Art Therapy and Cancer Care: A Qualitative Analysis of Visual Oncology Narratives

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ART THERAPY AND CANCER CARE: A QUALITATIVE ANALYSIS OF VISUAL ONCOLOGY NARRATIVES

A DISSERTATION
(submitted by)

Jill Virginia McNutt

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

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I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

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I hereby accept the recommendation of the Dissertation Committee and its Chairperson.

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TABLE OF CONTENTS

LIST OF TABLES ........................................................................................................... 8

LIST OF FIGURES ........................................................................................................... 9

ABSTRACT ....................................................................................................................... 11

1. INTRODUCTION ......................................................................................................... 12

   The Guiding Questions ............................................................................................... 12
   Rationale ..................................................................................................................... 13
   Assumptions .............................................................................................................. 14
   Art Therapy as Healing ............................................................................................... 15
   The Research ............................................................................................................. 16

2. LITERATURE REVIEW ............................................................................................... 17

   Cancer in the United States ....................................................................................... 17
   Defining the Patient Experience ............................................................................... 18
   Concerns for Survivors ............................................................................................. 21
   Mental Health Concerns ............................................................................................ 24
   Cultural Variation in Cancer Experience ................................................................ 26
   Healthcare Disparities in the United States ............................................................. 28
   The Survivorship Identity ......................................................................................... 30
   Meaning Making as a Stage toward Identity Integration ........................................ 31
   Art Therapy and Cancer Treatment .......................................................................... 34
   Benefits of Art and Art Therapy ............................................................................... 39
   Conclusion .................................................................................................................. 43

3. METHOD ..................................................................................................................... 45

   Visual Narratives Design ........................................................................................... 45
   Research Methodology ............................................................................................... 46
   Grant Process and Pre-Research Design .................................................................. 46
   Creation of the Visual Narratives ............................................................................. 47
   Art Therapy Facilitators ............................................................................................ 47
   Art Therapy Sessions ................................................................................................. 47
   Exhibition .................................................................................................................... 48
   Research Data ............................................................................................................ 49
   Interviews .................................................................................................................... 49
   Journal Process .......................................................................................................... 50
   Data Analysis ............................................................................................................. 50
   Phase I ......................................................................................................................... 50
   Portraits of two participants ..................................................................................... 51
   Summary Collage ....................................................................................................... 52
4. RESULTS

Presentation of Themes

Theme 1: Diagnosis and the Onset of the Cancer Journey
- Reaction to diagnosis
- The perception of control

Theme 2: Instilling Hope and Recognizing Strength
- The Need for Hope
- Strength, Encouragement and Possibility
- Trust

Theme 3: Ongoing Treatment and Support
- Physical Experience
- Experienced Healthcare Disparities including Perception of Control
- Coping with Treatment
- Support, Family Relationships and Community

Theme 4: Relaxation and Re-Focus
- Expression
- Catharsis
- Distraction and Setting the Pain Aside

Theme 5: Transition to Life after Cancer Treatment
- Ongoing Distress
- Emotion
New Life ........................................................................................................81
Freedom .........................................................................................................82
Theme 6: Defining ongoing Survivorship, Re-establishing Resilience ..........82
  Self-Learning ...............................................................................................83
  Metaphor .......................................................................................................84
  Purpose and Meaning Making .....................................................................86
Theme 7: Post-Cancer Growth .....................................................................87
  Gratitude ......................................................................................................87
  Increased Vitality .........................................................................................88
Theme 8: Refining a Creative Identity and Re-Imagining the Self ...............90
  Creative Identity ..........................................................................................90
  Transformed Identification .........................................................................91
Summary ......................................................................................................93

5. DISCUSSION ............................................................................................95

  Functions of Art and Art Therapy ...............................................................96
  New Insights ..............................................................................................98
  Limitations ................................................................................................99
  Implications ...............................................................................................100
  Recommendations ...................................................................................101

APPENDIX A Share Your Cancer Story .....................................................103

APPENDIX B Visual Narratives .................................................................105

APPENDIX C Collage Summary I ...............................................................122

APPENDIX E Collage Summary II ...............................................................125

REFERENCES .............................................................................................127
List of Tables

TABLE 1 Participant Diagnoses ........................................................................................................57
TABLE 2 Art Therapy Participation ..................................................................................................59
TABLE 3 Themes and Sub-Themes ..................................................................................................61
TABLE 4 Healthcare Relationships ..................................................................................................71
LIST OF ILLUSTRATIONS

Figure

1. Untitled. Detail demonstrating direction and encapsulation ........................................... 63
2. My Room. Depiction of a comfortable hospital room. .................................................. 67
3. Before and After. Detail of before. .................................................................................. 70
4. Before and After. Coy pond extending boundaries of castle walls .................................. 73
5. Women Carry a Cross ...................................................................................................... 75
6. Demonstration of Cathartic Release of Energy .................................................................. 77
7. Detail of Lymph Nodes in Annie’s Visual Narrative .......................................................... 79
8. Metaphor in Visual Narrative .......................................................................................... 85
9. Web Detail ....................................................................................................................... 87
10. Feminine Figure and Books for Wisdom. Detail .............................................................. 89
11. Eileen’s Longest Ongoing Project ................................................................................... 93
21. Share your Cancer Story ................................................................................................. 104
22. Untitled .......................................................................................................................... 106
23. Untitled .......................................................................................................................... 106
24. Untitled .......................................................................................................................... 107
25. Strikeouts, Stitches, Zippers, and Spider Webs ............................................................... 108
26. Ugly and Beautiful ......................................................................................................... 109
27. My Handprints on a Piece of Paper ............................................................................... 110
28. Untitled .......................................................................................................................... 111
29. Untitled .......................................................................................................................... 112
30. My Room ....................................................................................................................... 113
31. This Unholy Illness ........................................................................................................... 114
32. Untitled ................................................................................................................................ 115
33. Before and After ..................................................................................................................... 116
34. Untitled ................................................................................................................................ 117
35. Life Gives You Lemons .......................................................................................................... 118
36. Untitled ................................................................................................................................ 119
37. Cancer Free............................................................................................................................ 120
38. A Thing of Beauty .................................................................................................................. 121
39. Summary Collage I ............................................................................................................... 123
45. Summary Collage II ............................................................................................................... 126
Abstract

This document reviews the artworks created in the form of visual narratives of cancer survivors. The work sought to explore the subjective experience of cancer and explore potential functions of art therapy in oncology care. Previous research found stages of the cancer trajectory and psychosocial benefits of art therapy. Fifteen adult cancer survivors created visual narratives and participated in this qualitative inquiry. The research was action-based and used arts based and qualitative methodologies. Eight themes emerged and reflected stages of the cancer experience and corresponding functions of art therapy participation. The themes included: diagnosis and the onset of the cancer journey; instilling hope through imagery and recognizing strength in self-expression; ongoing treatment and support; relaxation and re-focus by means of creation, repetition and containment; transition to life after cancer; defining ongoing survivorship and re-establishing resilience; post-cancer growth; and refining a creative identity and re-imagining the self. The work will add to competencies of art therapists working in oncology care and add literature supporting the addition of art therapy to oncology treatment centers.
Recently in attendance at a cancer survivorship celebration, I had the opportunity to hear the keynote presenter, Robert Taylor MD challenge the perception that working in oncology care was depressing. The physician exclaimed that those who see his work as intense and negative have it wrong and to the contrary, working in oncology care is an adventure of hope, healing, and affirmation of life (Taylor, 2013). Perception on both individual and societal levels affects the experience of any situation including cancer diagnosis and care. The term perception is used intentionally in this context as the notion that has become apparent from this research process includes a reality only known through sensation and experience. The cancer journey, as described in this research, demonstrates not the reality of cancer, but the expressions of the patient’s cancer experience.

The landscape of understanding surrounding the cancer experience has been vast. Scientists work to solve the mysteries of cause and effect while physicians work to overcome what is often perceived as a death sentence, and patients and families struggle to find faith and make sense of resulting life changes and adaptations to cancer. The cancer experience, whether for the patient or caregiver, is largely determined by subjective experience. The sentient self, embedded and embodied in the human experience, associates the situation with existing schemas to make sense of the lived life (Fisher, 2001).

The Guiding Questions

The central focus and guiding question of this research was to achieve an understanding of the subjective experience of cancer through a series of visual cancer
stories or narratives created by cancer survivors. A cancer survivor is defined for this study as someone who has been diagnosed and treated for cancer. A second focus or question was to examine the attributes of art therapy participation used in the expression of or adaptation to a new life following resolution of the cancer treatment. This action and arts based methodology examines the visual narratives, artist statements, and interviews of 15 cancer survivors. The majority of art therapy research to date focuses on the outcomes of art therapy participation as opposed to the functions of the art therapy process. In contrast, this research moves toward identifying potential focuses of art therapy that would be useful for cancer patients and survivors related to the personal experience of the cancer trajectory.

**Rationale**

The researcher, having provided art therapy services to oncology patients and family members for 15 years, had seen clients grow from the experience of cancer and participation in art therapy. Through this experience, it was assumed that the participants in the grant study would benefit from the experience of visually telling their cancer stories and that the results the visual narratives process would illuminate the subjective experience of the cancer journey. The researcher was also guided by a curiosity about what functions of art therapy were beneficial in this context.

An understanding of the trajectory of the cancer experience and how art and art therapy can function for patient benefit will add to the case for inclusion of art therapy services in oncology settings. The results of this study will serve to inform art therapists who choose to work in oncology settings about the clients they intend to serve. It is anticipated that this work will add strength to the language used to introduce art therapy
services to new venues. The language will also help to articulate the usefulness of services to cancer patients and family members who may benefit from services.

Assumptions

The researcher held the assumptions that the experience of cancer was determined by past experiences and beliefs and that the resolution of the cancer journey built upon those experiences in the form of continued development. In constructivist thought, this process is known as an autopoiesis (Maturana & Varela, 1980). Another assumption held by the researcher was that a disruption, such as a cancer diagnosis, to the life process of an individual could lead to growth.

The central tenets of understanding the constructivist perspective begin with the autopoietic process. The term autopoiesis describes a system of human understanding, perception, and behavior continually influenced by internal feedback cycles (Maturana & Varela, 1980). From this perspective, human insight and growth are seen as reflexive and recursive developing through sensations and recognitions of past experience (Piaget & Inhelder, 1969).

Communication between the cancer patient and healthcare professionals may be inhibited by difficulties in sharing the subjective experience. Subjective realities cannot be accurately translated between communicators as each communicating partner hears and speaks from personal constructs. Furthermore, constructs distort what would appear as reality in every situation. Constructs as ideas imbedded in cognitive processes provide a pseudo framework for understanding the world. New experiences are considered pro or con within existing schemas (Kelly, 1963). Reality from this perspective is man-made (Watzlawick, 1977). Reality is a subjective translation of experience.
The assumption that a disruption such as cancer can lead to human growth is also based on an autopoietic system. Bateson (2000) explained the autopoetic process for human understanding through the idea of a cybernetic system, three cycles that create feedback loops allowing the re-creation of subsequent actions based upon experience and perception. The three cycles, individual, societal, and ecological, interact and compete with each other creating a discourse through which change and growth occur. The cybernetic cycles strive for homeostatic states and are called to action with the onset of homeostatic disruption.

A person’s subjective experience of illness is seen as largely determined by past experiences and development. The human experience is replete with crisis and growth. Erickson (1994) viewed human development as a series of crises each building upon the other. The crises were defined as age related and pertinent to social relationships. Successful navigation of stages of crisis defined social maturation in Erickson’s 1959 model. It was through repeated trials and stages of crisis that human beings navigated the life cycle, and transformed into their present state.

**Art Therapy as Healing.** When the homeostatic state of equilibrium is disrupted and an urge toward problem solving or change occurs there is a point where many clients enter psychotherapeutic services. Patients are experiencing loss, looking for meaning and starting to look for ways of coping with changing realities (M. K. McGraw, personal communication, December 1st, 2009). Images that occur during these times can be difficult not only for the patients, but for the art therapist as well. This moment exemplifies the value of incorporating trained arts therapists in the arts in healthcare arena (Harter, 2007).
The Research

The participants in this research have each experienced cancer diagnosis, treatment, and life after treatment. Each has experienced reactions associated with diagnosis and treatment expectations. Through the creation of a visual narrative, participants shared their subjective reality as their experience. Each story maintains its identity as an account of what has happened and although wide in content, all stories contained a degree of commonality. Honoring the subjective experience of cancer is seen as necessary when treating the whole person. Research that exemplifies cancer stories will provide medical professionals reminders of the patient experience and empower patients to become active members of their own healthcare teams.

This investigation into the subjective cancer experience through the visual narratives of cancer patients was expected to allow insight into the subjective experience of cancer survivors and explore components of the art therapy process that showed promise during the cancer trajectory. Phenomenological inquiry into the visual stories and verbal reflections of 15 cancer survivors coupled with an action and arts-based inquiry led to an increased understanding of cancer experience. Also discovered within the data analysis were categories of art therapy that corresponded with stages within the cancer trajectory.
CHAPTER 2

Literature Review

Cancer diagnosis can be traumatic for patients and may be accompanied by turbulent emotions during treatment and beyond. The medical culture in the United States acknowledges psychosocial dimensions of oncology treatment and survivorship and efforts have been made to treat the whole person along with their families. A small percentage of hospital based treatment centers incorporate art therapy (NEA and SAH State of the Field Committee Report, 2009). Research into cancer and its treatment is vast; research into art therapy in oncology care is limited. This literature review focuses on the experience of the patient through cancer treatment and into long-term survivorship. Art therapy as a treatment modality is explored at various stages of the treatment process.

Cancer in the United States

The American Cancer Society estimated 589,430 cancer deaths in 2015 placing it only behind heart disease as having the highest mortality in the US. They further estimated 1,658,370 cancer cases would be diagnosed in 2015 (American Cancer Society, 2015). Cancer instances and mortality rates showed a downward trend between 1990 and 2006; and the numbers of cancer survivors living in the US has increased annually (Edwards et al., 2010). With new diagnoses each year and mortality rates decreasing, it is expected that these numbers will continue to rise. The numbers of psychosocial research
studies concerning the cancer patient and survivor are increasing in kind. The purposes of this review are to examine the literature on the experience of the cancer patient and survivor through treatment and transition back into “normal” life patterns and to review ways that the psychosocial support of art therapy may enhance experiences for patients and survivors.

**Defining the Patient Experience**

A frame of reference through which the trajectory of the cancer experience may be examined is “the seasons of survivorship” (Mullan, 1986). Seasons are similar to stages in that they are both chronologic and exclusive. The seasons of survivorship were defined originally by Mullan (1986) following reflection on his own journey through the cancer experience. As a physician, and cancer survivor, Mullan was able to articulate his connection to both provider and patient perspectives. In light of advances in cancer treatments and changes of the survivor experience over two decades in the United States, the seasons of survivorship were redefined and adjusted by Miller, Merry, and Miller (2008). The seasons included (a) acute survivorship, (b) transitional survivorship, (c) extended survivorship, and (d) permanent survivorship. Acute survivorship included the timeframe when patients are diagnosed and treatments are prescribed and administered. The transitional season was the bridge between the treatment phase and ongoing monitoring or maintenance. The extended season was refined to include three sub-seasons: “maintained remission, cancer-free, and living with cancer” (p. 371). The final season was permanent survivorship. Permanent survivorship was the preferred cancer outcome and was in accord with a cancer-free diagnosis. Subsections of this season included continued cancer-free diagnosis, the development of long term problems as a
result of cancer and/or treatment, and those who develop cancer again, either as a result of earlier treatment or a new cancer diagnosis. Re-diagnosis returned the patient to the acute season of survivorship.

