpose (Hardin, 2004). As a result before discussing the theoretical impetus for implementing art therapy in chronic pain treatment, the general considerations for chronic pain treatment must first be addressed including the general treatment goals. Furthermore, because art therapy is currently considered to be a CAM treatment, consideration must also be given to the nature of CAM treatments. Finally, the qualities that make art therapy an appropriate treatment for chronic pain will be discussed.

Treatment Considerations

The treatment considerations for a complex condition such as chronic pain are numerous. First, because chronic pain treatment typically takes place in a multidisciplinary setting it is important for the different professionals working on the team to possess an understanding of different approaches to treatment (Lipman, 2005). Furthermore, it is important that each professional on the pain management team have a clearly defined role. With professions that are well-established in pain management such as psychology,

medicine, physiotherapy, occupational therapy, and nursing, this is not a problem. However, when it comes to CAM therapies like art therapy, the roles are not as clear (Heywood, 2003; Shapiro, 1985). As discussed in the previous section, because chronic pain is such a complex and highly individualized condition it is important that treatment is also highly individualized. As pain can impact and be impacted by so many different factors, it is important to be aware of the possible barriers in chronic pain treatment.

Barriers to Treatment

Phillips (2008) posits ten reasons why people do not heal from pain. One, people might experience a freeze response, which constricts breathing and other vital rhythms. Two, a disconnect between mind and body may be experienced. Three, the ability to feel positive sensations might be lost. Four, individuals may not be adequately informed about chronic pain and related resources. Five, the ability to focus or engage in mindfulness could be impaired. Six, the energies in the human system can be disorganized and blocked. Seven, as a result of the pain individuals may have decreased his or her level of physical activity leading to further physical deconditioning. Eight, one may have a history of unrelated trauma related to the pain. Nine, some individuals may experience difficulty due to unaddressed emotional pain. Ten, individuals may be subject to internal conflicts. In addition to the barriers cited by Phillips (2008), other barriers have also been identified by other sources as well. In writing about somatoform disorders, Janca, Isaac, and Ventouras (2006) posit that another barrier to treatment can be the comorbidity of mental and physical disorders.

To effectively address these barriers, it must be determined how individuals living with chronic pain are impacted by their pain experience, which barriers are standing in the way of rehabilitation, and how the individual is doing in the pain management program.

Understanding the barriers experienced by an individual with chronic pain requires collaboration between professionals and the presence of these barriers should be reassessed regularly in order to ensure the goals of treatment are met.

Goals of Treatment

Treatment goals in chronic pain naturally differ from one person to the next depending on the factors involved in the pain experience. However, a general goal common in chronic pain treatment is self-management (Asmundson, Vlaeyen, & Norton, 2004; Butler & Moseley, 2008; Caudill, 2002; Hardin, 2004; Landgarten, 1981). Self-management involves a number of different components including: increased self-awareness (Caudill), minimizing catastrophic thinking (Asmundson, Vlaeyen, & Norton), encouraging pacing, identifying triggers for pain flare ups, and fostering creative thinking with respect to lifestyle change.

Treatment

There are a variety of approaches to treating chronic pain and all of them depend on the context in which they are implemented (Butler & Moseley, 2008). While some contexts allow for long-term treatment (Bullington, Nordemar, Nordemar, & Sjöström-Flanagan, 2003; Bullington, Nordemar, Nordemar, & Sjöström-Flanagan, 2005; Pavlek, 2008; Theorell, et al., 1998), other treatment contexts employ a disease model of treatment, which supports individuals in their chronic condition and assists individuals to maintain healthy coping (McCarberg & Turk, 2005). Some contexts even look outside the medical model for alternative and complementary treatments. In other cases, it is the client who seeks out different kinds of treatments when pain persists. In fact many chronic pain patients turn to alternative methods when they feel like conventional medical interventions have failed them

(Harstall & Ospina, 2003; Koenig, 2003). Because treatment involves both professional referral and self-referral by persons living with chronic pain, it is important for all professionals working in the field of chronic pain to understand different kinds of treatments including CAM.

What is CAM?

According to the NCCAM “CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (NCCAM, 2007, p. 1). However, CAM does not refer to one kind of intervention. In fact, there are three distinct systems of treatment: complementary medicine, alternative medicine, and integrative medicine. Complementary medicine is used in conjunction with main-stream medical interventions, alternative medicine is used in place of conventional medicine, and integrative medicine combines conventional medicine with CAM approaches. Further subgroups that fall under the CAM umbrella are: (a) whole medical systems like Ayurveda, traditional Chinese medicine and homeopathic medicine; and (b) mind-body medicine including the creative and expressive therapies, biologically-based practices involving treatment with natural substances, manipulative body-based practices like chiropractics or massage, and energy therapies like Reiki (NCCAM, 2007). Due to the biopsychosocial characteristics of chronic pain, the most commonly discussed CAM treatments are mind-body treatments such as relaxation and bio-feedback. However, there are many kinds of mind-body treatments and not all of them fall under CAM. For instance, cognitive behavioural therapy was once considered a CAM approach, but since a great deal of research has found it efficacious, it has been moved into mainstream classifications (NCCAM).

To better serve individuals living with chronic pain, there has been some attempt to systemize when, how, and which types of pain syndromes are treated with which kind of mind-body treatment. Garguilo, McCaffery, and Frock (2003) identified three categories of chronic pain (somatic, visceral, and neuropathic) and paired them with the most appropriate pharmacological, mind-body, or spiritual treatment. In the attempt to try to systemize treatment and make it more efficient, it is understandable why such classification might be made. Also given the varying knowledge of CAM treatments by medical professions, such a classification might serve to raise awareness of different CAM treatments and how they might be used and when. On the other hand, this view is not universally shared since this kind of model implies a curative approach. Butler and Moseley (2008) describe diagnosis as less important simply because one individual's condition can be diagnosed in many different ways. Instead, Butler and Moseley explain that it is more important for an individual living with chronic pain to understand the symptoms that differentiate tissue damage from a nervous system that is erroneously transmitting signals of danger.

Why Art Therapy?

The foundation for the theoretical applications of art therapy in pain management rests in the primary goals of pain management. Unmanaged chronic pain can erode a person's sense of self, leaving him or her feeling hopeless and at odds with the life he or she once knew (Landgarten, 1981). Given the possible effect of chronic pain, one might ask how art therapy can help with self-management.