Mortality is a concern for cancer patients and caregivers during the illness trajectory. Cancer diagnosis often results in death. Palliative care is the model of treatment used to care for transition to the end of life. The needed attention during this phase of the cancer journey was illustrated by the creation of a scale intended specifically for this point of the journey. Mack et al. (2008) developed *The Peace, Equanimity, and Acceptance Scale* for emotional acceptance in order to rate struggles versus peace in end of life cancer care. The survey scale rated anxiety, depression, coping, spirituality, awareness, and limitations. Palliative care efforts that have included art and art therapy to comfort the patient and for pain management has been particularly useful (Luzzatto, Sereno & Capps, 2003; Nainis et al., 2006) in the areas of quality of life including meaning making (Duffy, 2009; Gabriel et al., 2001), and caregiver support (Painter, 2006; Walsh, Culpepper Martin, & Schmidt, 2004). Examples of locations where art and art therapy services have existed in oncology palliative care in US cities include Chicago, IL (Nainis et al., 2006), New York City, NY (Gabriel et al., 2001; Luzzatto et al., 2003), and Vancouver, Canada (Collie et al., 2006). Other integrative modalities used in palliative care include meditation, yoga, massage, music, music therapy, nutrition, spiritual counseling (Holland & Breitbart, 2010).

Support services for family members including art therapy can help to decrease anxiety and stress as well as increase communication between patient and caregiver (Walsh et al., 2004). Services can help patients and families find the courage to move
through these times. May (1975) termed the phrase “social courage” as the decision to hear and speak in terms of emotional context as opposed to professional terminology (p. 17). An illustration of such social courage was offered by Duffy (2009). As an oncologist, Duffy was witness to the ongoing series of self-portraits by a patient named Aaron as he progressed through two rounds of cancer treatment. After the Aaron’s death, the series of portraits left a narrative that was shared with medical professionals. The portraits offered an example of non-verbal expression of physical and emotional reactions to treatments and diagnosis. Duffy wrote, “It is easier to discuss the details of chemotherapy and blood counts than to enter the dangerous, precarious, painful, mysterious, and fertile regions that Aaron’s portraits depict” (p. 223).

Another case study example gave accounts of the stories of women diagnosed with terminal breast cancer. Radley and Bell (2007) used the artwork of terminal breast cancer patients, Jo Spence (a photographer), and Marsha Hall (a book maker) to investigate the potency of artwork in the realm of social movements in breast cancer awareness. Spence’s photograph *I Framed my Breast for Posterity* (p. 373) showed a staged compilation of meaningful artifacts surrounding a portrait of the photographer with a frame around her naked bandaged breast. The frame covers the mouth of the patient in this photo taken prior to lumpectomy. Hall’s art book *Tattoo* (p. 377) illustrated a pattern of references that represented her need to speak out coupled with illustrations of regret for being silent. The book addressed some areas of stigmatization and revealed components of the cancer care experience not readily known outside of the medical scene. The intent in sharing these artworks was not as an expression of the grief of individuals, but as a social expression of the experience of breast cancer. All three patient narratives offered
compelling examples of the potential for art and art therapy services available in palliative
cancer care and as elements of social activism.

**Concerns for Survivors**

Cancer diagnosis can be a shock and is often followed by rapid decreases in
psychological health (Andrykowski, Lykins & Floyd, 2008; Clemmons, Knafl, Lev, &
McCorkle, 2008; Reb, 2007). Physical treatments and care for the body are of primary
importance. Time is of the essence in conquering physical ailment. The immediacy of
need often leaves psychosocial and holistic treatments secondary. Prescriptions of
chemotherapy, surgery, and radiation complete the schedules regularly attended to by
oncology physicians. Patients often experience nausea, loss of body image (both physical
and psychological), possible loss of jobs, and loss of ordinary lifestyles (Andrykowski et
al., 2008).

Oncologists, surgeons, radiation specialists, nursing staff, social workers, and a
myriad of others are available through the treatment process. For those who do not
succumb to cancer, the trajectory continues to bring challenges. Obstacles to a return to
normal life include physical disability, behavioral challenges, dynamic life changes, fear
of recurrence, emotional distress, and loss of the safety net of healthcare (Allen, Savadatti,
& Levy, 2008). Post treatment transition back to everyday life also includes concerns of
body image, social narratives of cancer, and others’ attitudes toward survivorship
(Heywood, 2003).

Although counter-intuitive, keeping hopeful and positive attitudes during early
cancer treatments may be considered by investigators a less than adequate coping
mechanism. The degree to which this is true might depend on stage and type of cancer.
Lebel, Roseberger, Edgar, and Devins (2008) found that those who rely primarily on hope by keeping a positive attitude as their primary coping strategy are at higher risk for emotional distress during later stages of survivorship. When looking at the experience of ovarian cancer patients, Reb (2007) found that overall hope was not a main concern for the patients. Twenty women within five years of diagnosis participated in Reb’s grounded theory study had finished treatment and had no sign of recurrence. Reb found that feelings of hope needed grounding in experience and reinforcement and that spirituality and support were alliances that helped to support feelings of hope. Allen et al. (2008) believed that attention should be paid to the transitional phase of patient status from acute to extended survivor. With psychosocial interventions including art therapy, healthy coping skills can be supported, stress can be reduced, and education on expectations offered (Levine & Silver, 2007)

Four potential post-cancer life definitions for the cancer survivor were delineated by Andrykowski et al. (2008). Termed state paths, these definitions included (a) continued deterioration, (b) continued impairment, (c) recovery and return to former life patterns, or (d) growth in light of cancer experience. Continued deterioration entailed a continual loss of functioning and held the highest degree of despair. Continued impairment included physical, cognitive, and emotional residue from the cancer experience that inhibits return to prior levels of functioning. In recovery and return to former life patterns, the survivor would be able to return to life as it was before cancer. Growth in light of the cancer allowed survivors to re-frame the experience into one where life was accentuated following diagnosis. Cancer survivors in Mullan’s (1986) transitional or extended season
of survivorship, whether living cancer free, with cancer, or in remission can be said to follow one of Andrykowski et al.’s four state paths.

Other researchers have looked at life beyond cancer treatment as well. Clemmons et al. (2008) found concerns with the availability of resources including literature, professional expertise, and social support systems for long-term survivors of cervical cancer. A study of 19 long-term cervical cancer survivors reported experiencing the initial shock of diagnosis. Semi structured interviews, which focused on of quality of life and psychosocial consequences, were conducted and transcribed. The interviews were qualitatively analyzed separately by each of the three authors. Of the 19, nine found new appreciation for life, four were able to move on, and six showed ongoing struggles in dealing with life after cancer (Clemmons et al., 2008). Six of the participants expected to return to normal life following treatment and were unprepared for the long lasting ramifications of the illness.

Reb (2007) conducted a grounded theory study of 20 women with stage III or stage IV ovarian cancer using data collected via personal data forms and a focused interview guide. The focused interview guide provided open questions regarding hope and its orientation regarding cancer diagnosis. Data were analyzed by coding using Ethnograph 5.08. Ethnograph is an electronic data analysis tool useful in coding themes within qualitative data. Through the analysis, Reb (2007) found three phases of diagnosis and survivorship: shock, aftershock, and rebuilding. Aftershock included monitoring resources and internalizing illness. Internalization of the illness referred to accommodation of the illness experience into the subjective self-identity. Rebuilding involved a search for meaning (Reb, 2007). Overall, Reb found that increased information
including review of expectations and honest communication with medical professionals combined with meaning making and spirituality increased participants’ perception of control influencing “women’s ability to transform the death sentence” (p.70).

On a similar note, Reynolds and Vivat (2010) interviewed 13 women to study the effects of art making and its impact on how chronic illness was experienced and perceived. This work was not cancer diagnosis specific, but focused how women accommodate the life-changing ramifications of debilitating illnesses like fibromyalgia and diabetes. The women were interviewed about their illness, ongoing pain, and art making practice. Through the coding process, Reynolds and Vivat were able to identify two primary ways that women integrated the experience of illness. The first method of integration was the perception of being bound or identified by the illness. The second included the idea of living beyond the illness through the art making process. Those who were found to be bound by illness reported art making processes bound by restrictions. The resulting images demonstrated suffering. Women who integrated and moved beyond the illness reported higher rates of identification as artists and described art making as demonstrating possibilities as opposed to restricted by illness.

**Mental Health Concerns**

A mental health diagnosis made during cancer treatment adds to the perception of illness associated with cancer care. Commonly associated psychological conditions include post-traumatic stress disorder (PTSD), depression, and anxiety (American Psychiatric Association, 2014). A mental health diagnosis may help providers with third party reimbursement, but at the cost of added patient anxiety regarding the diagnosis. Bush (2009) found that the risk for anxiety and depression increases after the shock of
cancer diagnosis. Although symptoms are often present, actual diagnosis is rare. Andrykowski et al. (2008) felt that the reason for this was that there was little evidence that normal functioning was impeded beyond what would be expected following diagnosis with cancer.

Regardless of lack of actual diagnosis, mental health concerns are important for those experiencing cancer and survivorship especially when it comes to quality of life. Levine and Silver (2007) used a quality of life scale measuring physical, social, familial, emotional, functional, and spiritual well-being. Seventy-five women diagnosed with ovarian and cervical cancers were invited of which 53 agreed to participant and 23 followed through to completion. They found that patients diagnosed with ovarian and cervical gynecological cancers provided services at a psychosocial facility associated with a gynecological oncology clinic showed overall reduced anxiety and depression on the quality of life scale. At the one-year mark, anger and confusion around diagnosis with these most fatal cancers dropped as well.

Hoffman, McCarthy, Recklitis, and Ng (2009) reviewed results from a National Health Interview Survey in the U.S. and compared distress levels in 4,636 cancer survivors to 122,200 people with no cancer diagnosis. Three percent or 3,666 of those with no cancer diagnosis were found to have to have serious psychological distress compared to 5.6 percent or 297 of those who had experienced cancer. They found the degree of distress suffered by cancer survivors was significantly higher than those who did not have cancer. The reasons for distress included fear for the future, cancer in general, poor perceived health, and poor coping skills. The report also noted that two-thirds of those suffering with distress had not met with mental healthcare providers.
Mental health concerns extend beyond the initial shock of diagnosis and coping with changing life patterns through diagnosis. Boyes, Girgis, Zucca, and Lecathelinais (2009) through an Australian cancer registry identified 1,374 cancer survivors diagnosed five to six years earlier. One thousand-eight agreed to receive the surveys in the form of self-report questionnaires assessing depression and anxiety. Eight-hundred-sixty-three or 85.6 percent of participants returned them. The surveys indicated distress levels after five years of survivorship were still slightly higher than the general public in the areas of psychological issues, poor coping skills, and social structure. They indicated a need for continued monitoring of psychosocial needs even beyond the five-year mark that traditionally is used as an indicator of being cancer free (Mullan, 1986).

Cultural Variation in Cancer Experience

Ethnicity plays a major role in the survivor’s experience of cancer, as such it contributes to the emotional distress experienced overall (Thomas, Carlson, & Bultz, 2009). The intersections of ethnicity and culture affect all chronological stages of the cancer experience including diagnosis, treatment, transition and survivorship. Thomas et al’s (2009) review includes reference to efforts being made in many areas of the world to take care of individual patient needs. Other constructs that may affect the experience include geographic, spiritual, and familial patterns.

Ten terminally ill Japanese patients were interviewed about what having cancer meant to them to find out what types of transformation they went through and what kind of meaning they attributed to their experience (Ando, Tatusuya, Lee, & Okamoto, 2008). Responses ranged from peace of mind to uneasy feelings, and from finding meaning to regret and sorrow. Most reported a natural acceptance that the researchers attributed to the
Zen philosophy followed by many in Japan. One of the 10 patients attributed a high quality of life to her engagement in personal art making.

Interviews about the subjective experience of cancer and a 24 question Chinese Cancer Coherence Scale developed to measure the cancer survivor’s ability and process of de-creating and re-creating worldviews in light of cancer diagnosis were used to investigate the experience of Chinese women with breast cancer (Chan, Ho, & Chan, 2007). Meaning making was found to be multi-faceted and involved sense making, benefit finding, coherence and incoherence. These researchers did interviews with 22 women in Beijing undergoing treatment for breast cancer. The six most pertinent struggles that the women experienced were “facing the reality of cancer diagnosis, taking an active part in cancer treatment, sustaining an optimistic spirit, sustaining physically, lessening the impact of cancer on others, and reflecting and moving on” (Fu, Xu, Liu, & Haber, 2008, p. 258).

In the United States, the concerns of the quality of life of African American breast cancer survivors were translated into a scale they termed proximal distal dimensions (Russell et al., 2008). Russell et al. (2008) identified twenty-six quantitative and qualitative research studies that examined both deficits and positive outcomes that demonstrated racial demographics. The studies were deconstructed and assessed according to reported quality of life. The review added a perspective of balance in relationship between the internal and the external to the importance of cancer narratives. The strength in relationship between patient and healthcare provider and social support were seen to be associated with satisfaction of life in African American breast cancer
survivors. African American women were more likely to report reliance on faith and spirituality than their Caucasian American counterparts.

Yoo, Aviv, Levine, Ewing, and Au (2010) conducted in-depth qualitative interviews including demographic information with 176 women from various ethnic groups about their patterns of breast cancer diagnosis disclosure. The findings indicated a need for women to engage in honest disclosure as opposed to protecting other’s emotional states and a need for further education of what to expect from cancer treatment and trajectory. Yoo et al. (2010) alluded to the idea that these findings may reflect the social traditions of racial minorities where women are expected to tend to the emotional needs of the family. This expectation may be less acute in other races.

Health Disparities in the United States

The dynamics of culture in the oncology patient’s identity must be considered when determining psychosocial needs. Cultural lenses comingle to create the ways events are experienced (Talwar, 2010). Medical illness is not an exception. Healthcare disparities in the United States include, but are not limited to economy, geographic location, and race. The American Cancer Society report (2015) showed that African Americans have higher rates of cancer diagnosis and mortality. Barton-Burke, Barreto, and Archibald, (2008) through the use of narratives explained the complexity of the cancer experience through a multicultural lens and share a need for “different models of understanding and treating the disease” (p. 235). The authors noted socio-political discrimination in high-risk populations in healthcare inequity and barriers to healthcare including factors like health insurance coverage.
African American breast cancer survivors were shown to have lower scores on patient-to-care provider relationships. They also were shown to have higher levels of spirituality and meaning making in reporting survivorship experiences. African American breast cancer survivors tended to take a more active role in prevention education within their own communities (Russell et al., 2008). Cultural identity must be considered during meaning making and re-identification interventions.

The geographic proximity of healthcare in relation to the patient also affected the patient experience and resulting narrative. Rural areas provide the additional challenges of long travel for access to adequate healthcare and limited remote access to up-to-date cancer information. Limited access to accurate healthcare information has led to misconceptions regarding treatment and survivorship and has limited the creative potential of rural cancer survivors. Through a comprehensive review of research studies, rural survivors were seen to have reduced adjustment, lower quality of life and higher perceived stigmatization following oncology treatment (Bettencourt et al., 2007). Reported unmet needs were reduced when rural patients were provided telephone contact with supportive staff able to answer questions and concerns and refer to appropriate resources (Girgis et al., 2009).

Difficulties for rural patients included lack of access to treatment resources, long distances for medical care, limited options for healthcare, isolation leading to difficulties with psychosocial adjustment and a lack of social and psychological support. Coping strategies of rural cancer patients showed the possibility of becoming avoidant (Bettencourt et al., 2007). The rural survivor was more likely than urban or suburban
survivors to describe cancer diagnosis as the most stressful life event (Bettencourt et al., 2007).