Phenomenology and Communication

Art therapy regardless of the theoretical approach depends on the individuals' phenomenology and provides an opportunity for communication in a way that allows

individuals living with chronic pain to express feelings and emotions that might otherwise be difficult to express (Queen, 1998). This quality of art therapy can help individuals in a number of ways. First, because pain can be aggravated by psychological factors, art therapy can be initiated to address and explore unaddressed emotions and internal conflicts. Second, the motivations for creating art and the dynamics responsible for the creation of muscle tensions appear to come from the same source (Dannecker, 1991). In this way the communication and self-expression can help with increased muscle tension. Third, in the case where pain may be linked to unresolved trauma, art therapy can be used to circumvent alexithymia (the inability to verbally express intense emotion), help the individual remember and process trauma, and neutralize body memories which are linked to the trauma. Fourth, art therapy can provide a safe context in which the client can gain insight into the nature of his or her pain. Finally, self-expression through art therapy can also aid with assessment. From a professional point of view, communication through art can reveal attitudes towards treatment, provide information regarding pain behaviours, and provide a visual account of progress (Landgarten, 1981).

Overcoming Blocks

Knill (2004) proposed that people experience emotional difficulty when they lose their ability to be creative. Professionals outside the art therapy world also support this. Butler and Moseley (2008) posit that one of the keys to rehabilitation is creativity. While Butler and Moseley were referring to utilizing creativity in finding new ways of moving that would not initiate a pain response and creating new lifestyles that are not limited by incapacitating flare-ups. Of course achieving the necessary change in lifestyle does not

happen instantaneously. An individual must first come to a realization that his or her life has not stopped completely and the art-making process is a way of doing this.

An inherent quality of art therapy is the tendency to engage in self exploration to shift attention away from the problem in order to address it (Knill, 2004). In this way clients are able to re-conceptualize and overcome barriers, which formerly restricted their lifestyle. For instance perhaps clients are able to make art without pain or without a flare-up. Such an experience can be beneficial in two ways. First, making art without pain can be a source of positive emotion. Second, the art therapist can work with the individual to understand why pain may have been absent and how to transfer this into the client's daily life. Conversely, a client might find prolonged art therapy painful in which case pacing of physical activity can be addressed. This scenario is also beneficial to learning. Through the art process, the individual has the opportunity to practise mindfulness and body awareness. As such, clients can learn to listen to their body so that they can more effectively learn how to pace themselves which is yet another coping mechanism they can apply to their daily life.

In this chapter the theoretical reasons for implementing art therapy in chronic pain treatment were discussed in relation to the nature of the pain experience, treatment goals and treatment barriers. The primary and general goal of treating chronic pain was self-management. This provided an excellent platform from which art therapy theory could be applied to chronic pain since the primary goal of art therapy is to promote personal expression, personal growth, integration, and healing as opposed to cure. Specific areas of art therapy theory which illustrated this compatibility were: (a) the creative process inherent in art therapy, (b) the allowance of alternate and creative communication, and (c) allowing people to overcome creative blocks which hamper their ability to cope with chronic pain and

its resulting impacts on sense of self. Furthermore there is a compatibility of art therapy with other forms of mind-body treatment implemented in chronic pain treatment. In a multidisciplinary treatment program clients are able to learn and practise self-management in all areas of treatment. In this multifaceted context of treatment, art therapy offers a means in which clients are invited to explore emotion, meaning, self-awareness, and communication at their own pace using terms that make sense to them. Also clients might learn something about themselves in the safe context of art therapy and be able to apply the learnings analogously to real life adaptations.

CHAPTER V: A REVIEW OF THE LITERATURE

After a thorough search of the University of Calgary electronic databases, it is clear that the literature on art therapy interventions in relation to chronic pain treatment is sparse. A plethora of themes, approaches, and populations are addressed in the literature. In this chapter, an attempt will be made to investigate how art therapy is useful in the treatment of chronic pain. Books, journal articles, abstracts, and relevant websites relevant to how art therapy is used in chronic pain treatment will be searched and reviewed.

In reviewing the literature, a clear distinction can be made between investigating the application of art therapy and exploring the benefits of recreational art-making that appears to have therapeutic value. Art therapy is a modality of treatment carried out by professional art therapists with the explicit intention of using art as a form of therapy for chronic pain. On the other hand, the literature found pertaining to the therapeutic benefits of art-making were carried out by a wide range of professionals who recognized and were interested in the inherent therapeutic quality of art-making but not trained in art therapy specifically. Despite the division recognized in the literature there are still many overlaps between the two areas which can serve to further the understanding how art therapy works in chronic pain treatment. For the sake of clarity the articles from each of the aforementioned areas will be presented in separate sections followed by a discussion of how the areas of art therapy and therapeutic art-making intersect. The contributions and limitations of the current literature will also be highlighted. To further assist in analyzing the current state of the literature, two tables were created outlining the method, findings, and limitations of each journal article in the art therapy and therapeutic art-making sections.

Art Therapy and the Psychological Components of Chronic Pain

One of the main reasons for implementing art therapy in chronic pain treatment is due to the importance of treating chronic pain from a mind-body perspective. To date there are relatively few articles regarding the use of art therapy in chronic pain treatment. Several journal articles were found to specifically address psychosomatic symptoms in chronic pain. Theorell and colleagues (1998) conducted a longitudinal study investigating how art psychotherapy might be useful for patients suffering from psychosomatic symptoms. In this article art psychotherapy was used to refer to creative modalities such as visual art, music, dance, and drama therapy. The results of this study were based on evaluations given to patients during their treatment and after they had completed art psychotherapy. The average time each patient stayed in the program was two years.

This study is of particular interest for the topic at hand. First, Theorell et al. (1998) based the treatment approach on psychosomatic theory and alexithymia. From the questionnaire distributed to patients who participated in the program, as well as those who dropped out, a number of interesting results were discovered. The study showed that art therapy did not help all patients. Some patients felt that the treatment helped them with either somatic or psychological symptoms, both, or neither. However, for those patients who found art therapy beneficial to their rehabilitation, they did not all respond in the same way. While many patients were decidedly positive towards art psychotherapy, others felt that the therapy was “too nice” (p. 55), or that it should be practised in conjunction with other forms of therapy.

The aforementioned article draws attention to the variable perception between patients regarding the efficacy of their treatment. Brown (2004) addressed the issue of how effective chronic pain interventions are and what treatments chronic pain sufferers found

most helpful for their condition. Though art therapy is not specifically addressed in this article, Brown found that patients who felt a sense of trust towards their healthcare professionals were more likely to be compliant. In effect a key component to effective treatment is a strong working alliance.