The Survivorship Identity

Kaiser (2008) conducted interviews with 39 US cancer survivors and found that many have rejected the identity of cancer survivor. Reasons for that rejection included not being sick enough, not wanting to be part of that group, preferring to be identified beyond the illness, or because they still had cancer. The perception of survivor does not necessarily combat the pain or address the reality of breast cancer directly. Kaiser concluded that some post cancer patients may prefer labels of warriors or thrivers as opposed to being seen simply as part of the collective survivor identity. Svensk et al., (2009) noticed a perceived personal invisibility for the patient in treatment when seen through the lens of medical discourse.

A balance in patient perception between subjective and objective, stress burden and coping resources, and perhaps a balance between external and personal aspects of survivorship define patient experience (Andrykowski et al., 2008). An imbalance of community identity and benefit between breast and ovarian cancer survivors can be seen when comparing resources. Community outreach and education in the area of breast cancer far exceeds the efforts and information available for ovarian cancer. Due to fewer publications, patients with ovarian cancer have less access to literature than breast cancer patients, and thus are less prepared to deal with the implications of the illness (Reb, 2007). Information access to both medical discourse and personal accounts of survivors may help the patient retain power and investment into treatment and outcomes.
Artwork created by patients can portray a worthwhile disclosure of the cancer experience. Radley and Bell (2007) illustrated how art and art making can add to the social support structure in cancer care. The artwork of two breast cancer survivors showed transitions from the passive victim of cancer to the angry participant in care (Radley & Bell). Generalized and social narratives helped to inform individual perception by providing a framework of reference and validating the voice and experience of the individual. Individual identities are preserved through the process of art making. Visual images help to relate individual experience to the generalized as opposed to the patient survivor becoming lost in the collective identity (Radley & Bell). Maintenance of the self is imperative in the subjective narrative of cancer from diagnosis through all levels of survivorship. McNiff (1984) found “interdependence between universal and particular forms of communication” (p. 126). McNiff wrote that the relationship to the universal is found through the creativity and the understanding of the self. A balance between the individual identity and that of the cancer survivor is pertinent in preservation of the self during identity integration. Dreifuss-Kattan (1990), one of the earliest voices in art therapy and cancer care, demonstrated the art therapy process as one that would hold the personal experience and emotions of cancer patients as they faced what was defined as the general or assumed experience of cancer.

**Meaning Making as a Stage toward Identity Integration**

Finding ways to blend past events and cancer experiences into reformulated identities is necessary for the person who has experienced cancer in order to be able to move beyond the illness. Andersen, Bowen, Morea, Stein, and Baker (2008) sent 1,391 requests stratified between two, five and ten years post cancer diagnosis. Of the 1,391
requests, 45% or 636 surveys were returned. Through these surveys they found two modes of meaning making used by survivors integrating the cancer experience. Meaning making involved either making sense of the cancer or finding personal growth from the experience. Reynolds and Prior (2006) reported that the patient must take personal account of their identity before cancer and synthesize components of the experience of cancer. This self-re-construction is one of the benefits of participation in art making and art therapy. Consciousness in integration of personal and collective identities has the potential to build optimism and advance the collective identity. The collective identity of breast cancer survivors provides a frame for patients who are newly diagnosed or are in treatment to begin to form their survivor identity. Identity integration in this form can mirror both positive and negative aspects (Kaiser, 2008).

Levels of need for support vary between individuals. The subjectivity of self-report and surveys relied on the patient or survivor’s discernment. Devine, Parker, Fouladi, and Cohen (2003) looked at the effects of patients’ experiences of support. From an interpersonal support evaluation list, the authors found respondents reported from perceived rather than the actual level of support. Perceived stronger levels of social support were associated with decreased levels of psychological distress and increased quality of life for individuals undergoing experimental treatment for melanoma (Devine et al.) As such, reframing may be a valuable intervention for the survivor who has not been able to move on (Clemmons et al., 2008).

Evans, Crogan, and Bendel (2008) compared cancer support groups to test the efficacy of a storytelling format designed to add a narrative impact to the patient’s experience of cancer. The storytelling group format was intended to help reframe cancer
experiences. The study was comprised to two groups, one that incorporated the narrative component of storytelling and a control group where the narrative storytelling component was not used. The experimental narrative group facilitator was a nurse familiar with cancer treatment trained in the narrative storytelling process. The researchers indicated that storytelling group participants were found to prefer personal stories to medical stories. The storytelling group was said to have helped participants to find meaning and transform suffering in spite of the criticism of the facilitator. The results of this study were non-generalizable with an N of only 10. The pre and post measures did allow statistical comparison and only provide initial support for the use of narrative storytelling formats in the psychosocial treatment of cancer care.

Narratives of cancer survivors can be helpful for cancer patients. When exploring the effects of cancer stories, Kreuter et al. (2008) found that effective stories involved emotion that engaged the listener; self-disclosure helped to build trust in the storyteller, and imagery evoked unified language and elements of cultural relevance. Stories were assessed on narrative quality and strength of healthcare message. Participants were asked to gauge level of engagement, recall key messages and positive thoughts. The cancer narratives were shown to model good coping skills and changed viewer’s appraisal of the situation (Kruetner et al., 2008). Telling their own stories through art making can offer survivors the opportunity to give back. It can also help them to further re-define themselves.

Patients may have the ability to choose to incorporate the cancer experience as a form of post-traumatic growth as opposed to stagnation in suffering. Self-expression through art making in art therapy has the potential to enable the patient to take cancer as a
challenge advocating for greater meaning instead of a life sentence (Dreifuss-Kattan, 1990). Dreifuss-Kattan, an art therapist specializing in oncology, points out that through this art therapy processing of the personal cancer journey that “the artist’s inside is no longer only an incubator for a malignant, cancerous process, but is a healthy soil for symbolism and form giving” (p. 133).

**Art Therapy and Cancer Treatment**

The following section covers the availability, justification and benefits of art therapy in cancer care. It includes a review of research that has taken place within art therapy and its use in oncology care. Many of the authors are art therapists; authors whose writing is related to this topic are also included.

According to McNiff (1984), art making and thoughtful reflection are theorized to bring about a balance of internal and external locus of control adding a sense of purpose to life. Though McNiff’s work in cancer care was limited, his theoretical ideas remained pertinent. A sense of knowing or conscious connection adds resonance to experience (Allen, 1992). A patient, having the sense of purpose can find motivation and a will to live. Also available are feelings of satisfaction and fulfillment leading to a sense of integrity and accomplishment as opposed to despair (Erikson, 1994). From conscious participation in the creative process comes the means for meaning making, increased coping strategy development, increased active engagement in health care and self-care, and decreased stress, anxiety and depression (Heywood, 2003; Luzzatto & Gabriel, 2000; Monti et al., 2006; Svesnk et al., 2009). To date, research has shown that art therapy is effective in these areas, but there has been little work in explaining why and even less in defining what is unique about the practice of art therapy specific to cancer care that
address the human psyche in ways that traditional methods of counseling, therapy, and medical treatment do not.

Among the many oncology treatment facilities in the United States, there are few art and art therapy services available for patient use. The Society for Arts in Healthcare and the National Endowment for the Arts brought together a State of the Field Committee comprised of a group of artists, researchers, and professionals. The group surveyed 1807 US hospitals. Three hundred of those US hospitals reported having some kind of arts in healthcare program and 141 had creative arts therapy services. Fourteen percent reported having access to an art therapist (NEA and SAH State of the Field Committee, 2009). “The participants in this landmark symposium included representatives from the Johnson & Johnson Foundation, the American Hospital Association, Johns Hopkins University, Americans for the Arts, National Institute on Aging, and The Joint Commission” (p. 2).

Studies have been published about art therapy with patients hospitalized with cancer (Breslow, 1993; Burns & Perisoglou, 2009; Gabriel et al., 2001; Greece, 2003; Luzzatto, Sereno, & Capps, 2003, Nainis et al., 2006; Rockwood-Lane, 2005), art therapy services for patients while in treatment (Bar-Sela, Atid, Danos, Gabay, & Epelbam, 2007; Forzoni, Perez, Matignetti, & Crispino, 2010; Oster et al., 2006), and support groups for cancer patients and survivors (Monti et al., 2006; Puig, Lee, Goodwin, & Sherrard, 2006; Svensk et al., 2009; Thyme et al., 2009; Visser & Op ‘t Hoog, 2008). The generalizability of the results of these studies was questionable at best, due to the small numbers of participants and lack of cultural variation. These studies are successful as guides, but are not enough to demonstrate the effectiveness of art therapy in cancer care.
The variety of art therapy methods used was also diverse. Some use art as a process of assessment (Bar-Sela et al., 2007; Elkis-Abuhoff, Gaydos, Goldblatt, Chen, & Rose, 2009) while others use art for cathartic introspection (Forzoni et al., 2010; Luzzatto et al., 2003; Thyme et al., 2009; Oster et al., 2006) and yet others for art making and witnessing (Nainis et al., 2006; Visser & Op ‘t Hoog, 2008). The variance in methodology was reminiscent of the perceived dichotomy that has existed within the field of art therapy since its inception (Wadeson, 2002). At one end of the continuum there was studio arts or art as therapy, with clinical or art psychotherapy at the other end. Each art therapist practiced from a frame somewhere on that continuum.

The previously mentioned research pointed to the reasons cancer patients or survivors (in their acute and transitional seasons) should participate in art therapy sessions. Some indicated reduced symptoms including pain, anxiety, depression and fatigue (Bar-Sela et al., 2007; Luzzatto et al., 2003; Nainis et al., 2006; Thyme et al., 2009), while others showed increased coping mechanisms, quality of life and self-esteem (Monti et al., 2006; Svensk et al., 2009; Oster et al., 2006; Visser & Op ‘t Hoog, 2008), and still others show promise in the areas of assessing reoccurrence and treatment preference (Elkis-Abuhoff et al., 2009). However, there was no indication that art therapy was a preferred method of reaching these goals or any evidence that its practice was unique.

Randomized control trials of group art therapy have shown encouraging improvements in cancer patients’ quality of life and decreases in fatigue, anxiety and depression. Monti et al. (2006) conducted control group studies of 111 women undergoing cancer treatment attending a Mindfulness Based Art Therapy group (MBAT). The MBAT was a standardized group process that combined stress reduction and art
therapy. Groups meet regularly on a weekly basis. Control groups were generated from wait lists. Results showed the use of the MBAT intervention reduced anxiety and fatigue and improved patient well-being. Due to the combined focus of mindfulness and art therapy, it is impossible to extrapolate whether it was the stress reduction component, the art therapy component, the combination of the two, or the group process that was responsible for the reduction in anxiety and fatigue. In addition, the results are viable only to the MBAT intervention.

Garland, Carlson, Cook, Lansdell, and Speca (2007) conducted a non-randomized comparison trial where they separated the stress reduction component and the art therapy component. Participants were given the choice as to which groups they would like to attend. The mindfulness based stress reduction group (MSBR) group had 60 participants while the healing arts (HA) group had 44. Measurement tools included: the Post-Traumatic Growth Inventory-Revised, the Functional Assessment of Chronic Illness, the Therapy- Spiritual Well-Being, the Symptoms of Stress Inventory, and the Profile of Mood States. Both groups showed improvement in spiritual awareness, anxiety, anger management, and mood. After attrition in both groups, participants attending MSBR showed a higher increase in spirituality and decrease in stress, anger and anxiety than those in the HA groups.

In another randomized controlled study by Thyme et al. (2009), patients were divided into two groups for comparison. Patients either attended individual art therapy sessions or became part of the control group receiving no art therapy. Through pre and post-surveys, the World Health Organization Quality of Life survey (Swedish version), and a four month follow up with self-report measures, art therapy was shown to reduce
depression, anxiety, and somatic symptoms. The results of the follow up indicated that attendance at art therapy sessions was associated with long-term reduction of psychological symptoms (Thyme et al., 2009). One limitation of this study was the small number of participants (N = 42). Svensk et al. (2009) compared art therapy sessions for patients receiving radiation therapy 21 participants received art therapy and 20 did not receive art therapy. A quality of life questionnaire was used pre art therapy and pre radiation, the questionnaire was used again two months after and again six months following treatment. The results showed that participating in art therapy encouraged patients to become more active in their own treatment and improved quality of life. In another study at the same site, art therapy was shown to increase coping resources as early as the second or third session (Oster et al., 2006). All of these studies add merit to the successes of certain art therapy protocols.

Art therapy education groups were offered to cancer patients in the Netherlands (Visser & Op’t Hoog, 2008). Groups were given pre- and post-test surveys. Thirty-five of 36 participants completed both pre- and post-tests. The first session involved imagery exercises to increase fluency in media use and later sessions focused on developing coping strategies and meaning making. Pre- and post- survey results indicated no change in mood, however, there was positive change in coping strategies, indication of the beginnings of a search for meaning in life, and increased creativity development (Visser & Op’t Hoog, 2008).

Art therapy was offered to 157 patients receiving chemotherapy in Italy over four to five sessions each. Fifty-four agreed to be interviewed by a psychologist regarding their perception of the benefit of the art therapy services. Of the 54, three found it not
helpful, 19 noted it was creative and relaxing, 17 found the relationship between themselves and the artwork was helpful and 15 were able to identify the relationship built between themselves, the artwork, and the art therapist as beneficial (Forzoni et al., 2010).

**Benefits of Art and Art Therapy**

Participation in art therapy has been credited with encouraging active participation in healthcare, creative construction of personal coping strategies and the stimulation of catharsis leading to emotional balance (Heywood, 2003). Luzzatto and Gabriel (1998) describe art therapy to psycho-oncology professionals as offering opportunities for containment, catharsis, community, creativity, communication, and the ability to change the image. Much of the research in art therapy and cancer care has shown that art therapy is effective in treatment of the cancer patient and cancer survivor. There seems to be a gap between showing the efficacy of art therapy treatments and the building of theories of why and how it works. It remains the responsibility of art therapists to research and translate how and why art therapy is effective and to share that knowledge with other art therapists, other professionals, and clients (Carolan, 2001).

Works of art and the engagement within the creation of art have elements leading to homeostatic motivation, illumination of affect, and cognitive orientation (Camic, 2008). Homeostatic motivation was a tension created by the interaction between personal internal ideas and the artworks of engagement. The tension was then integrated or habituated and released by the viewer (Dewey, 1934; Kreitler & Kreitler, 1972). The affect illumination exists beyond cognitive structures and reflects the resonance and connections a viewer has while witnessing an art process. The affect resonance was seen during the observation of the Museum of *Modern Art’s Meet Me* at MoMA project with patients experiencing
Alzheimer’s (Parsa & Humble, 2008). Cognitive orientation was experienced during the integration of new stimulus into existing knowledge structures and may be seen in aha moments (Kreitler & Kreitler).

Heywood (2003) alluded to the art therapists’ reactions to patient artwork. This exemplifies the need for the art therapist to be trained in issues of counter-transference in order to account for personal biases so that the best interests of the patient are served. It is the job of the art therapist to protect art created in this context from inadvertent and premature analysis. The art therapist working with a cancer survivor holds the space and gives full attention the patient. He or she listens and witnesses with empathy and metaphorically holds the patient (Heywood).

Qualitative case study samples have been published that show the impact art and art therapy have had on individual patient experience. An individual case study by Jones and Browning (2009) details catharsis, relaxation, and empowerment among the attributes of art therapy leading to symbolic communication through the art. The researchers noted that the art therapy process helped the cancer patient to non-verbally explain reactions to the situation and grasp the overall impact of cancer. Greece (2003) used art therapy to help a veteran work through prior life traumas to clear the focus and encourage ability to be an active participant in his cancer care.

Rockwood-Lane (2005), an oncology nurse interested in the artwork of patients, investigated the work of 63 patients hospitalized for cancer care. Through a qualitative inquiry into the patients and their artwork, she found the following themes: (a) Artwork was created in a spiral growth process initiated from psychic or physical pain. The artwork triggered and documented personal development through the pain; (b) Patients’
were able to witness their own art helping the discovery of self as body energy including feelings of compassion, oneness and transcendence; (c) A shift in awareness occurred during the art and/or storytelling process where insights included “emerging from darkness,” (d) “surrendering to the process,” and (e) “slipping through the veil” or recognizing psychic dimensions of perception (p. 288).

Art therapy as a means of identity integration or re-integration has been used successfully to help patients maintain their self-identity as they integrate the idea of being a cancer survivor. The art making helps people to recognize instances of themselves and deter a generalized self-definition based primarily on cancer diagnosis (Reynolds & Prior, 2006). An early researcher in this area was Predeger (1996) who asked about the meaning of healing through art. Predeger formed an art therapy breast cancer focus group in which participants reflected on artwork and engaged in group discussions. The integration of the feedback from the artwork, narratives of group discussion and co-researchers reflections formed the basis for the inquiry. Predeger was looking for elements of the art and art therapy process useful in the co-creation of personal and collective identities. Her results also included the finding of art as a method of inquiry helping to tap inner creativity, making notable progress in meaning making, providing connections and empowerment and a source for a way of knowing. Women attending the art therapy group also reported the following benefits: actualization of a need to express, illustration of loss and gain of control, illumination of a changing perspective, transcendence of the experience leading to braver perspectives, connection with others, fuel for a creative spark, and celebration of the feminine (Predeger, 1996). According to Predeger, the group provided a safe-harbor
within which participants could explore and express the successes and hardships through the scope of the cancer journey.

Collie, Bottorff, and Long (2006) interviewed 17 cancer survivors about their experience with art and art therapy. Of them, 10 reported experiencing “art as a harbor.” Nine participants in art therapy used art to “get a clearer view,” while 12 participants used art to “clear the way emotionally,” and 10 found that art “enhanced and enlivened the self” (p. 765). Art and art therapy were found to reduce the threat of annihilation of the self, affirm and appreciate present existence, and enhance the possibility of an ongoing self.

Art and art therapy benefits listed in the survey of cancer survivors who had participated in the past included (a) promoting emotional expression, (b) permitting trust in what has been expressed, (c) facilitating personalized expression and resistance to disempowering discourses, (d) bringing a sense of personal worth, (e) providing intrinsic motivation through its aesthetic dimension, and (f) bringing a feeling of connection with a larger whole (Collie et al., 2006).

The balance between individual and collective identity was made by each individual. Collective efforts are comforting and provide feelings of belonging. The cancer experience also has a subjective component that must be considered as the survivor integrates the experience into personal narratives. A striking metaphor of such individuality was shown in the art making of Martha Hall whose artist books were one of a kind and made duplication impossible (Radley & Bell, 2007). Through their investigation into the social impact of two artists’ experiences with cancer they found visual images helped to make visible connections to individual experience. They maintain the importance of consideration of the individual story (Radley & Bell).
Cancer survivors, whether participating in art making or art therapy or not, may also benefit from reaching out to others. Efforts have been made by the Ireland Cancer Center and University Hospital of Cleveland to develop a psychosocial registry to allow researchers to access quality of life data. Ninety-two percent of survivors who chose to register indicated having a desire to help and were willing to be contacted for follow up interviews (Daly et al., 2007). The large percentage of survivors willing to reach out to help may indicate altruistic inclinations (Burns & Perisoglou, 2009). This inclination can be seen in the numbers of survivors willing to tell their stories through art making and exhibition outside the context of art therapy. Art exhibitions of cancer survivors have been shown to have aesthetic benefit. They improved cancer awareness for the public and encouraged preventative care (Lamberg, 2005; Thomas, Marshall, Goldsmith, & Forrest, 2004; Ponto et al., 2003).

**Conclusion**

The increasing numbers of art therapy articles available in journals outside the field could indicate a growing interest and acknowledgment of the potential benefits available to cancer patients and/or survivors and family members. Although the results included in their review of arts therapies in healthcare were not generalizable, Stuckey and Nobel (2010) affirmed “it is likely that creative engagement contributes to many aspects of physiological and psychological conditions typically associated with improved health status” (p. 261). Further research on the potential benefits of art therapy with cancer patients was indicated and could take on either qualitative or quantitative methodology.

This review illustrated interest and attention to art therapy throughout the treatment trajectory of cancer care. The cancer experience has been discussed as collaboration
between individual and communal experience. Psychosocial needs for the cancer survivor are paramount in the movement toward patient centered care. Art and art therapy have demonstrated attributes accentuating personal, group and social benefits. Literature finds missing quantified control based studies exemplifying art therapy’s efficacy (Stuckey & Nobel, 2010). Considering the wide variety of art therapy practice models, narrowing practice models to quantifiable levels remains difficult (Wadeson, 2002).
Chapter 3

Methodology

A grant was received from the Wisconsin Arts Board and National Endowment of the Arts through a partnership between the artist author and a large urban medical facility. The grant was intended to fund art therapy sessions for cancer survivors with the purpose of creating visual narratives for display in oncology settings as possible inspiration to newly diagnosed cancer patients.

The works created by the survivor artists were in compliance with the parameters of the grant prior to the beginning of the research protocol. The subsequent research was approved by the IRBs at both Lesley University and Aurora Health Care where the study took place. It was anticipated that the participants would benefit from the experience and that the resulting visual narratives process would illuminate the subjective experience of the cancer journey.

Visual Narrative Design

The visual narrative is the participant’s cancer story in visual form. Visual narratives were to be accompanied by artist statements written by the participant to accompany the artwork during display. Participants were recruited by invitational flyers (appendix A) in oncology-based departments of the medical center. Each participant self-selected by responding to the flyer. Participants learned of the opportunity through physicians’ offices, a psycho-oncology clinic, infusion clinics and the art therapy program.

Following the completion of the project, participants were eligible to become subjects in the research. One hundred percent of the cancer survivor artists agreed to participate. The research was action based using arts based and qualitative methodologies.
The exploratory focus questions asked 1) What was the subjective experience of cancer that could be seen through the visual narratives and 2) How could art therapy provide benefit across the trajectory of cancer survivorship beginning at diagnosis.

**Research Methodologies**

The action-based methodology was chosen because of its exploratory intent and to engage the participants in the research process. The method allowed variance in direction and focus into the insights that emerged. Action-based methodologies promote exploration beyond the current scope of understanding (Sumara & Carson, 1997). The researcher found gaps in understanding, considered her contribution, and developed expanded perspectives. Revised methods were implemented and outcomes were evaluated. This modified the researcher’s understanding of the experience.

Qualitative methodology was incorporated in the forms of interviews and reviews of participants’ visual narratives. Arts based methods were used to explore the researcher’s perspective and help organize insights that arose from the data. Barone and Eisner (2011) describe arts based research as using the arts to expand paradigms as opposed to reinforcing or reducing dominant social structures. The arts based research components of this research included collage making, an altered book and a process painting.

**Grant Process and Pre-Research Design**

Fifteen cancer survivors participated in the visual narratives and in the research study. The research was completed in two phases. The first phase investigated the visual narratives, interviews, and portraits of two participants. An arts based collage summary of phase one (Appendix C) was created by the researcher and guided phase two of the
research. Phase two included visual narratives of all participants along with artist statements, intake questionnaires, and interviews. Phase two also included arts based response collages to five of the participants, and poetry co-created in response to the collages by the same five participants and the researcher.

**Creation of Visual Narratives.**

Three venues were available for participants to complete their visual narratives. The venues for creation were designed to provide the participant with a sense of safety and comfort in the creation of the artwork. The first option was through one-to-one art therapy sessions where participants met with an art therapist or a graduate level art therapy intern for six to eight art therapy sessions in private meeting rooms in the healthcare center. The second was through small focused group work where participants attended small six week, one and one half hour group sessions facilitated by an art therapist with the intention of creating visual narratives. The third option was to create the visual narrative during open studio art sessions facilitated by the researcher. The open studio sessions were held in a hospital setting twice monthly for 5 hours. Open studio sessions were attended by patients with a variety of diagnoses along with family members and caregivers.

**Art therapy facilitators.** The researcher and graduate level art therapy interns supervised by the researcher facilitated art therapy sessions. The researcher was available for individual sessions and open studio facilitation. The graduate level art therapy interns facilitated individual sessions, small group formats and provided co-facilitation of open studios.

**Art therapy sessions.** The initial intake session included informed consent for participation, consent to photograph and display artwork and completion of a new
participant assessment form that asked for general data on demographics along with physical and mental health status. The form included questions regarding support systems and history of cancer treatments. The visual narrative process was explained to the participant by the art therapy facilitator and the participant was free to choose the medium in which the visual narrative would be created. The art therapy venue offered a wealth of supplies ranging in scope of controllability and versatility for dimensional work. Controllability ranged from graphite pencils with the highest degree of control and liquid paint on the more fluid end. Funds were available for any needed supplies that were not available. The goals of the treatment process were to facilitate reflection on the cancer trajectory and experience, assist clients with self-exploration including intricacies in recognition of psychological patterns, self-expression and self-definition, and to allow the opportunity for altruism through the intent of final product display.

When working in individual sessions, the art therapy facilitator kept progress notes. A general session note written by the art therapy group facilitator followed small group sessions. Only field notes were kept for participants in the open studio, as it is not a part of customary practice to write progress notes in that setting. Thirteen of the 15 participants completed their work. Following the completion of the visual narrative, participants were asked to create an artist statement to accompany the artwork on its display cycle.

**Exhibition.** An exhibit was held in the hospital setting where the research occurred. Twelve of the participants, guests of participants, and medical professionals attended the opening exhibit. Following the opening event, the work began a touring exhibition displaying one or two of the visual narratives at a time in oncology clinics,
radiation treatment centers, infusion clinics, counseling centers specializing in oncology, and on hospital oncology treatment floors within the regional medical system. The artworks were displayed in each location for a period of two to four weeks depending on the preferences of the facility.

**Research Data**

The data used in this research included: intake assessments, the visual narratives created by the participants, artist statements by the participants, session notes kept by the art therapists who facilitated visual narrative creation, recorded interviews with the participants, portraits painted of two participants by the researcher during phase one of the research, an ongoing process painting created by the researcher, responsive collage work by the researcher, co-authored poetry by the participant and researcher, and a memo journal kept in the form of an altered book.

**Interviews**

Following the creation of visual narratives and corresponding artist statements, the researcher interviewed participants. The interviews included six general questions and allowed the participant to expand and describe their relationship with cancer, healthcare, and the art therapy process. The questions included: please tell me 1) about your experience with cancer, 2) about your relationship with healthcare professionals, 3) about your relationship with the art therapy facilitator, 4) about the artwork, 5) about your experience with art making prior to this this experience, and 6) is there anything else you feel it is important to share. The researcher interviewed each participant individually in a place where the participant could be comfortable. Nine of the interviews were completed
before the works were displayed and four after. The two participants who did not complete the visual narrative were available for interviews as well.

Interviews for phase one of this research were coded using ATLAS.ti software. ATLAS.ti is a software system designed to aid in the analysis of large amounts of textual, visual or auditory data (ATLAS.ti, 2015). Interviews for phase two were coded by hand. The change in format was partially due to a preference of the researcher for experiencing the physical aspect of qualitative data analysis and in part due to a change in computer access and ATLAS.ti software. The hand coding involved a variety of colored highlighters, scissors and tape. The process was similar to collage art making.

**Journal Process**

The researcher engaged in keeping a memo journal in the form of an altered book and in the creation of a process painting to help capture intuitive understanding of these processes. An altered book process is when one takes an existing book that is recycled and/or repurposed and adds imagery and text to it, often covering the text and images in the original book. The particular book altered for this study was a photography book illustrating the Cascade Mountains. The book was chosen primarily for its size. The surfaces are large enough to support related images and supporting text. The book alterations included cutting, collage, painting and writing. The work contains both cognitive insights and intuitive musings regarding the work related to this study.

**Data Analysis**

**Phase I**

Two participants were selected randomly for phase one of the inquiry. The first participant (Sophia) completed her visual narrative through sessions with an art therapy
The second participant (Clara) completed her visual narrative in art therapy sessions with the art therapist researcher. Phase one of this study aimed to explore the terrain of the cancer experience of two women in order to identify potential elements of art therapy treatment that could affect the perceived survivorship trajectory and inform phase two of the research.

Data were drawn from session notes and interviews with the two cancer survivors, the artwork narratives created by these two participants, and portraits of the participants painted by the researcher. Both interviews took place after visual narrative was created and before the artwork was displayed. Participant portraits were completed after the visual narratives were exhibited. The researcher used photographs of the participants to aid in the creation of portraiture. The portraits were created with the intent to draw upon insights through empathic connections.

**Portraits of two participants.** The researcher created portraits were gleaned from the expressions of hidden aspects of the researcher’s relationship with the participant. The portraits served as visual documentation of the researcher’s intuitive perspective of the participant’s experience. Following portrait completion, the process of imaginal dialogue (McNiff, 1998; 2008) was used. Dialoguing with the portraits was a path for accessing the imaginal material not readily accessible consciously for the researcher. There is an important distinction between the imaginal that is incorporated here and imaginary which is fictional. Imaginal in this context refers to underlying constructs or archetypes that operate outside of conscious awareness guiding psychic beliefs and behaviors (Corbin & Corbin, 1998). The imaginary that serves as fantasy does not possess the same metaphoric strength.
Imaginal dialogue is an internal communication between the artwork and artist/viewer that reflects a back and forth communication within realms of awareness. This communication connects cognitive, emotional, and spiritual realms and has the potential to transcend dominant constructs such as societal expectations and unconsciously held beliefs (Barone & Eisner, 2011; McNiff, 1998). This imaginal dialogue process began with a quiet room with no interruption and focused attention. This space was focused on the subject of the portrait via the researcher’s familiarity with the participant. The visual narrative and artist statement was reviewed immediately preceding the imaginal dialogue. The portraits were addressed individually with respect and openness. A journaling process was used in which open questions were written and responses that arose in the form of insights or feelings were recorded in response.

Interviews and journal documentation of imaginal dialogues were coded separately using ATLAS.ti software and later compared with the other. The evaluation of interviews, artwork and portraits for each participant was evaluated independently before being compared to the other.

**Summary Collage**

Following the completion of each phase a summary collage was created by the researcher with the intention of gaining insight into the cancer experience of the participants and to direct the trajectory of the research. The collages were created incorporating a conceptualizing approach that worked to build a framework of understanding (Butler-Kisber, 2010). It was a form of responsive art making. Responsive art making is a process through which the art therapist focuses intention and attention on the subject creating connection with the essence of the client (Fish, 2012). Through this
connection, an artwork is created with the intent of gaining insight into clients’ schematic structures. The intention of the collages was to gain access to the gestalt experience, refine the research direction and add to the researcher’s understanding of the subjective experience of the participant. The collages as arts-based research were intended to recognize insights that were not apparent in the earlier review of the data (Leavy, 2008). The responsive collages (Appendix C) were intended to incorporate intuitive understanding into the direction of the research.

**Phase II.**

Phase two data included visual narratives, artist statements and interviews for all 15 participants. The researcher continued to engage in arts based methodologies. In addition, five of the 15 artist-participants were selected randomly for further inquiry using responsive collage making. The researcher created the collages and took them to the five participants where poetic responses were co-created by the participant and the researcher.