Brown (2004) is not unique in her assertion that the therapeutic alliance between health care professionals and chronic pain patients is important. Bullington, Nordemar, Nordemar, and Sjöström-Flanagan (2003, 2005) and Theorell (1998) also emphasized the importance of the working alliance. Specifically, Bullington et al. (2003) and Theorell et al. found that as patients made meaning of their art they reported an increased level of stress. This was reflected in various ways including temporary withdrawal from treatment (Bullington, Nordemar, Nordemar, & Sjöström-Flanagan, 2003), increased blood serum levels, and self report (Theorell, et al.). Furthermore, some case studies presented in Bullington, Nordemar, Nordemar, and Sjöström-Flanagan, (2003) and Dannecker (1991) revealed that patients with chronic pain who also had a history of trauma which served to aggravate pain symptoms. Sivik and Shoenfeld (2005) emphasized the importance of understanding and treating possible underlying trauma in patients diagnosed with psychosomatic-based chronic pain.

While psychosomatic theory appears to be a common approach to chronic pain treatment, two sources were found describing patients with similar diagnoses, yet approached therapy from a different theoretical orientations. Shapiro (1985) based the implementation of art therapy on theoretical considerations borrowed from psychosomatic theory but did not explicitly categorize the patients she worked with as suffering from psychosomatic disorders. The theoretical concepts Shapiro utilized were the presence of alexithymia and the

manifestation of unexpressed emotions as increased muscle tonus. As such, the article presented similar findings as related in previously discussed articles. Conversely, Pavlek (2008) appeared to adopt a more cognitive behavioural approach during the course of a ten-week integrative pain management program including such interventions as cognitive re-processing, progressive relaxation, and hypnosis. In this context art therapy was used in a very structured way in conjunction with progressive relaxation. Patients were directed to use color to represent tension in their body before and after progressive relaxation with the intention of creating awareness regarding the relationship between relaxation and pain intensity. Pavlek noted that through the use of the art patients were able to recognize some positive difference in the quality of their pain.

Issues in Practice

Art therapy can be incorporated in chronic pain treatment in a variety of different ways depending on the theory utilized and the population being assisted. Also, in addition to the importance of the working alliance, other issues in chronic pain treatment must be addressed. With respect to the practice of art therapy and other creative modalities in chronic pain treatment each of the articles provided some information regarding practice by drawing attention to the role of metaphor in chronic pain treatment, the role of art in self-management, and multidisciplinary approaches to treatment.

Metaphor and chronic pain.

A discussion common to a few of the journal articles was the identification of general themes arising for the patients during the course of art therapy such as dependence (Dannecker, 1991), only having the ability to feel pain (Shapiro, 1985), feeling separated from the body (Flanagan, 2004), and feeling a sense of chaos (Bullington, Nordemar,

Nordemar, & Sjöström-Flanagan, 2003, 2005). Furthermore, in an unpublished Masters thesis the theme of breaking free from the prison of a painful body was also identified (Queen, 1998). Due to the phenomenological nature of art therapy, the themes in art therapy treatment can vary from one patient to the next. In fact, an abstract of a Swedish study found 500 different themes regarding the chronic pain experience (Flanagan). Also, such themes appeared to change as patients moved through their treatment. This was supported by articles from Dannecker and Shapiro and case studies from a book chapter by Landgarten (1981).

With respect to art-making it appeared very important to allow patients to engage in the process in a way they felt most comfortable in order to build confidence. In a way this can be compared to the stages of change that are often assessed in chronic pain treatment using instruments like the Pain Stages of Change Questionnaire (PSOCQ). The PSOCQ is used to measure how ready an individual living with chronic pain is to make necessary life style changes (Maurischat, Härter, Kerns, & Bengal, 2006). For instance, if an individual has not accepted the chronicity of his or her pain and has not assumed responsibility for it, it is likely that teaching the individual self-management skills would prove ineffective. The reason for this is that with the absence of accepting the state of chronic pain, the individual will likely continue to look for a professional to cure his or her pain (Maurischat, Härter, Kerns, & Bengal).

Similar to stages of pain, readiness to create art must also be honoured. Dannecker's (1991) case study showed that in the beginning stages of art therapy, the patient was more interested in learning technical aspects of art-making and reproducing well known works of art. Dannecker interpreted this as a defense mechanism. This theme of guardedness also appeared in Bullington, Nordemar, Nordemar, and Stjöström-Flanagan (2005) during the

course of dance and movement therapy. However, instead of the patient being reluctant to creating art, the patient was reluctant to move her body. In both cases of visual art and movement therapy, patients were eventually able to move through their initial trepidation and explore underlying issues that aggravated their pain through the use of metaphor. Specifically, metaphors were used as a mechanism to bridge meaning arising from art-making to the reality of the patient. Overcoming initial reluctance towards the creative process would not have been possible without first allowing the patients to engage in a way that felt most comfortable to them without judgment.

This idea of taking small steps is similar to a movement-based intervention presented by Butler and Moseley (2008) who discussed activating the virtual body. The idea of the virtual body is derived from research conducted on phantom pain resulting from amputation. Quite often people living with an amputation continue to experience pain and other sensation in their missing limb. This is a result of the neural pathways connected to the function of the missing limb remaining intact despite the absence of the limb. While the limb was still present these neural pathways or virtual body map enabled proprioception (the ability to know where one's limbs are in relation to one another). To activate the virtual body described by Butler and Moseley, patients with chronic pain are encouraged to experiment with small modified movements to identify which movements do not elicit a pain response. On a neural level this was said to retrain the brain regarding what it considers to be dangerous stimuli while on a psychological level it is teaching the patient that movement without pain is possible. In the realm of creative modalities this theory can be capitalized upon because the art-making process provides a situation in which activating the virtual body can be carried out in an applied context.

Art therapy and self-management.

Teaching self-management is currently regarded as one of the most important components of chronic pain treatment. Consequently it is surprising that relatively little art therapy literature was devoted to this area. Many articles appeared to consider barriers to self-management as a consequence of un-resolved psychological issues (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan, 2005; Dannecker, 1991; Flanagan, 2004). While this is in agreement with the barriers presented by Phillips (2008) cited in the previous chapter, some case studies suggest that art therapy might have the potential to make a greater contribution to self-management. In her book chapter, Landgarten (1981) specifically addresses how art therapy can be used to explore and assess the level of self-management patients have achieved through making art.

In particular, two case studies contained in book chapters made a case for using art therapy in self-management of chronic pain. First, through a series of vignettes, Landgarten (1981) illustrated how art therapy could help chronic pain sufferers gain insight into their rehabilitation process with respect to both challenges and progress. This insight could then be re-applied to enhance the patients' self-management skills. This process served to stimulate the awareness of patients to which coping mechanisms were working for them and which were not. Second, self-awareness was also addressed in a case example by Long (2004). However, instead of using art therapy mostly as a way to measure progress, Long implemented art therapy as means of pain modulation. In the case of a 79-year-old woman who was nearly incapacitated by arthritis in her shoulders, art was utilized to identify the nature of her pain through colour and externalize it through metaphor. In this case the woman likened the pain in her shoulders to a clawed "pain monster" (p. 330). The woman was then

directed to depict her pain monster and illustrate through the art how to defeat it. As the client found a way to vanquish the pain monster in her art, the pain in her shoulder subsided. This method was also used in conjunction with the processing relevant psychological material that arose during therapy to address other painful areas in the woman's body. According to Long the results that came from her sessions with the woman were quite unexpected since this type of response was not documented in the literature.

This case example provides a surprising twist with respect to what the literature predicts as the outcome of art therapy. In this case, art therapy was a primary intervention which brought about the relief of pain. While Long (2004) also addressed psychological material with the woman she did not discuss the interplay between the symbolic battle with pain in conjunction with psychological material, or whether they related to each other at all. Furthermore, the results cited by Long are merely observations of a treatment process and lack the methodological rigor of a formal case study.

Multidisciplinary treatment.

Results from a few of the studies suggest that art therapy is best initiated as a part of a multidisciplinary team. While Bullington, Nordemar, Nordemar, and Stjöström-Flanagan (2003, 2005), Flanagan (2004), and Shapiro (1985) all carried out creative-based treatments as part of multidisciplinary teams, this did not appear to be the case with Theorell et al. (1998) and Long (2004). While the program in which Theorell et al. were working was said to be closely coordinated with a pain program, there was no discussion regarding multidisciplinary interventions. In consequence, some patients thought they might have benefited from a more multidisciplinary approach in conjunction with art therapy. Long on the other hand was working in an outreach context with an elderly individual who was not

being treated in a pain program. As a result, the art therapy interventions described by Long included pain modulation through imagery.

While art therapy is slowly starting to work its way into multidisciplinary teams, art therapists still have a lot of work to do in terms of raising awareness of what art therapy is, how it works, and how it might help people living with chronic pain and documenting its effects. These questions are important because art therapy is not the most obvious chronic pain treatment. While some patients might be comfortable with the art-making and welcome the opportunity to make art, others who do not think they possess the talent may be both resistant and skeptical towards art therapy as an adjunct treatment. As such, it is the art therapist's role to explain to patients and other professionals alike why art therapy is helpful, thus increasing the number of appropriate referrals to art therapy and patients' receptivity to trying a different kind of mind-body intervention.

Therapeutic Art-making and the Arts in Medicine

As discussed in the previous chapter devoted to art therapy, while creating art can have therapeutic benefits, it is important that art therapy and the therapeutic quality of art-making are not confused. In this section the interplay of art therapy and art as therapy specifically in the context of Arts in Medicine (AIM) programs will be discussed. While these following articles do not deal directly with chronic pain and art therapy, they serve to illustrate the necessity for some considerations to be taken into account in the incorporation of art therapy in a multidisciplinary setting. This in turn could be an asset to art therapists and agencies looking to integrating art therapy into their treatment approach.

What is AIM?

According to Rockwood Lane (2005, 2006) in AIM programs, all forms of creativity are employed including music, visual art, and dance. Furthermore, art is not only implemented as an activity for patients to engage in, rather AIM programs take a far broader approach to incorporating the arts in healing such as having performers in the foyer of the hospital, decorating patient rooms with art they like, and giving patients the option of listening to music during surgery or chemo therapy. The idea behind this being that if a patient is more comfortable the healing process will be more efficient.

All of the articles on this topic explain the many benefits art in medicine. Among the benefits cited are improving quality of life (Ross, Hollen, & Fitzgerald, 2006), evoking a relaxation response, stimulating the hypothalamus and encouraging homeostasis, more efficient immune function, changing emotional states, changing perception of pain (Rockwood Lane, 2005), shortening hospital stays, and decreasing the dosage of medication, (Rockwood Lane, 2006). Many of these findings are similar to the benefits observed in art therapy, yet they appear to be primarily anecdotal. It is true that there is much to be learned from observation in clinical practice. However the pitfalls of anecdotal evidence are many, especially because anecdotal evidence does not always cite contraindications of the interventions being implemented. Furthermore, evidence that is not systematically gathered and representative of a larger sample is not generalizable.

In addition to humanizing the hospital experience for patients experiencing medical issues impacting their quality of life, Rockwood Lane (2005) also notes that “it requires no special skill to acknowledge patients’ drawings as nonverbal forms of communication. To better learn about the patients’ attitudes, goals, fears, and pain nurses can ask the patient questions about the content of the displayed drawings. “ (p.124). This may be true and a

number of articles also take this stance that art, especially visual art is a form of communication that can be tapped to gain a greater understanding of the patients world (Shepard & Palmer, 2008; Collen, 2005; Henare, Hocking, & Smythe, 2003; Reynolds & Prior, 2003). Yet, without denying the implicit benefits of art listed in the aforementioned articles, questions regarding ethics arise. If art is a means of keeping people occupied during medical treatment, (Henare, Hocking, & Smythe, 2003), or an activity to distract patients' attention from their pain (Trauger-Querry & Haghghi, 1999), or a means for patients to achieve relaxation (Rockwood Lane, 2005), is it ethical for professionals to ask questions about patients' art? When patients are engaging in art work, do they know that their art might be used as a tool to elicit information from them?

Caution must be exercised with respect to questioning material in patients' art. Asking questions assumes that the patient is always trying to communicate. Asking questions also implies that art is always meaningful. Art therapists are specifically trained to address not only psychological issues that may arise in the art process but they are also trained to understand the creative process (Heywood, 2003). Furthermore, in contrast to exploring art content for information regarding patients pain as described Rockwood Lane (2005), art therapy focuses on approaching all art pieces with a sense of curiosity, thus allowing the patient to derive their own meaning from their art (Betensky, 2001). Also, if patients experience increased level of anxiety when they begin to make meaning of their artwork (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan, 2005; Theorell, et al., 1998), how are these individuals going to be supported in a non-therapeutic context when professionals untrained in art therapy begin asking questions? In the case of implementing art therapy as an adjunct to chronic pain treatment, once again it must be stressed that both art therapy and

chronic pain are specialized fields. Hence great caution must be exercised in who and how the process of art-making is facilitated and contained. Furthermore because the area of chronic pain is complicated, additional care must be taken to ensure that chronic pain theory is properly integrated with the art therapy process.