**Responsive collages.** The process of responsive collage making began in an effort to engage completely with the participants, the participant’s visual narrative was hung in a quiet space in the researcher’s office. The artist statements were reviewed carefully and the recorded interview of the participant was listed to intently. Following this engagement, the researcher moved to a table space with magazines. National Geographic Magazine was the preferred medium for collage as the images tend towards artistry and away from commercialism. Specific issues of the magazine were selected and paged through with the intention of selecting six images that created resonance with the space of engagement. Images were then trimmed and placed together as if they were a puzzle.
Participant and researcher created poetry. The individual responsive collages along with the first and second summary collages were presented to the five participants selected for responsive collage making. Participants were asked to report association with the two summary collages and the collage done by the researcher in response to their visual narrative. The stories and reflections about all three collages were reframed into poetic responses about the cancer experience in a collaborative effort between the researcher and each of the five randomly selected participants. The poetic responses were short poems written about the overall experience as related to participant perception.

Assessing the Outcome

All portions of data collected were analyzed separately. The coding of interviews for each participant was sorted into meaning units and cross referenced with themes that arose in the visual narratives, artist statements, session notes and intake assessment forms. The data for each participant was analyzed separately into meaning units before it was compiled with other participants. Meaning units for each of the participants were then distilled collectively. The themes that arose reflect the cancer experience as a process of human growth along with potential benefits for the use of art therapy in oncology care.
Chapter 4

Results

Results of this research include a synthesis of 15 subjective experiences of cancer along with methods of art and art therapy participation that aided subjects in their survivorship trajectory. Participant introductions demonstrated variance in the subjective experiences incorporated into the following themes. The eight themes presented reflect the two guiding questions. Odd numbered themes present the subjective experience of cancer and even numbered themes present the attributes of art therapy participation.

Visual Narrative Participants

Participants

All subjects included in this research participated in the visual narratives program. Each participant was unique and brought individual perspectives, experiences and talents to this research project. Thirteen of the participants were female and two male. Fourteen were Caucasian and one Native American. The age range of participants spanned from the mid-twenties into the early-seventies. Years of survivorship spanned from one to twelve years. Cancer diagnoses also varied amongst participants and are presented in Table 1.

Agnes. Agnes was a Caucasian woman in her 50s. She was a healthcare worker and familiar with the struggles of patients as they face medical, emotional, social and financial issues associated with life changing illnesses.

Alana. Alana was a Caucasian woman in her 50s who identified as lesbian. Alana’s breast cancer came as a shock in her life. She reported thinking about cancer regularly causing distress. She also reported finding value in the cancer experience.
Annie. Annie was a Caucasian woman in her 60s. An art teacher by trade, Annie explained that her art creations had no soul until her participation in art therapy following cancer diagnosis.

Brenda. Brenda was a Caucasian woman in her 40s. Brenda was very excited to participate as she considered herself fortunate to be a breast cancer survivor.

Clara. Clara was a Caucasian woman in her 40s. Clara travelled long distances for state-of-the-art treatment for the aggressive cancer. She perceived the treatment as poisonous and excessive and questioned the decisions of healthcare workers.

Darla. Darla was a Caucasian woman in her 50s. She found a self-determined role to spread cheer and hope. Darla had many success stories to share and does so with enthusiasm.

Eileen. Eileen was a Caucasian woman in her 70s. Eileen was a two-time breast cancer survivor. She found humor in the “bag of boobs” the distributor had given her to go through. Eileen described herself as a compliant patient and not a complainer.

Ellie. Ellie was a Caucasian woman in her 20s. She was a skilled artist. She shared gratitude for the experience and credits the life-threatening trauma for saving her from risky choices.

Gina. Gina was a Caucasian woman in her 50s. For years, Gina identified as a victim of breast cancer. In art therapy she became an active patient searching for answers and alternative treatments.

Jerry. Jerry was a Caucasian man in his 40s. Jerry participated in art therapy for eight years. He has been a survivor of stomach cancer for ten. His level of commitment was high, but ability to complete works was not.
Kurt. Kurt was a Caucasian veteran in his 50s. Kurt identified with his description of the general perception of a cancer survivor. He described the initial stages as shock and unknowing.

Margie. Margie was a Caucasian woman in her 20s who identified as lesbian. Margie was obese and struggled with embarrassment in healthcare. She was not surprised at her ovarian cancer diagnosis as she spent many months struggling with unexplained symptoms.

Monica. Monica was a Native American in her 60s. Monica remembered clearly the day she heard the words “you have cancer.” She felt isolated and very often found herself speaking up for the rights of Native Americans.

Sophia. Sophia was a Caucasian woman in her 40s. She reported vividly the experience of finding a lump on her back and how she discussed it with wealthy friends who were connected to the leading local dermatologist.

Vera. Vera was a Caucasian woman in her 60s. Vera described her art therapy work as “lifesaving.” She participated regularly in an ongoing art therapy open studio and credited that participation with giving her a reason to live.

Table 1.

Participant Diagnoses

<table>
<thead>
<tr>
<th></th>
<th>Diagnosis</th>
<th>Surgery</th>
<th>Radiation</th>
<th>Chemotherapy</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnes</td>
<td>Breast</td>
<td>Mastectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>Psychiatric</td>
</tr>
<tr>
<td>Alana</td>
<td>Breast</td>
<td>Mastectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>Psychology</td>
</tr>
<tr>
<td>Annie</td>
<td>Breast</td>
<td>Mastectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>Psychiatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Art Therapy</td>
</tr>
<tr>
<td>Brenda</td>
<td>Breast</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Clara</td>
<td>Breast</td>
<td>Mastectomy</td>
<td>Yes</td>
<td>Yes</td>
<td>Art Therapy</td>
</tr>
</tbody>
</table>
Participants’ diagnosis and treatment regimens vary between surgeries, radiation and chemotherapy treatments. Table 1 provides an overview of diagnosis, treatment options and psychosocial support.

There was variance in the psychosocial support and art therapy experience between participants. There was also variance in the method chosen by the participants for visual narrative creation. Eight participants used one-to-one sessions, three worked in only small groups, three used small groups and open studio and one participated only in open studio settings. Thirteen of the participants completed the visual narrative and were included in display. Table 2 describes the pre-participation professional support and experience with art therapy, mode of participation for visual narrative creation and data derived from that...
Table 2.

*Art Therapy Participation*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Psycho-social support Pre-participation</th>
<th>Experience with Art and Art Therapy</th>
<th>Art Therapy venue for Visual Narrative</th>
<th>Data collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnes</td>
<td>Psychiatric</td>
<td>One-to-one art therapy</td>
<td>One-to-one sessions with researcher</td>
<td>Incomplete Visual Narrative Interview</td>
</tr>
<tr>
<td>Alana</td>
<td>None</td>
<td>No art therapy Goldsmith</td>
<td>Small group participation</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td>Annie</td>
<td>Psychological Support</td>
<td>Individual and group art therapy</td>
<td>Small group and Open Studio</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Art Teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brenda</td>
<td>None</td>
<td>None</td>
<td>One-to-one session with art therapy intern</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td>Clara</td>
<td>Attempts at finding support groups</td>
<td>None</td>
<td>One-to-one session with the researcher</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td>Darla</td>
<td>Facilitated support groups</td>
<td>None</td>
<td>One-to-one session with art therapy intern</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td>Eileen</td>
<td>Psychiatric Psychological</td>
<td>Group art therapy</td>
<td>Small group and Open studio</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td>Ellie</td>
<td>None</td>
<td>Art Therapy student</td>
<td>Small group</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td>Gina</td>
<td>Psychiatric</td>
<td>One-to-one, Group art therapy, and</td>
<td>Open Studio</td>
<td>Visual Narrative Interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Choice of participation venue may have related to comfort with a formed or unformed artist identity. Five of the participants with no past experience in art or art therapy chose to participate in one-to-one sessions. None of the participants with no past experience chose a group format for visual narrative completion. Three participants with art therapy before participation chose one-to-one sessions as well. Two of the three would not complete the visual narrative. Six participants with artist identities formed through either an art based career or participation in art therapy chose the small groups. This may be due to the fact that the small groups were only open to cancer patients and survivors while the open studio was open to the community including hospitalized patients, out
patients, returning patients, family members, friends, neighbors, and caregivers. Four participated in open studio for either all or part of their visual narrative creation.

Data Analysis

Participant interviews were analyzed by identifying themes within the transcribed language. The themes were sorted to reveal meaning units. The meaning units were compared and supported by the visual narrative and artist statement. Following this in-depth analysis of each participant separately, the themes were analyzed collectively to arrive at composite themes (Creswell, 2012). Researcher insights gleaned through the engagement in arts based research helped to align the structure of the themes particularly in the area of art therapy treatment.

The composite themes that arose were situated within two topics. These two topics reflected the guiding questions. The themes were either about the experience of cancer or of art therapy benefit. Themes 1, 3, 5, and 7 correspond with physical and emotional stages of cancer survivors as described by Miller et al. (2008). Themes 2, 4, 6, and 8 center on methods of psychosocial engagement and art therapy that correspond to stages in cancer treatment. There were elements of alignment between the two topics. The themes presented in Table 3 are sorted according to these relationships.

Table 3.

Themes and Sub-Themes

<table>
<thead>
<tr>
<th>Cancer Experience</th>
<th>Art Therapy Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td>Sub-themes</td>
</tr>
<tr>
<td>1. Diagnosis and</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>The Onset of the</td>
<td>Reaction</td>
</tr>
<tr>
<td>Cancer Journey</td>
<td>Perception of Control</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Presentation of Themes

Theme 1: Diagnosis and the Onset of the Cancer Journey

For the majority of participants, cancer diagnosis came as a shock. Their reactions varied to the diagnosis and by perception of it. Some participants reported seeking additional support in the form of mental health care. Participants also had various ways of dealing with the loss of control that comes with a diagnosis. Some turned decision making over to medical staff, others did independent research and still others included family as support. Emotional reactions also ranged from fear of to a concern about being betrayed by medical professionals for Clara. Participants’ descriptions of reactions to diagnosis and initial treatment sequences are described through subthemes of diagnosis, reaction, and issues of control.

The first sub-theme that emerged was the idea of diagnosis as a shock. Alana’s work (figure 1) describes her cancer journey chronologically. The image began with the diagnosis in the bottom left. The bold black encapsulated the patient’s body. Encapsulation provided protection from the other elements in the image. According to Alana the bold jagged black served to separate the shock and threat of diagnosis from the remainder of the cancer experience. It served as an exclamation of trauma. The space
enclosed within the black was the darkest gray of the image and the reported most difficult to feel. Alana described feelings of brokenness or the perception that she was now damaged goods. She found herself unwilling to create space and time for treatment.

Figure 1. Untitled. Detail demonstrating direction and encapsulation.

**Reaction to diagnosis.** Following the initial shock of diagnosis, participants described their reactions to it. Seven of the fifteen participants sought mental health treatment following diagnosis and all seven had diagnoses of depression after cancer diagnosis. The high ratio in this sample of those seeking mental health services was likely due to a psycho-oncology clinic that specializes in mental health care for cancer patients serving as primary referral source for the visual narratives project.

Those who did not seek mental health services also expressed initial reactions. Kurt described cancer as “a sickness… that steals the future and replaces it with a breathless and a quiet terror….” Ellie reported experiencing confusion and high levels of anger directed toward her parents and the medical professionals who interacted with her. During the time spent learning about the aggressive form of breast cancer, Clara felt overwhelmed. She was unable to concentrate or take in the information being given to her, and described it as “listening through a fog.” Sophia described herself as “an absolute wimp. [She] thought it was a death sentence.”
An alternate perspective was reported by two of the participants. Darla’s cancer diagnosis came after many years of medical treatment for multiple diagnoses of other diseases and her reaction was to take “it in stride.” Margie was not surprised at her cancer diagnosis as she spent many months struggling with unexplained symptoms. She credited the medical staff that discovered it for saving her life.

**The perception of control.** The next sub-theme involved perceptions of control regarding the self, the illness and of the environment. The locus of control tended toward the external for 14 of the participants. Only one participant expressed an idea of partnership with the medical team during diagnosis and initial treatment. This may have been affected by the lengthy diagnosis process. Margie spent many months treated for gynecological symptoms prior to diagnosis. Regarding her pre-cancer condition, Margie says “I had no control over it what so ever.” “It will pop out of nowhere, won’t even know it is coming.” It was she who recognized “it wasn’t getting any better,” and that she needed to “find a way to deal with the things” both known and unknown. When it came to treatment decision making, Margie noted the loss of her family’s input because she “knew it would get frustrating” particularly when discussing the choice between chemotherapy and hysterectomy.

Others reported handing over treatment decisions to medical care teams. Clara’s report demonstrated best the perception of physician’s control. “Cancer was a different story. I was not in charge… I couldn’t go back and do or say something that would make it change.” “Because the tumor was growing so fast, decisions on treatment needed to be made immediately.” “I’m just the patient, I don’t know,” “I was led around by some doctors … ‘you need to do this… you need to get a stem cell transplant’” and so on.
Statements made by Clara during her interview illustrated losses both of control and voice and regret for not taking a more active role. Her frustration was heard through her words:

I feel like I have jumped through hoops and nothing worked out very well; how should I have known to check out other things? In my mind I kept saying are you guys sure this is right? I mean I’ve known a lot of people who have had breast cancer and I’ve never heard of anyone getting this burnt. I was having symptoms. I was having chest pains. I was having a hard time swallowing. I was having…and it was like they were saying ‘this isn’t for sissies,’ ‘stop complaining.’

Each of the 15 participants experienced diagnosis with cancer. Participant perception and degree of severity varied. Each participant made choices as to who would have control over cancer treatment and demonstrated some degree of coping. The overall experience was described as a shock.

**Theme 2: Instilling Hope and Recognizing Strength**

Instilling hope through imagery and recognizing personal strengths in self-expression added to the participants’ cancer experience. Cancer in and of itself does not have a generalized image that represents it. The word is abstract and initiates subjective associations. The subjective understanding is impacted by a secondary cognitive stage of decision-making that serves to form the image of experience (Trope & Liberman, 2010). Hope for survivorship, health or happiness is also an abstract concept and one that is considered essential in cancer care. Because of the subjective and personal nature of cancer and of its resulting imagery in psychological functioning, imagery and art therapy can encourage, ground and strengthen feelings of hope for patients. Subthemes related to
the instillation of hope and recognizing strength included the need for hope; strength, encouragement and possibility; and trust.

**The Need for Hope.** The transition into treatment required both hope and strength of the participants. Participants’ experience in treatment ranged in both method and perception. Cancer treatments ranged from a single surgery lasting a couple of hours to complex treatment regimens spanning several years. Perceptions ranged from hearing comforting angels and taking care of business, to isolation, anger and extreme fear as illustrated above. Prayer and faith during the time of treatment were reported by six of the participants. Four noted absolute faith in their medical teams. All participants moved immediately from diagnosis into treatment and only one reported psychosocial support or education on choices in initial treatment. Gina noted the experience as beyond hope or faith, “it wasn’t really a trust issue, it was just getting it done. It had to be done.”

A positive relationship between patient and physician may have altered the emotional impact, trust in treatment, and faith in medical staff for five of the participants. Annie’s cancer treatments were complicated. She felt several times as if she could be at “death’s door,” her response to the treatment protocols defined by her physician was to report that “everybody was professional and kind, even at the radiation.” Following multiple surgeries and a long diagnosis process, Margie was “praying, giving it all.” The cancer took her reproductive organs and Margie had to give up her dreams of giving birth to children. Following treatment she refers to her medical team as “miracle workers.”

Darla’s visual narrative (Figure 2) demonstrated the acuity of her comfort in the hospital room where she received treatment. Her work illustrated her faith in God,
relationship with healthcare workers, the importance of the particular day and the
inauguration of perpetual cheer spreading.

Figure 2. My Room. Depiction of a comfortable hospital room.