In consequence of the blurring between art therapy and AIM, one may beg to question where does one begin and the other end? How do they fit together and can a multidisciplinary milieu be created between AIM and art therapy? With respect to these questions based on the art therapy literature, it might be beneficial to continue supplying opportunities to make and experience art in all forms. Guidelines to safeguard the well-being and safety for clients in how art is used to assist them with chronic pain should be developed. Also, in the realm of art in medicine, it would also be important to include therapists specifically trained in art, music and dance therapy to be working these programs. In doing so, the benefits of the arts would be expanded and diversified, there would be increased interdisciplinary learning opportunities, and ensure that appropriate referrals would be made to professionally trained art therapists when the need arises, especially when there appears to be volatile material in the art-making or in client responses to the arts.

In theory, the idea of incorporating creative arts therapists in AIM programs seems like a good one. However, as noted in an article by Stoll (2005), there are a number of barriers such as the peripheral placement of art therapists on treatment teams and their input into protocols for medical management. Contributing to the barriers is a lack of international unity when it comes to defining what art therapy is and who should be practicing it (Stoll). For instance, in France, art therapy is not even recognized as a profession on its own because psychologists and psychiatrists are predominantly trained in the Jungian psychology which

already uses art in psychotherapy (Stoll). Also the only professionals who can perform psychotherapy are psychiatrists and psychologists. In the United States and Canada there is another issue. In order to work in hospital settings it is required that all professionals be licensed. However not all regions have a licensing requirement for art therapists. In New Mexico, this is not a problem because it is the only state in the US which requires art therapists to be licensed, ensuring that only art therapists are practicing art therapy. In other regions however, art therapists are quite often registered as counsellors, social workers, psychologists, or occupational therapists and are only able to find employment under these titles (Stoll). The resulting situation is one in which there is not a clear boundary between art therapy and therapeutic art-making and the professional training required to conduct art therapy.

Another issue that must be addressed when considering the initiation of interdisciplinary involvement in art programs is creating a clear definition of roles and effective communication between professionals. Lipman (2005) cites that there is quite often a blurring of roles on a pain management multidisciplinary team where a psychologist may inquire whether a particular physiotherapy intervention would be appropriate. In such cases it is important that a professional with the proper qualifications is present to answer these questions (Lipman). The same would have to happen in an art therapy multidisciplinary context. If a professional noticed in a patient's art work elements that caused him or her to believe that there might be something of concern, as part of multidisciplinary it would be ethical practice to consult with the art therapist.

If AIM programs were to be expanded to include an art therapy component, in addition creating clear a definition of art therapy, other ethical concerns must be considered. Due to

the nature of the therapeutic relationship in art therapy practice and the conceptualization of the art as an entity in and of itself, special care should be taken with respect to handling, storing, and displaying patient art work (Moon, 2006). In a therapeutic setting touching, displaying, and interacting with the art products can have a series of therapeutic implications (Moon). As such, all patients should be aware of their rights, the right of their art, and what to expect from a program that incorporates art therapy as part of an AIM program.

Heywood (2003) describes her experience with running an art therapy program parallel to an AIM program. Her integration depended on explaining what art therapy is and who might benefit from it. It is very important to recognize that, like other therapies, art therapy is not for everybody and it is up to the art therapist to ensure that the needs of the client will be met through the art therapy process. Heywood posits that patients may be suitable candidates for art therapy if they appear distant, uncommunicative, obviously distressed, are experiencing pain or respiratory distress due to anxiety, or require assistance in adapting to their medical condition.

Overlap Between Art Therapy and AIM

Most of the literature discussed how art therapy was a useful treatment for psychosomatic pain (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan, 2005; Bullington, Nordemar, Nordemar, & Sjöström-Flanagan, 2003; Dannecker, 1991; Flanagan, 2004; Long, 2004; Pavlek, 2008; Shapiro, 1985; Sivik & Shoenfeld, 2005; Theorell, et al., 1998). In some cases of psychosomatic pain, a history of trauma was said to exacerbate pain (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan; Dannecker; Long; Sivik & Shoenfeld). In such cases art therapy was reported to address alexithymia and consequently reduce muscle tonus (Shapiro, 1985). Also with respect to trauma, art therapy provided

patients an outlet for communicating unaddressed trauma material without having to verbalize their trauma experience immediately. In this way patients were able to ventilate difficult emotions and verbalize them at a time when they felt more comfortable. In addition to verbalizing psychological material, some articles devoted attention to art therapy as a means of pain modulation (Long, 2004) or as a means to enhance progressive relaxation (Pavlek, 2008).

While some valuable information was gathered through the studies presented in this chapter, only two articles provided quantitative evidence regarding the efficacy of art therapy in chronic pain treatment (Pavlek, 2008; Theorell et al., 1998). While it true that Sivik and Shoenfeld (2005) also carried out a quantitative study is difficult to properly discern the quality of their study due to the brief and unsystematic presentation of the results. The rest of the articles depended on qualitative case studies (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan, 2005; Dannecker, 1991; Shapiro, 1985) and anecdotal evidence from case examples in book chapters (Landgarten, 1981; Long, 2004). Nonetheless in congruence with assertions by McCarberg and Turk (2005) and Butler and Moseley (2008), findings from the art therapy/chronic pain research showed that not all patients benefited from art therapy. In fact Theorell and colleagues (Theorell, et al., 1998) only found borderline efficacy with their art therapy interventions.

It is evident from the small volume of literature regarding the use of art therapy in the treatment of chronic pain that there is much to be learned and understood in this field. In addition to the sparse nature of the literature there are also issues with the kind of literature available. Typically, the studies both quantitative and qualitative contained small sample sizes. As such, findings were not generalizable to other situations. Furthermore art therapy

was used in conjunction with other treatments and it was not clear what affect art therapy had on the patients involved in that study. With respect to the case studies and case examples presented, the issue of small sample size and generalizability surface once more. There are additional problems with case examples found in textbooks. Such examples may be informative, but are not subject to peer review and do not employ systematic research method to ensure a comprehensive analysis of all case variables.

At first glance, when reading the literature regarding AIM programs, similarities with art therapy can be identified. However, it is the process embodied in art therapy which sets it apart from recreational art-making in the hospital setting. Pain is certainly a condition which is encountered in the hospital setting and due to its phenomenological qualities it is only understandable that healthcare professionals would want to capitalize on the communicative qualities of art products to offer better treatment (Rockwood Lane, 2006). However, such professionals must exercise caution with respect to addressing patient art. Specifically in trying to make meaning of clients' artwork, professionals may bring up additional undue anxiety as observed by Bullington, Nordemar, Nordemar, & Stjöström-Flanagan (2005) and Theorell et al. (1998), who noted that as patients made meaning of their art they experienced an increased level of anxiety. As such if art therapy is to be integrated in AIM programs in which pain management would be a component, it is improtant that firm guidelines are installed with respect to referrals and competence to practise in art therapy (Heywood, 2003).

While AIM programs don't deal exclusively with chronic pain, there are several points that are helpful to note regarding how studies examining therapeutic art-making can inform art therapy. AIM programs are in part responsible for raising awareness of creative self-expression in healing. With respect to chronic pain, the literature in AIM serves to

inform art therapy in a multidisciplinary context. Because art therapy is grounded in psychotherapy practice, it is important that certain ethical considerations be made. Furthermore it is important that other professionals understand the ethical consideration involved in art therapy to avoid the inappropriate blurring of disciplinary lines. Finally in some instances the study of recreational art has informed art therapy practice by raising awareness of how some art materials can stimulate the onset of pain flare-ups in individuals who suffer from migraines (Sexton-Radek, 1999; Sexton-Radek & Vick, 2005). Although these articles yielded some beneficial information regarding how individuals were affected by art making, the articles presented were few, originated in different countries, and portrayed a mosaic of contexts and purposes because they were written by authors with different professional backgrounds like nursing (Rockwood Lane, 2005; 2006), occupational therapy (Henare, Hocking, & Smythe, 2003), and social work (Shepard & Palmer, 2008). Also, some articles provided only observational data which was not collected using rigorous research methods (Rockwood Lane, 2005; 2006) or relied on personal commentary (Collen, 2005).

CHAPTER VI: SYNTHESIS

The primary focus of this paper was to examine the psychological treatment of chronic pain from an art therapy perspective. Specifically an attempt was made to clarify how art therapy is used in the treatment of chronic pain, to identify both strengths and weaknesses in the current literature, and to propose possible avenues for further development. In order to clarify how art therapy is currently used in chronic pain, four major topics were discussed : (a) chronic pain; (b) art therapy; (c) theoretical impetus for incorporating art therapy in chronic pain treatment; and (d) the state of the literature with respect to how art therapy is used in treating chronic pain.

Chronic Pain

The chapter regarding chronic pain provided some basic historical and theoretical information informing current approaches to treatment in chronic pain. The information presented was by no means exhaustive. Rather it was meant to emphasize chronic pain as a highly unique, multi-factorial mind-body phenomenon requiring chronic pain professionals from multiple disciplines to assess how each individual is affected by chronic pain and initiate treatment accordingly.

Through examining history, current definitions, and psychological perspectives, a theoretical base for chronic pain was established in order to incorporate art therapy theory. The major points emphasized were: (a) the idiosyncratic nature of pain and how variable it is both within and between individuals (Butler & Moseley, 2008; McCarberg & Turk, 2005); (b) that pain can be exacerbated by emotions and external factors such as stress and maintained by decrease activity, acceptance of the sick role, loss of hope, and dysfunctional relationships resulting from the pain experience (Asmundson, Vlaeyen, & Norton, 2004; Butler & Moseley, 2008; Caudill, 2002; Gatchel, 1996; Hardin, 2004; Keefe, 1982; Melzack

& Wall, 1965; Niv & Devor, 1999); (c) perception of pain and subsequent behaviours can be influenced by the unconscious, thus pain can also be impacted by untreated trauma (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan, 2003; 2005; Janca, Isaac, & Ventouras, 2006); and (d) no treatments consistently and predictably alleviate chronic pain (Butler & Moseley, 2008; McCarberg & Turk, 2005).

Art Therapy

In the chapter addressing art therapy, an attempt was made to synthesize the theoretical concepts in order to provide a definition of art therapy and describe the mechanisms involved in the art therapy process. The discussion of these topics revealed that art therapy is a phenomenological form of psychotherapy which emphasizes the healing nature of creativity in order to overcome personal challenges (Knill, 2004). Due to the nature of the triangular working alliance involved in art therapy, individuals are able to externalize their problems through the creation of a physical art object and process it in terms of metaphor (Betensky, 2001; Knill; Schaverien, 2000). This process unique to art therapy provides a way of bridging meaning gained from the creative process with real life situations (Betensky, 2001). In this way, mobilizing creativity through art therapy supports problem-solving skills which can be applied in everyday life.

The Impetus for Using Art Therapy in Chronic Pain Treatment

The theoretical reasons for implementing art therapy in chronic pain treatment were discussed in relation to the nature of the pain experience, treatment goals and treatment barriers. The primary and general goal of treating chronic pain was self-management. This provided an excellent platform from which art therapy theory could be applied to chronic pain since the primary goal of art therapy is to promote personal growth, integration, and

healing as opposed to cure. Specific areas of art therapy theory which illustrated this compatibility were the creative process inherent in art therapy, the allowance of creative communication, and fostering the mobilization of new coping skills.

State of the Literature

With respect to the literature review undertaken in chapter five the search words were limited specifically to gain an understanding of how art therapy literature addressed chronic pain treatment. While there are other areas which are closely linked to art therapy such as the literature regarding mind-body medicine, such an inquiry did not serve the specific purpose of this paper.

One of the original objectives of this paper was to examine how art therapy was used in the treatment of chronic pain in relation to etiology. However, due to the lack of agreement towards definitions in both respective fields as well the phenomenological nature of both art therapy and chronic pain, creating a systematic if-then discussion regarding etiology and treatment within this subject was deemed to be inappropriate and premature. In fact Butler and Moseley (2008) suggest, “pain is so unique, a ‘recipe’ for management that is the same for all pain situations will not do” (p. 99). Consistent with this assertion, findings from the art therapy/chronic pain research showed that not all patients benefited from art therapy. In fact Theorell and colleagues (1998) only found borderline efficacy with their art therapy interventions. Furthermore, most studies to date have been based on case studies with individual clients. Hence the findings of studies are limited by their methods and sample size.