Above a large mirror hung a heavy metal angel. This angel is said to have visited
Darla the night before her surgery. The angel maintained a central position in the work as
Darla’s faith remained central in her life. The healthcare worker present in this work was
located lower right and is the only two dimensional element inside the room. The size of
the nurse is reported by Darla to reflect that the power to heal resides in the patient and in
faith. The events that occurred in this room were a turning point in Darla’s life and the re-
creation of it included memories vivid after many years. Since this time, Darla has had an
internal drive to spread cheer, which she did enthusiastically spreading yellow happy faces
to those in need.

Strength, Encouragement and Possibility. Reminders of a patient’s own
strength and endurance in surviving the treatment regimen built hope and trust in their
own survival. Participants found a need to stay strong and expect the unexpected as they
addressed the unknown. “The cancer – the blood – the tears- the pain – Today I can say
that I am stronger – I am handling it – I made it – I found myself,” wrote Margie in her artist statement. Vera’s interview included this encouraging statement, “new patients should know that they would find strength they did not even know that they had.”

Clara expressed gratitude and appreciation for the opportunity to participate in art therapy where she found internal encouragement to continue the fight. Annie expressed, “my life is a miracle. I found myself through faith, courage, tremendous support, and amazing medical treatments … Life is a death-defying act.” Gina through her participation in the visual narratives project “found a correlation between the butterfly and the human spirit. Humans have the instinct to survive, even when given the worst odds.”

**Trust.** Between trusting the process of art making (McNiff, 1984) and trusting the process of healing through cancer treatment, participants found ways to survive and to find meaning that eased their angst. Annie found making art “is giving into life.” “I feel grounded by it. I have done many spiritual types of things, but art is always the thing that gets me grounded.” Alana, in her new found painting practice found projected images developed further as they remain unnamed. Alana’s image (figure 1) illustrated her own image at different points along the trajectory of cancer. When avoiding naming each image, she found potential and lessons learned from the vulnerability. Gina described her art therapy participation saying, “there are no words” and, “happy accidents… Happy accidents are something I learned.”

Each of the participants found attributes in art therapy or art making that helped to provide hope, strength or faith as they remembered the cancer journey. The interviews reflected the need for encouragement and psychosocial support at the onset of treatment.
They also reflected ways that imagery and art helped to provide both the encouragement and support.

**Theme 3: Ongoing Treatment and Support**

Ongoing treatment and support includes the physical experience of treatment, healthcare disparities and perception of control, coping with treatment, and support during the treatment process. As reported in Table 1, treatment protocols varied among participants. Treatment reception varied as well. Seven of the participants reported feeling moderate to severe distress throughout treatment, five experienced low to moderate distress and three reported feeling little distress due to trust in medical care.

**Physical Experience.** Five participants included detailed illustrations of their physical experience of medical intervention in interviews. Three of the five detailed reports were from participants who reported low to no distress. Eileen experienced low levels of distress, used humor in the description of surgeries for mastectomy and included laughter in the “bag of boobs” offered for prosthetic choice. Margie talked in emotional detail about the entire process from excessive bleeding to hysterectomy. She described her experience as “really sick, like going through chemo sick.” Due to her trust in the medical team, Margie spoke of low distress in retrospect. Sophia remembered disgust in seeing the tumor placed in a jar following its removal. Sophia recognized no distress throughout treatment. All three described connections in access to healthcare and trusting relationships with medical staff.

Annie attributed her high level of distress to fear. She “only knew one person who survived.” Clara described isolation as a component of the distress felt during treatment. “When I had my breast removed, there was no help or therapy available.” “I felt isolated
because I never had the chance to speak to any survivors and did not know what to expect.” Clara’s life vision was broken at diagnosis and continued to be impaired throughout her treatment.

The visual narrative Clara created around her cancer experience displays buildings that represented the far away medical system where she was treated (Figure 3). The distance to the building was emphasized by the trees in the foreground. In retrospect, Clara found the red sky and yellow haze coupled with the confusion between the lack of sun in the sky and the large circular white light below the horizon echoed the muddle Clara felt during her cycle of treatment.

![Figure 3. Before and after. Detail of before.](image)

The Experience of Healthcare Disparities including Perception of Control.

Access to healthcare and its disparities were noticed in this small sample. Table 4 illustrates variables that seemed related during data analysis. Reported distress was
related to perception of patient’s choice in medical staff and who was involved in decision making.

Table 4

*Healthcare Relationships*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Residence</th>
<th>Employment</th>
<th>Insurance Perception</th>
<th>Social Economic Status</th>
<th>Reported Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnes</td>
<td>Urban</td>
<td>Healthcare</td>
<td>Average</td>
<td>Middle</td>
<td>High</td>
</tr>
<tr>
<td>Alana</td>
<td>Rural</td>
<td>Creative</td>
<td>Low</td>
<td>Low</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Annie</td>
<td>Urban</td>
<td>Education</td>
<td>Average</td>
<td>Middle</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Brenda</td>
<td>Urban</td>
<td>Service</td>
<td>Average</td>
<td>Low/Middle</td>
<td>Low</td>
</tr>
<tr>
<td>Clara</td>
<td>Suburban</td>
<td>Service</td>
<td>Low</td>
<td>Low/Middle</td>
<td>High</td>
</tr>
<tr>
<td>Darla</td>
<td>Urban</td>
<td>Occasional</td>
<td>Average</td>
<td>Low/Middle</td>
<td>Low</td>
</tr>
<tr>
<td>Eileen</td>
<td>Urban</td>
<td>Healthcare</td>
<td>Average</td>
<td>Middle</td>
<td>Low/Moderate</td>
</tr>
<tr>
<td>Ellie</td>
<td>Rural</td>
<td>Youth</td>
<td>High</td>
<td>Middle</td>
<td>Moderate</td>
</tr>
<tr>
<td>Gina</td>
<td>Urban/Rural</td>
<td>Service</td>
<td>Average</td>
<td>Low/Middle</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Jerry</td>
<td>Urban/Rural</td>
<td>Construction</td>
<td>Average</td>
<td>Middle</td>
<td>Moderate</td>
</tr>
<tr>
<td>Kurt</td>
<td>Suburban</td>
<td>Military</td>
<td>High</td>
<td>Middle</td>
<td>Moderate</td>
</tr>
<tr>
<td>Margie</td>
<td>Urban</td>
<td>Healthcare</td>
<td>High</td>
<td>Low</td>
<td>Low/Moderate</td>
</tr>
<tr>
<td>Monica</td>
<td>Rural</td>
<td>Service</td>
<td>Low</td>
<td>Low</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Sophia</td>
<td>Suburban</td>
<td>Occasional</td>
<td>High</td>
<td>Middle/Upper</td>
<td>Low</td>
</tr>
<tr>
<td>Vera</td>
<td>Rural</td>
<td>Service</td>
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During phase one of this study, healthcare disparities were found in the experiences of Sophia and Clara. The disparities between the two demonstrate effects from perceived medical choice and participation of their healthcare decision making.

Sophia’s social connections included medical professionals in high socioeconomic status. The potential of her healthcare connections provided immediate attention and her fear became trust in the medical profession. Sophia reported gratitude in the experience.
Clara on the other hand did not have the resources and was led to her treatment team through a series of professional referrals at one point led by television commercials. She felt over treated and not listened to. She experienced new diagnoses as a result of cancer treatments. Cancer reoccurrence proved chemotherapy resistant and after multiple surgeries and multiple rounds of radiation, Clara experienced side effects including radiation burns and congestive heart failure. In the end, Clara felt cheated and used by doctors’ networks.

Coping with treatment. Coping with treatments and side effects is a necessary component of cancer survivorship. Coping styles differed between participants and included both active and passive styles. The differences depended on personalities, social systems and life experiences. Active coping styles included engaging in communication, education and seeking out support, gathering resources and finding out alternative healthcare options. Passive coping skills required no action and included keeping a positive attitude, hope, faith, and trusting medical care teams with decision making.

Annie focused on the doctor’s words and still maintained that he used the word “cure” in his presentation. Her response following diagnosis was pragmatic. She “called the next week to get a sedative in order to sleep and night, and called the Cancer Counseling Center right away.” Annie began mental health treatment and looked for support in survivorship groups and art therapy. Annie’s overall effort to maintain a hopeful demeanor was demonstrated in her description of reading a book with her husband about the cancer experience. While reading, when they realized “there weren’t too many people at Annie’s stage of cancer that survived,” so they “got rid of the book” to eliminate negative thoughts.
Clara described her experience as “jumping through hoops.” Clara had difficulty coping with the experience and reached out for help. Her experience with support groups was unsuccessful. She reported signing up for them until they failed to happen due to lack of attendance. She remembered some supportive care during treatments but reported it was “very on the surface stuff …” with the exception of a friend also undergoing breast cancer treatment, Clara indicated the art therapy sessions with the art therapist/researcher she entered two years after diagnosis were the first time she found support around her experiences. Clara’s life has been altered by the diagnosis and art therapy helped her to develop resilience and return a sense of vitality. Clara’s new found confidence initiated in art making accented her newfound sense of control. Her artwork showed that her healing perspective was unable to be contained by thick walls (Figure 4.) The koi pond in the lower portion of the image was clearly not contained by the walls of the castle windows.

Figure 4. Before and After. Koi pond extending boundaries of castle walls.
**Support, family relationships, and community.** Each participant described familial relationships. Participants’ family roles varied from patriarch through protected child and levels of family disturbance varied as well. Participants also shared social and community influences that had a bearing on the cancer experience. Where the participant was positioned within family and societal structures effected resilience, hope, and perceived experience of the cancer.

Kurt identified with his description of the general perception of a cancer survivor. When making plans for survival, he engaged in a questioning process including who needed to know and who should be told first. Very cautiously, he deliberated on how to shield his family from the pain. Kurt explained that all the males in his family have had cancer and he has experienced the pain of having a loved one die. It was only after determining he did not want to be unsupported he told his mother three weeks after diagnosis. Kurt explained “It’s not just me who is affected. The whole family is. That is kind of the nature of the beast.”

Monica was the head of her household and demonstrated a strong need to take care of her family and others to whom she felt connected. Monica was raised by a “White family” after her Native “parents were deemed alcoholic.” Her Native American identity was spawned by her search for biological parents that ended in her “40th year.” Monica is proud of her heritage and communicated regularly with tribal Elders in her ecumenical endeavors. Monica’s cancer experience became a quest for her own wholeness. Her passion for her roots has since sent her on travels to Moscow as representative for her Ottawa tribe of origin to help “bridge the cultural gap of the Bering Strait.”
Alana who identified as a lesbian expressed feeling isolated from her family both by distance and her children’s distastes for her life patterns. She described her mother as “guarded” and her father as “cold.” The cancer journey took away Alana’s ability to work. Loss of vocation and familial support left her in low-income status and at one point homeless.

Jerry was a divorced father when diagnosed. His daughter lived in another state and visited only four times per year. Jerry included his daughter in art therapy treatment whenever she came to town. The cancer sparked a sharper interest in family relationships between Jerry and his daughter and his mother. Jerry lost his vocation following cancer treatment and gave his extra time to his ailing mother as she transitioned into hospice care.

Vera identified as being middle class owing a home in a rural town with access to many amenities. During the series of diagnoses and treatment protocols, Vera’s economic status had changed. She had moved into a low-income residential facility and worked with social support services. Even through the personal struggles, Vera found herself being an advocate for women. One of her visual narratives (figure 5) was described as depicting that “women carry the cross internally and externally.”

Figure 5. Women carry a cross.
Theme 4: Relaxation and Re-Focus

Relaxation and re-focus or interactive distraction aided participants by means of active creation, repetition, and containment. If for nothing more than putting space between thoughts, art making and art therapy were reported to have been beneficial and enjoyable during this time. Relaxation and re-focus was inclusive of subthemes including expression, catharsis, and distraction or the capacity to set the pain aside. Interactive distraction pulled attention away from the experience of pain and occupied time alleviating boredom. The researcher’s memo described an art therapy process as “quieting intrusive thoughts, helping to keep spirits out of the doldrums, and simply coloring away boredom. The markers work magic.”

Expression. The visual narratives created by the participants were forms of self-expression. The healing capacity was recognized and reported by six of the seven participants who were new to art therapy with the onset of the visual narrative participation. Monica called the participation “healing for the first time.” Before art therapy, Monica had not had the chance to express her cancer experience. Alana called the visual narrative process “something tangible to help express my feelings.” Clara reported gaining a new way of looking at the experience. Darla recognized the importance of self-expression for healing. Sophia said it was something everyone should consider due to the cathartic release of expression. And Brenda reported it was a great way to “look back and see what I went through.”

Jerry’s personal expression was seen in retrospect following his participation in the visual narrative project. Jerry was unable to complete the visual narrative which he found to be correlated with his inner perception of not finishing his career that was cut short by
cancer and his family from which he was separated by divorce. Cancer treatments and responses to them prohibited Jerry’s return to work. He was divorced and his wife and children left the state leaving him without means to help or witness his children’s development. Jerry made several attempts to complete work through art therapy and had only one completed piece throughout his 14 years in relationship with an art therapy program.

**Catharsis.** Catharsis here is the purging of negative energy and has been effective in reducing anxiety and calming the spirit. Vera described her art therapy work as “lifesaving.” The bulk of her participation in art therapy had been in open art studio groups. She brought a considerable amount of distress to each session and used liquid paint to release the physical and psychic tension that had built up over the course of the weeks between group meetings. She described her attendance as both a place to get rid of the negative energy and re-charge her spirit. She allowed the force with which she pushed the paint from the bottles to become a metaphoric representation of releasing the tensions felt in her struggles with healthcare. An example of Vera’s cathartic release of energy is available in figure 6.

*Figure 6.* Untitled. Demonstration of cathartic release of energy.
**Distraction and setting the pain aside.** Annie reported at first “art therapy was a distraction.” “I found I could put some of the bad things away.” It was “very soothing and calming.” Gina said art therapy “lets you play. It lets you play when thinking about play is a hard thing to do.” Sophia reported art therapy could help with stress and to unwind. She called art therapy therapeutic by “just doing it.” The interview emphasized process over product and Sophia reports little positive aesthetic value in her visual narrative. Sophia states “I wouldn’t hang that in my living room to save my soul, but it was therapeutic just doing it.” Ironically, Sophia made a replication of her piece to hang in her home.

**Theme 5: Transition to Life after Cancer Treatment**

Following the end of scheduled cancer treatments participants reported differing responses. Releasing connections to healthcare workers was the first step for some. Letting go of the treatment team, the cancer itself, and often control seemed to be a step toward healing, and increased confidence. Subthemes that surfaced around transition from cancer treatment included ongoing distress, emotion, new life, and freedom.

Four participants made direct references to letting go at this point in the transition. Margie, during her art therapy sessions demonstrated determination in letting go. “Even in the winter [through snow on a rooftop garden], we threw the paper cranes off the side of the building.” Gina reported that when she “put[s] attention into art it gave [her] a reason to let it out.” Annie has “found great comfort in expressing my strength of hope, not only for myself but for others in the form of artwork,” and Alana stated “Maybe it’s that the art therapy is letting my self move past it a little bit.”
Ongoing Distress. Following the initial loss, residual effects continued. Participants reported both physical and emotional impacts from the experience of cancer. For the participants, immediate surgical effects included mastectomy, stomachectomy and hysterectomy. Non-direct physical results included burns, scars, neuropathy, congestive heart failure, lymphodema and diabetes. Regular monitoring continued for most of the participants. Annie was the only participant who included the physical losses in the visual narrative. Figure 7 demonstrated the mastectomy and tumor removal along with lymph nodes tested at intervals for tumor markers.

![Figure 7. Untitled. Detail of mastectomy, tumor, medication and lymph nodes](image)

Purpose and vocations for the participants have changed due to cancer as well. Kurt, Craig, Clara, Alana and Gina were unable to return to work for a period of time following treatment. Three others would likely not be able to return at all. Margie lost her ability to give birth to children.
Twelve participants reported some degree of fear for reoccurrence and six experienced recurring memories of diagnosis. Ten years have passed since Monica’s breast cancer diagnosis. She remembered clearly the day she heard the words “you have cancer.” She remembered feeling confused and lost. Alana, in metaphoric recognition reported feeling “broken surfaces like ice breaking over a water mass, fragmented, shallow, afraid. I hear the cracking; see chunks of ice float away. I sit poised, waiting for the supportive frozen surface to leave me plunged into the dark, cold water.”

Not all changes post cancer are seen as negative. Clara reports since the cancer, … I was so busy and stuff and I didn’t feel like I appreciated the summer, just taking my dog for a walk and seeing, well I never realized that those trees are really round on the top. So I think in some ways the cancer thing has opened up different avenues than what I was doing before but it’s totally not a place that you really would ever want to get to.

In her interview, Clara credited both the cancer experience and the art therapy treatment for her new vision in appreciation for the little things in life. Clara also reports an increase in spirituality since her diagnosis.

**Emotion.** Fear, anger, frustration, sadness, embarrassment, and betrayal were reported in retrospect by participants during the initial periods of diagnosis, treatments and beyond. The fear was represented frequently in interviews. “This word… [cancer] brings fear and tears of what may be…of pain yet waiting” (Kurt). “It feels cold and tries to freeze my psyche” (Monica) “Fear, I feel fear” (Agnes). Margie “felt like there was no hope.” She hated the feeling of “fear, always hanging over everything.” “You never know if it will come back or if something will change. I had a scare that a different cancer
would come. I cried all the time, no idea why.” And Annie reports “I didn’t have a lot of
time to fear then. Now I have time.”

Anger and frustration were directed toward the cancer, loss, healthcare
professionals and family. Kurt’s artist statement called the cancer an “unholy
illness…feeding on cells where only love is allowed.” Margie expressed frustration in
continually reminding people that the alternatives to child bearing are not the same as
having a child of one’s own. Clara reported feeling like the doctor’s “experimental
pincushion.” Ellie continued to reprimand parents and categorized healthcare
professionals as insensitive.

The amount of embarrassment was extremely high. Margie described the
embarrassment as “burning, pain, and anguish.” “Knowing the mess left behind, so much
blood lost in such a short period of time,” “just take me to the hospital … don’t touch me.”
Her boss would see her “crying in the bathroom and send [her] home.” Margie reported
there are “other secrets and feelings inside it is hard to express.” She notes that the “tears
have become a way to let it out.” Monica’s sense of imperfection following surgery left
her feeling “like nobody wanted [her]… cause I felt broken.”

New Life. Reflections on healing included Margie who somehow found an
indication that healing had occurred when she “remembered staying up until two in the
morning to work on a collage.” Gina found healing in “flora, fauna and art.” She reports
“Petting animals and planting something helps me… now I have chickens.” Gina made
regular appearances at an art therapy open studio where she stated “I keep coming back
and staying connected I don’t know why, but that’s the way it is. This must be where I
belong.” Regarding frequent questioning statements about her artwork, Eileen stated “I
am not at all a perfectionist, but I don’t function the way I used to.” Eileen did not identify as an artist when she began art therapy treatment and her artist identity has evolved through her participation in art therapy in multiple venues.

**Freedom.** Participants found a break from treatment and from cancer following treatment. Clara’s freedom came with a cancer free diagnosis. Until that day there was trepidation in artistic performance. Following the good news, decisions regarding image placement began, brush strokes were laid down with increased confidence, and day to day experiences fed the visual narrative direction. Alana’s language shifted following her participation in visual narrative and reflections. The language used moved from “finding a way to deal with it” to “coming into freedom.” Kurt reported that the visual narrative allowed him to feel it was “okay to express” his pain, and Gina noted the art therapy helped her to see that she was “allowed to feel” the hurt of cancer.

Annie explained her post cancer freedom as:

> having trust that [she] could float. I remember those days. I am stronger and different. I just wanted to dunk my head. Now I worry a heck of a lot less. I am still afraid of dying, but not so afraid of the cancer coming back. The cancer experience is different than something like MS – chronic, there all the time. When it comes to new things, if it is going to be a one shot deal I think maybe I should do it. Part of me doesn’t want to be a responsible adult. I have had to reign myself in.

**Theme 6: Defining Ongoing Survivorship, Re-Establishing Resilience**

All participants in this study had completed their treatment regimens. Following treatment, each worked to re-establish self-perceptions and create a definition for life after cancer. Following treatment, some participants found time to engage in art therapy. For
others, there were years that passed before they found a relationship with an art therapist. Through engagement in the visual narratives project, participants reported resonance between their inner and outer selves and found personal strength to help in the re-adaptation to life after cancer. Many began to recognize metaphors that added meaning to experience. Reflections led to the subthemes of self-learning, metaphor and finding purpose and meaning.

The term mask was used to describe subjective personas that shifted during the transition from cancer care. The mask Sophia described served as the “filters” that limited what she heard during her diagnosis and treatment. Margie found through her visual narrative that, until her story was told, she was “wearing a mask.” She remembers “wearing sunglasses, walking down the street crying and nobody would know anything.” She continued, “even after you tell your story there is still an element of wearing it because no one around you really knows what you went through.” Wearing the mask became a way of “getting through the everyday routine.”

**Self-Learning.** Each participant recognized elements of themselves within the context of creating the visual narrative. Some recognized events from personal history, some found coping skills, some found themes in life that they wanted to change, and others began to trust themselves.

Brenda came to understand some of her own dynamics in the way she approached traumatic situations. She found lessons learned in response to prior abuse useful in facing her cancer diagnosis and through her art making was able to identify the pattern. As her image of self expanded, the surface of the image became too small to contain the whole story, so another canvas was affixed to accommodate. In accord with this move toward
holistic awareness, Brenda used the word illusion to replace the word cancer and followed it with a fork in the road of life. The intent of using the word was to highlight the subjective nature cancer understanding.

Ellie’s work in art began long before her participation in this project. She reported that each time she engaged in art making it helped to clarify her new found life even more. Ellie has come to understand that the cancer was a “stop sign” intended to direct her course. As a youth, Ellie reported “some bad behaviors” and believed that the behaviors would have taken her life in an “un-desirable direction” had the cancer not intercepted. At 17, she was able to self-reflect through the light of the cancer.

Metaphor. Metaphors in behaviors and artworks were recognized by participants. The metaphors were elements of self-recognition and helped participants re-acclimate to post-treatment existence. Eleven of the 15 participants made direct reference to metaphors during interviews.

As a Native American story teller, Monica explained her experienced of world in metaphor. Her two piece visual narrative contained many metaphors (figure 8). Monica explained

I did it backwards because I did the dream catcher first. The other is the heart with the tears. When I was first told my heart broke. We have tears and if someone could reach out and touch us, then the heart would heal. So we hurt, but we heal. And the only way we are going to heal is if we move beyond.

My message across one of the pieces was an Indian woman sitting in the corner looking at the sky. And we have lost a lot like the buffalo. The buffalo came and went. The buffalo are gone, stuff like that. Oh the buffalo are gone, the
deer have gone, but came back. The broken glass signified that we are all walks of life, all different colors, all broken glass. I think that’s the best way I could put it.

I just started putting it on canvas.

Figure 8. Metaphor in visual narrative.

Annie explained how early work in art therapy led her to recognize a metaphoric experience when camping. She remembered walking by a river that had a cool name she could not remember. She reported having

had a butterfly experience. Away from noise, [television], phone, computer. In the tent, miles away, physically away, it was scary to be away from care providers.

We went on this hike and took an offshoot. It took an hour or two, it was a difficult trek. Just before Memorial Day. The path led to a bench over a body of water where a whole bunch of butterflies were hovering over some water. It was quieting ... It was a good sign.

Margie allowed a move to be reflected in her survival status. “Keep walking, stand tall.” Margie told herself “the healing is sneaking in.” Margie saw her upcoming move to
a new apartment as a metaphor for moving into another phase of life. She saw it as a “transitional move in more ways than one.” She likened challenges in the light of cancer experience as having “walk[ed] through the path of fire.” Margie became stronger following cancer by using the skills of metaphoric recognition she learned in art therapy.

**Purpose and Meaning Making.** The cancer experience solidified a sense of community responsibility for some participants. Others recognized connection to a larger life vision and made meaning from events. Ten of the 15 participants described increased meaning in life following the cancer experience.

Gina reflected on the handprints and human figure in her work and found “a higher power emerging.” She continued her musings to include her recent affinity for butterflies and her belief that “the caterpillar knows its future even before it had wings.” “The butterfly knows its path,” she said. From this artwork she “found a correlation between the butterfly and the human spirit. Humans have the instinct to survive, even when given the worst odds.” The creation of this work improved her awareness of connectedness to Earth and a higher power.

Margie reported that through her experience in art therapy following the cancer, her “life is a project, and experiment in art on many levels.” Ellie remembered elements of the cancer in her artworks and her patterns of behavior. She made sense of the image by labeling symbolically significant items and relating them to her cancer experience. Ellie reported while reflecting on the web representation in her visual narrative (figure 9) “the web I have weaved repeatedly every year by going to the doctor and getting checked has continued to bring me some good luck.”
Theme 7: Post-Cancer Growth

Reflection on the experience throughout the trajectory of cancer has shown growth and positive change in many of the participants. “Something that I have learned is that life is sacred and fragile” started Annie’s declaration of gratitude for the “gifts” of the cancer journey. Eight participants expressed gratitude and/or increased vitality in light of the cancer experience. Three others found gains in personal attributes, and recognized their own inner strength. The two subthemes of post cancer growth were gratitude and increased vitality.

Gratitude. Ellie expressed gratitude for the experience and credits the life threatening trauma for redirecting her life from risky choices. “In a way, the cancer saved my life.” Ellie was diagnosed at 17 during a time when she was involved with “the wrong crowd.” Looking back, Ellie saw jail and death as potential endings to her life direction.

Margie acknowledged that the art therapy sessions she participated in following her cancer diagnosis helped her to find alternate states of awareness. She credits the struggle of dealing with cancer for opening her ability to “transition to my happy place.”
“It is my happy place,” she continued and the art therapy treatment for cancer care transferred to her ongoing coping skills to deal with depression. Margie also credited the cancer for her “learning to say no.” She reports having new awareness recognized that always complying with others’ wishes “it like giving away a piece of [her]self.”

Monica noted that the cancer made her “look at her previous self.” The experience of healing from the cancer helped her to recognize “stages of self.” Monica recognized a cumulative process in her life where one experience built upon the next to create the person she was. This introspection has resulted in increased self and cultural identity and confidence enough to travel across the world as a representative of her native tribe.

Sophia credited the cancer and her ability to cope for her feeling “a lot more free.” She reflected on the mismatched figure in her visual narrative as “She is coming out okay.” The whole experience taught her that she would come through any challenge with a can do attitude. Sophia reported being “fearless when it comes to taking chances that will benefit her life.”

Gina noticed changes in her interest in art. She noted that since the cancer she “knows when it’s right and when it’s not right” when referring to artwork completion. The style of her art participation has moved from “more crafty jewelry and things” to metaphorical collage and fine art. Since the cancer, Gina has identified as an artist for her primary vocation.

**Increased vitality.** Brenda described herself as being aware and mindful of everything that happened in her life. She credited the cancer experience with her enhanced awareness. In her journey collage (figure 10), she pointed to both losses like her feminine identity and gains in knowledge. Overall, she found cancer brought gifts of self-
recognition and clarity. She described “wisdom of life along with sorrow of loss of youthful figure.”

*Figure 10.* Feminine figure and books for wisdom. Detail.

Eileen was a “compliant patient.” She followed doctor’s orders, healed and went about living. It was at her doctor’s request that she sought psychological treatment for depression that led her to art therapy. It was the art therapy that led her to identification as an “amateur artist.” Eileen’s sense of being has been enhanced by ongoing participation in open art therapy studios. She has continued to participate and indicates that “the art making in community gives [her] life purpose.”

Margie credited her participation in art therapy and her experience with cancer as precipitators of her new self. Margie has since identified as an artist and has taken an active role in her own lived experiences. Neither Eileen nor Margie was as Clara said, “hiding anymore.”

Clara’s life vision was broken at diagnosis and continued to be impaired throughout her treatment. She gave her voice away to oncology specialists and discredited her own active involvement in decision making. Clara’s life has been altered by the
diagnosis and art therapy helped her to develop resilience and return a sense of vitality.

Art therapy helped her to “connect with and learn to appreciate the little things in life.”

Annie explained that her art creations had “no soul” until her participation in art therapy following cancer diagnosis. “Some things I am better for going through” she shared. Annie described the cancer as “a trial by fire.” Annie remembers the phrase “when pigs fly,” as one that demonstrates survival against all odds. She became “the flying pig” when she decided to beat the cancer. She picked up on this metaphor for life a year after diagnosis when her son was getting married. She took on the identity of the “almost possible.” “My life is a miracle. I found myself through faith, courage tremendous support, and amazing medical treatments. I am a flying pig.”

Alayna recognized that in her life, “the ugly part is where life changes.” Monica explained “it was different before cancer and before art therapy.” Ellie spoke of “acceptance,” “moving forward,” and “letting the cancer be the past, it is where life began again.” The whole experience “led into self-learning and a kind of transformation” reported Clara. “I see it more and more and more.” “It is part of my healing process, a revered part of the journey that seemed a little bit distant, a little fuzzy.” “I am a different person now that I was then.”

**Theme 8: Refining a Creative Identity and Re-Imagining the Self**

**Creative identity.** Nine of the 15 participants identified as creative in varying capacities following participation in art therapy. Two others have built identities that involve creativity. Vera did not identify as creative when she began art therapy treatment and her personal identity has evolved through her participation in art therapy in all venues. Alana through her relationship with the art therapy intern developed strength in her former
artist identity. She had exhibited her work in two medical venues and is currently working on a body of work to display in galleries.

Margie, since her diagnosis and treatment, had an entire closet dedicated to art stuff.” While picturing her art closet she said, “Look at the stack... art, art, art, art even after I downsized,” even the “door is covered in collage. I will have to transfer it piece by piece when I move.”

Annie stated “the art thing continues to this day. I did not make art that was meaningful until the cancer.” She saw the art that she made previously as superficial and since the cancer and art therapy, she finds increased importance in her imagery. Annie was employed as an art teacher. Since the engagement with art therapy, she noticed “the art came from inside. It surprised me that my [visual narrative of a translucent] body form had made people cry. I was just at five years post diagnosis when I made it.”

Gina reported “sometimes I dance with the art. It will always be a part of my life.” She continued: “During my cancer journey, I would be up until 2 am working on art because it helped me forget about what was going on.” “I wanted to clean the room where I do art, but it doesn’t work out that way. The art just keeps expanding.”

**Transformed identification.** Following cancer and participation in the creation of the visual narrative, participants reported alternate identifications as cancer survivors, persons of enhanced vision or spirituality, helpers and artists. Clara, Alana, Monica, and Jerry reported finding benefit in both reception and in offering support through cancer support groups. The identification as a cancer survivor provided a kind of membership leading to mutual support. Sophia also found identification in response to the cancer but
prefers the title champion. She explained that “the term survivor did not imply active participation” she felt necessary in the “battle with cancer.”

Gina, Annie, Brenda, and Clara all reported gaining vision or heightened spiritual awareness through the cancer journey. Annie called it a “heightened appreciation since the cancer.” Clara credited the art therapy with her “expanded vision” and tendency to “notice the little things.” She continued “in some ways the cancer thing has opened up different avenues.”