Gaps in the Literature and Further Research

It is not a surprise that there are many gaps in the literature regarding the use of art therapy in chronic pain treatment since this topic of inquiry is still nascent. Most of the art

therapy literature addressed psychosomatic forms of pain, and even then only a handful of articles were found. Most studies describe how art therapy was used in long-term treatment (Bullington, Nordemar, Nordemar, & Stjöström-Flanagan, 2005; Long, 2004; Theorell, et al., 1998). Only Pavlek (2008) used art therapy in a comparatively brief integrative treatment program (10 days). More studies need to be carried out to test the efficacy of brief forms of art therapy described by Pavlek. Second, most of the sources included were of a qualitative nature with only Theorell and colleagues (1998) and Pavlek (2008) providing quantitative data . As such, more quantitative studies must be carried out in order to gain a better understanding of how many people find art therapy beneficial to their chronic pain treatment, making the findings more generalizable. Finally, there was relatively little information regarding how art therapy operated in conjunction with other chronic pain treatments. Consequently a multidisciplinary study might provide some valuable insight into how art therapy complements other treatments. As part of investigating the role of art therapy in multidisciplinary setting, it might be valuable to further explore the collaboration between the different modalities of creative therapy as well.

In closing, to date, art therapy has been found to be an effective adjunct to chronic pain treatment for some individuals. However, the effectiveness of art therapy was not as clearly defined across all studies. For art therapy studies to be meaningful, the researchers need to specify what kind of “art therapy” was carried out. The term art therapy was overly flexible as the different modalities of art were often lumped together. At the moment it appears that most of the studies being carried out with respect to art therapy as an adjunct treatment to chronic pain are a means of exploring a new approach to providing more holistic treatment. Exploration is the key to learning more about a new field of study. While interest

has been shown in the use of art therapy in chronic pain treatment, this area of study remains relatively unexplored with only a handful of articles on this topic in peer-reviewed literature. It is undoubtedly an important topic for future research.

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TABLES

Table 1

Art Therapy and the Psychological Components of Chronic Pain

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Meaning out of Chaos: A Way to Understand Chronic Pain. (Bullington, Nordemar, Nordemar, & Sjöström-Flanagan, 2003)	- Focus group of clinicians	- 1 Occupational therapist/music therapist, - 1 physiotherapist/ dance therapist, - 1 medical doctor - 2 adults with prolonged somatic symptoms.	- Enrich the clinicians' understanding of the unique nature of the chronic pain experience.	- Both cases derived meaning from chaos.	- Results were solely based on clinicians' interpretation. - Results were not confirmed with patients. - Results were not generalizable.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
From Pain Through Chaos Towards New Meaning: Two Case Studies (Bullington, Nordemar, & Stjöström-Flanagan, 2005)	-Focus group of clinicians. - Information from focus group was used to construct two case studies.	- 1 Occupational therapist/music therapist, - 1 physiotherapist/ dance therapist, and - 1 medical doctor - 2 adults experiencing prolonged incapacitation from somatic symptoms.	-Inform clinicians understanding of phenomenology of the pain experience by investigating “meaning out of chaos” as a theoretical construct to describe successful rehabilitation.	-Two types of chaos were identified: Chaos I - the patients’ lack of understanding towards their condition. Chaos II- the lived experience of chaos as patients gained more awareness about their condition.	- Respondents were not randomly chosen. Rather the patients who best illustrated meaning out of chaos were chosen. - Case studies are subject to clinicians’ interpretation.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Body and Expression: Art Therapy with Rheumatoid Patients (Dannecker, 1991)	- Case illustration.	- 3 women diagnosed with rheumatoid arthritis.	- Investigate how art therapy is helpful in the treatment of rheumatoid arthritis.	- Evidence of patient defense mechanisms evident in the art. - Patients initially desired objective critique and instruction with respect to their art. -As patients progressed art changed. - Partial alleviation of pain.	-Because this article is a case illustration, results reported are not generalizable.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Paining out: An Integrative Pain Therapy Model (Pavlek, 2008)	- Therapy model evaluation by anonymous questionnaire.	- Adults between the age of 25-55. - 6 females and 3 males -Diagnosed with various pain syndromes.	- To investigate the effectiveness of an integrated model. - To contribute and complement already existing knowledge of mind-body interventions for chronic pain.	- Integrated model presented in the study was successful in decreasing intensity and frequency of subjective pain events. - An increase in functional coping skills was also found.	- Small sample group limits the generalizability of findings. - Results were not compared with other models of treatment. - No comparison was made with a different group of people completed the same program.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
All I have is Pain (Shapiro, 1985)	- Case illustration.	- A woman in her sixties who experienced life long problems form back and neck pain as a result childhood injury.	- Investigate how art therapy can be used to assist with the treatment of chronic pain.	- Client was able to use art to work through issues of body image and self-esteem while physiotherapy provided increased physical comfort and strength. - Art therapy offered and unique perspective in a multidisciplinary setting.	- Because this article is a case illustration results reported are not generalizable. -This is an older study based on few scholarly sources.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Psychosomatic Integrative Treatment program and Rehabilitation (Sivik & Shoenfeld, 2005)	- Longitudinal evaluation.	- 650 men and women experiencing chronic psychosomatic symptoms enrolled in a Swedish integrative rehabilitation program.	- Measure how effective a currently running integrative health program is in the treatment of psychosomatic symptoms.	-Patients reported significant improvement in emotional and relational coping, somatic symptoms, anxiety, muscular tension, decreased verbal aggression and internalized anger. - Levels of prolactin in 10 randomly chosen participants coincided with positive patient reports.	- The description of this program evaluation is brief and does not provide critical and rigorous discussion of its findings.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
The Treatment of Patients with Chronic Somatic Symptoms by Means of Art Psychotherapy: A Process Description (Theorell et al., 1998)	- Quantitative, 2 year longitudinal, pilot study.	- 24 patients (22 women; 2 men) who had been unable to work for over a year due to their somatic symptoms.	- To describe and test the feasibility of art psychotherapy with patients experiencing long term symptoms.	- The first year of treatment was marked by emotional turmoil, followed by a slow improvement after two years. - Authors found this approach to rehabilitation more successful than others.	- Small sample size. - Patients may have been reluctant to describe themselves as feeling better since that would mean the cessation of treatment. - No direct comparison with other forms of psychotherapy so the efficacy of art therapy as a modality cannot be confirmed. - Art Psychotherapy is not clearly defined.

Table 2

Therapeutic Art-making and the Arts in Medicine

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Life of Pain, Life of Pleasure: Pain from the Patients' Perspective- The Evolution of the PAIN Exhibit. (Collen, 2005)	- Personal commentary.	- 1 middle age man with long term incapacitation due to pain.	- Describe personal pain experience and the barriers encountered. - Raise awareness of the pain experience and the difficulties facing pain sufferers.	-Communication of the pain experience was difficult. Author experienced disbelief from health professionals. - Found that art was the most effective way to describe his symptoms. - An online gallery was created so that other pain sufferers can share their experiences.	- The information from this personal commentary is not generalizable. - Does not employ any qualitative research methods.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Chronic Pain: Gaining Understanding Through the Use of Art (Henare, Hocking, & Smythe, 2003)	- Small-scale qualitative study.	-14 patients, ages of 27-63 attending a pain rehabilitation program. - 10 women; 4 men - Unlimited cultural backgrounds	- Provide a detailed description the pain experience.	- Five general themes were identified: gaining pain, losing self, redefining self, identity, through others, being hopeful and being on a journey. - Engaging in meaningful occupation was strongly associated with redefining self, experiencing oneself as a whole, and being hopeful about the future.	- The themes identified in the study are subject to both researches interpretations and the - Narratives of art work were not explored through questioning. As such only the “in the moment” experience was captured.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Introducing Art Therapy into the Christie Hospital Manchester UK 2001-2002 (Heywood, 2003)	- Program description and case illustration.	- 3 adult females receiving in-patient radiotherapy.	- To explore how individuals could address their psychological needs and gain understanding of their diagnosis of cancer through art therapy.	- Art therapy can offer patients: Support during times of distress. - Alternate ways of addressing frightening experiences related to the course of illness. - Safe environment for the expression of emotions. - Greater awareness of spiritual and existential issues. - A different means of playing an active role in rehabilitation.	- Findings are based on author's interpretations and the self-report of clients. - Small sample size thus findings cannot be generalized. - No standardized method was used to gather and present client reports. - The population served by the program described in this article was not clearly defined.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
'A Lifestyle Coat- Hanger': A Phenomenological Study of the Meanings of Artwork for Women Coping with Chronic Illness and Disability. (Reynolds & Prior, 2003)	Qualitative study using a phenomenological interpretive analysis.	-35 female artists, ages of 29-72 living with various chronic illness lasting longer than two years. -Homogenous socioeconomic and cultural backgrounds.	-Explore meaning of living with chronic illness.	- Art was found to be a distraction from illness, a way of expressing grief, filling an occupational void, increasing choice and control, increasing present moment awareness, encouraging spontaneity, revising priorities, facilitating positive emotions, restoring self image building new relations, contributing to others, and regaining the ability of projecting oneself into the future.	-Narrow Socio-economic class. - Experiences are based on interview and self-report thus making the findings impossible to generalize. - No men included in the study. - Only artists participated in this study.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Arts in Health Care: A New Paradigm for Holistic Nursing Practice (Rockwood Lane, 2005)	- Program description.	- Individuals confined to hospital care.	- To describe a model of implementing an AIM program and how nurses can incorporate art in their practice.	- Describes benefits of AIM programs at various hospitals around the world. - Benefits of AIM programs include patients reporting being happier, reduced physical symptoms, and decreased pain.	- This article merely describes AIM programs and their positive benefits. - Information is purely anecdotal. - AIM programs are not compared for reliability. - Article provided on systematic critique of AIM programs. - Article provided no case examples.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Creativity and Spirituality in Nursing: Implementing Art in Healing (Rockwood Lane, 2005)	-Program description.	- Individuals confined to hospital care.	- Explaining how nurses can implement creative and spiritual modalities as advanced therapeutics.	<p>- Nurses from their first contact with patients can assess what patients' interests are and encourage them to engage creative activities such as music, dance, drawing, and journaling.</p> <p>- Characterized the nursing role as the best suited to guide patients to use creative outlets as methods of healing.</p> <p>-Creative activities can elicit positive physiological responses.</p>	<p>- Theories and suggestions for nursing practice overlap with those of the art therapist yet there is no mention about ethical implications for practicing outside nursing competencies.</p> <p>- Does not discuss contraindications of engaging in creative activities.</p>

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Interplay of Art Making Practices and Migraine Headache Pain Experience (Sexton-Radek, 1999)	- Qualitative study using mail-in survey as primary tool for gathering information.	- 151 participants of an American art contest for migraine sufferers.	- To explore the relationship between art-making and the migraine pain experience.	<ul style="list-style-type: none"> - In some cases different art materials and processes were associated with different kinds of migraine pain. - Respondents devised coping strategies to alter their art-making habits. - Emphasized the importance of taking detailed headache history prior to engaging in art therapy with migraine patients. 	<ul style="list-style-type: none"> - Not all respondents reported the process or materials involved in art making as triggers. Some experienced relief. - Results on generalizable. - This information was not compared to individuals experiencing migraines who engaged in art therapy. - No investigation of addressing the emotional effects of migraines on respondents through art therapy.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Art and Migraine: Researching the Relationship Between Artmaking and Pain Experience (Sexton-Radek & Vick, 2005)	- Qualitative study-127 using mail-in survey as primary tool for contest for gathering information.	participants of an American art contest for migraine sufferers.	-To explore the relationship between art-making and the migraine pain experience.	-Found that sometimes the art making process and/or art materials triggered migraines. - Some migraine sufferers continued to engage in art making despite the migraines	- Only leisurely art making was explored and results cannot be directly generalized to the art therapy process. -This information was not compared to individuals experiencing migraines who engaged in art therapy. - No investigation of addressing the emotional effects of migraines on respondents through art therapy.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
An Art Inquiry Into the Experiences of a Family of a Child Living with a Chronic Pain Condition: A Case Study (Shepard & Palmer, 2008)	- Multi-method qualitative, case study using art inquiry, to collect information.	- One family coping with chronic pain in their 6- year-old daughter.	- Developing a detailed description and understanding of the personal experiences of a 6- year-old child with chronic pain and her family.	- Family was under great strain. - Child felt reluctant to report when she experienced pain. - Using art as a means of inquiry allowed members of the family to better understand each other's individual experience.	- Findings from this article cannot be generalized to other situations. - It is unclear how the family situation impacts the pain experience of the young child.

Title and Author	Type of Study/Method	Sample	Purpose	Results	Limitations
Balancing the Focus: Art and Music Therapy for Pain Control and Symptom Management in Hospice Care (Trauger-Querry & Haghghi, 1999)	- Qualitative description of pain modulation techniques. Used brief clinical examples.	- 4 individuals (2 women; 2 men) in hospice care. - Age 33-76.	-To explain how art and music therapy can be used as a means of pain modulation.	- Music and art therapy served to shift patients' focus away from their pain. -When practiced by a trained therapist, art and music therapy aided in significantly reducing patient pain. - A sense of balance can be evoked through the art making process allowing for a more peaceful and meaningful death.	- The results presented in this study are anecdotal and not systematically explored. - Presented benefits are not generalizable.