Kurt, Darla, and Ellie have all found an internal drive to give back. Kurt founded an agency designed to support veterans who have been diagnosed with cancer. Darla spent hours weekly in oncology patient rooms as a companion through treatment. Ellie, after finding healing in the art making process has pursued a career in art therapy.

Nine participants continued in art making and identified as artists since cancer and art therapy. Gina and Annie have moved beyond art therapy and sell their work in art fairs. Both reported changes in creativity since diagnosis. Annie noted that her artwork pre-cancer lacked “soul.” Clara’s development as an artist was seen in the development of confident brush strokes as she learned to paint for her visual narrative. Margie, Vera and Eileen continued to participate through an art therapy open studio. Eileen shared that the visual narrative work (figure 11) was her “longest ongoing project.” At first she felt overwhelmed. After completion, she expressed joy in the articulation of detail and points to the giraffe that she calls “so perfect.”
Summary

The themes presented in this chapter correspond to chronological and emotional stages in oncology care and art therapy treatment (Miller et al., 2008). They provide qualitative evidence of the progression and changes available through participation in art therapy during and after treatment for cancer. Instilling hope provided strength, encouragement and trust in making it through treatment and corresponding emotional responses. Relaxation and re-focus provided time and consciousness to the transition back to normal life. Through the transition from medical treatment, resilience was discovered in self-learning that helped participants to make association and accommodations that led to increased self-knowledge and added meaning to experience. Overall, participants were able to recognize creative efforts and areas of transformation that occurred through the trajectory of cancer.

Many who have experienced cancer have demonstrated growth in light of the experience (Andrykowski et al., 2008). It is believed that participation in the art therapy
process aids patients in re-acclimating to a post-cancer life accentuated by growth and insight due to the work with art therapy imagery.
Chapter 5
Discussion

The action-based methodology of this work led the researcher on a qualitative investigation through art making into the experience of cancer survivors with art therapy. The cancer survivors told their stories through the visual narrative process and those stories, along with participant interviews were synthesized by the researcher. Insights gleaned through this process began with the understanding of a subjective and time sensitive nature regarding the cancer experience. The subjective experience of the cancer trajectory and attributes of art therapy participation by cancer survivors were explored through the visual narratives.

Correlations were found between this research and existing research into the cancer patient’s subjective experience. Participants in this study followed phases of treatment and beyond that were similar to Miller et al.’s (2008) stages of survivorship. Kurt, Vera, and Eileen were at some points during the study in the acute stage of survivorship. Clara and Margie were categorized as in the transitional stage of survivorship, Vera when not in an acute stage was considered in extended survivorship. The remainder of participants would be considered in the permanent survivorship stage.

The experiences described by participants are in line with the findings that the initial shock of diagnosis is often coupled with higher levels of anxiety and depression years into survivorship (Andrykowski et al., 2008; Clemmons et al., 2008; Reb, 2007). Seven of the 15 participants in this study were diagnosed with depression following cancer diagnosis. This supports Bush’s (2009) findings on increased incidences of depression diagnosis resulting from cancer diagnosis. Participants also demonstrated through the art
process and interviews progression through the shock into what is described by Reb (2007) as aftershock and into rebuilding.

Andrykowski et al.’s (2008) projected state paths were also apparent in the research. Some participants lost the ability to work and maintain normal functioning, others returned to a lifestyle impacted by the cancer, but still productive. Others returned to normal functioning. The final state path, growth in light of the cancer was not limited or hierarchical in this research study. Participants who lost functioning to either level were still able to experience growth in light of the experience. Alana, Annie, Gina, and Kurt, experienced growth in the light of cancer even though they would have been considered at the lower state path returning to a lifestyle impacted by the cancer.

The lack of rural resource availability was apparent in statements by Alana, Monica, and Clara. Each of the three resided in less populated areas and each of the three reported not finding adequate support services until coming into art therapy. In accord with Bettencourt et al.’s (2007) findings, the three reported high levels of distress and low access to support services. Girgis et al. (2009) reported distance connection with media diverted some of the reported distress, however, none of the three rural participants in this study reported access to electronic means of resources aside from television commercials.

**Functions of Art and Art Therapy**

The results of this study aligned with the work of Reynolds and Prior (2006) who found that the patient who took personal account of identities pre and post cancer were able to construct meaningful experiences. The art therapy process used in this process of creating the visual narrative helped Clara find a new way of looking at the world. It
brought new energy and commitment to making the world a better place for Vera, Annie and Monica. The visual narrative also helped to build artist identities for Gina and Alana.

Elements of the interviews with participants who had participated in art therapy as part of their treatment during the acute and transitional stages revealed support for research done previously that indicated reduced symptoms including reduced anxiety and depression (Bar-Sela et al., 2007; Thyme et al., 2009). The interviews also revealed a tendency for art therapy to help with quality of life and self-esteem that aligned with the findings of Monti et al., (2006), Svensk et al., (2009), and Visser and Op’t Hoog, (2008).

Findings of this study demonstrate difference from the results of Rockwood-Lane (2005). Rockwood-Lane investigated hospitalized patients’ artwork and discovered themes of spiritual growth, body energy, shifting awareness and “passing through a veil” (p. 288). The artwork created in this study revealed themes in accord with cancer and cancer care. The art therapy based themes included instilling hope and recognizing strength, relaxation and re-focus, defining survivorship and re-establishing resilience, and building a creative identity and reimagining the self. This differences may be due to timing and the cancer trajectory of which the participant. Participants of this study were able to look at the cancer experience in retrospect and through art therapy while participants in Rockford-Lane’s study were in the acute stage cancer and going through treatment. Participants in Rockford-Lane’s study did not receive art therapy; they were patients who made artwork on the unit.

The functions of art therapy illuminated by this study are in accord with the benefits of art therapy found by Predeger (1996). Participants were found to have increased creativity in the development of artist identity. The introspective benefits were
also demonstrated in recollection and the identifications of metaphors. The actualization of expression was seen throughout the visual narrative process.

Collie et al.’s 2006 study was the closest related to this research. Participants in both approached cancer recollection post treatment. The difference in the study was that participants in this study were asked to participate in art therapy sessions and create artwork in the form of visual narratives. Participant reflections of the art therapy process reflect the reports of Collie et al.’s results. Participants in this study referred to the supportive nature of the art therapy sessions, while Collie et al. reported participants found a “safe harbor” (p. 765). Reflection on the art therapy and visual narrative process demonstrated validation of participant’s value and identity. Collie et al. found that art therapy helped to reduce the threat of annihilation of the self and affirm and appreciate present existence.

**New Insights**

Unlike the studies mentioned previously, this study revealed chronological stages or interventional approaches that may be correlated with chronology of diagnosis, treatment, and survivorship. This study found that the functionality of art therapy varies over the developmental course of oncology survivorship.

Through the structure of the eight articulated themes, correlations between stages of cancer survivorship and art therapy participation were seen. The cancer experience has been seen to start with reactions of shock to diagnosis and chaotic feelings (Andrykowski et al., 2008; Miller et al., 2008). The initial art therapy intervention found helpful in the acute stage of survivorship was most likely in building hope and strength.
During the time when patients were actively engaged in treatment, interventions designed toward relaxation and re-focus were seen as able to settle feelings of anxiety and sadness. Art therapy and other experiences that helped patients to rest, quite excited thoughts, relieve pain and anxiety, and enhance communication with healthcare providers and caregivers were seen to help surmount the trajectory of treatment.

The next theme in the chronological order was seen as a support to the transition of the cancer survivor out of medical treatment and into re-acclimation to life. This stage focused on self-learning and building resilience for the continued struggles of cancer survivorship. The visual narrative facilitator worked with the participant to allow the visual narratives to help define or re-define the patient experience. Participants entered this space at a rate of their own comfort and readiness. The introspective, self-learning elements of this work demonstrated an access to see the self as a creative being.

The final theme of art therapy that corresponded to extended survivorship (Miller et al., 2008) was building a creative identity and transformation. In light of the previously mentioned experiences, cancer survivors chose to take control over their own reality and life experience and re-write their narrative. The opportunity exists here to empower and re-author the metaphoric domains from which life is experienced.

Limitations

Participants in this research were from a relatively small area in the Midwest. Cancer care varies geographically so the perspective is centralized to the area. Only 15 participants were included making generalization impossible. There was also wide variety in diagnosis, age, number of years since diagnosis, stages of survivorship and gender. Results from future studies focused in these areas of demographics may yield
more focused results. This research also had only one non-Caucasian participant. Needs for the cancer patient and/or survivor may vary according to age, gender, race or geographic location.

There was also a wide variance of materials chosen for visual narrative creation and in selection of format for visual narrative creation. Participants chose the format in which to create the visual narratives. Formats available were open studio, small closed group or one-to-one sessions. Some participants selected one of these formats and others participated in both one to one and open studio. It could be that some art therapy venues, individual, small group or open studio might be more suited for particular patients or survivors.

The researcher is employed in cancer care and often is relied upon to speak in support of art therapy services in medical settings. These talks are prepared specifically in support of building art therapy programming within medical systems. Both the preparation and presentation of this material may have built a biased vision of art therapy in cancer care and reduced the ability to see limitations. This pattern may demonstrate bias on the part of the researcher.

**Implications**

Through the experience of this research and interaction within the dynamics of the medical system, insights have accumulated. The value of art therapy in oncology is still relatively unknown. Outreach to explain the function of art therapy in the medical system needs to take place in order to have the art therapy become an integral part of the treatment team. These insights have led to an articulated explanation of art therapy within
the medical system particularly in the area of cancer care. The language used should be understandable to medical staff and to patients.

The four-stage chronology begins with the use of art therapy and imagery to build hope and strength in the newly diagnosed patient. The imagery operates in a primary process and targets the shock and trauma experience of diagnosis. The second stage of art therapy centers on relaxation and re-focus or interactive distraction. Art processes that include sensory elements and repetition draw energy away from worry, sadness, and boredom. This stage of art therapy intervention is particularly helpful for hospitalized patients or those spending long periods of time in infusion clinics.

The third stage works toward creating a definition of the self as cancer survivor; it builds resilience and helps patients transition back to life after cancer treatment. The final stage provides transformation and creative identification in order to help survivors re-create favorable lives.

The ability to articulate the functions of art therapy in oncology care clearly in language that is understandable by both medical professionals and patients will help to open doors of medical facilities to art therapy services. This four-stage explanation simplifies the art therapy language so that it translates more readily outside of the art therapy profession.

**Recommendations**

Research in art therapy is limited in breadth and depth (Stuckey and Nobel, 2010). This researcher has been unable to uncover a viable explanation of the functions of art therapy in cancer care through the presented research. There has been research that explains benefits and research that has demonstrated positive effects of participation. The
establishment of an understanding regarding the healing properties of art therapy will provide a frame within which future research can develop. This was a qualitative study and is not generalizable, but the developmental aspects found through this study are able be used as an initial understanding that needs to be further researched. As a constructivist thinker, the researcher recognizes that the establishment of a framework such as this is only one of many possible explanations.

As an outcome of this study, a distress inventory has been created and is being tested at the medical center where the researcher is employed. The instrument asks for patient report regarding the chronological level of art therapy based upon the findings of this study. It also asks for basic demographic information and pre- and post-distress measures. Early tests of this instrument have shown a 3.8-point reduction in distress on a ten-point scale. Further testing will take place investigating participation venues and preferred media cross-referenced with demographics.

The creation of studies that reflect and illuminate these functions of art therapy will provide the beginning of an evidence base. Art therapy found in the work of this document did not focus on specific art therapy protocols or art therapy assessment. However, within the work lies language that may help to articulate and incorporate future research into evidenced based practices.
APPENDIX A

SHARE YOUR CANCER STORY
Share your cancer story

Through the Expressive Arts for Healing Program

Invitation for Participants

The Wisconsin Arts Board has awarded a grant to provide cancer patients and survivors the resources to visually tell their story through art.

All current and former cancer patients are invited to share their experience and survivorship stories through art.

- Patients come into the Expressive Arts for Healing Program with varied experience.
  - Some already have developed strength in the artistic voice.
  - Others have no experience, but all have a personal journey to explore.
  - You do not need to have an artistic background or experience to participate.

- With the artists’ permission, the visual stories will be displayed as a rotating exhibit throughout Aurora Health Care, sharing hope and encouragement to other patients and caregivers in a variety of oncology settings.
- Participating patients are not required to display their creations in the exhibit.
- Those who choose to display their artwork are helping others by building a community of hope, support and strength.

For more information on how to participate in the Expressive Arts for Healing Program, please contact:

**Jill Wargolet at the Cancer Counseling Center, 414-649-6018.**
APPENDIX B

VISUAL NARRATIVES
Figure 22. Untitled. Acrylic 18” x 24”. Vera.

Figure 23. Untitled. Acrylic 18” x 24”. Vera.
Vera’s artist statement

I saw this picture in a National Geographic and it really touched me. A woman was carrying a cross which I feel is symbolic of all the women in the world. Many women suffer for love and freedom. Sometimes, they are not free culturally, religiously, or traditionally. Women carry the cross internally and externally. People forget about half the women in the world. Women always sacrifice for their family and their children. The picture illustrates the journey a woman takes from birth to death. Who is going to save the world? Man is against man and it is inhumane. Amen. This journey can relate to any illness. You never know when it is your time. You must always be ready for peace and whatever comes because you do not have control over things. Amen.
Figure 25. Strikeouts, Stitches, Zippers, and SpiderWebs

Pencil and Charcoal. 18” x 24”.

Ellie’s Artist Statement

“But you were so young” … is what I am told over and over when I tell my story of falling ill, ending up in emergency surgery, and recuperating in the hospital during the summer between my Junior and Senior year of high school in May 2002. Slow growing, commonly found in 50-year old men, resistant to chemo and radiation. My 17-year old body endured, the carcinoid tumors along with the pieces of me it had claimed were removed. I healed. I moved forward. I consider myself a lucky one so far. I tattooed a zipper over my scar to remind me to find humor in my life. Today the web I have weaved repeatedly every year by going to the doctor and getting checked has continued to bring me some good luck. However, the future, as the “Magic 8” ball quotes, is unclear. So I continue to make art not only about my caner, but about life as well. Strikeouts can either take you out of the game, or win the World Series. Stitches either tear over time or hold us together. Spider webs can get crushed by birds, but the silk of a spider is one of the strongest natural materials found on Earth, even stronger than steel. I have learned that life consists of making what we can out of it; not feeling it or ignoring it doesn’t make it go away.
Brenda

Figure 26. Ugly and Beautiful. Magazine Collage. 32” x 20”.

Brenda’s Artist Statement

My life has been highs and lows with many challenges and changes. Looking back, I realize now how much control I really had when at the time, I thought I had none. Cancer was a different story. I was not in charge… I couldn’t go back and do or say something that would make it change. But I had two things going for me: I was blessed to have zero stage cancer and I have been through much worse in my life! So I had two options: be positive and embrace my good luck or feel sorry for myself.

The Golden webbing is my path of life. My serenity has come from my love of animals and nature. I bought the ring after my diagnosis because it intrigued me – the large pink stone, surrounded by the smaller shimmering ones represented the cancer diagnosis and the wonderful nurses and doctors who have dedicated their lives to helping us. Ugly and beautiful – that is what cancer represents to me.
Only two colors were used, black on white. This was an exercise in self-control and discipline; an exercise to simplify how I felt. It was something I needed to do to become grounded.

In this work I see a lot of different things. Handprints, a human figure or a higher power emerging, I like the symbolism of the butterfly. The caterpillar knows its future even before it had wings. The butterfly knows its path. From this artwork I found a correlation between the butterfly and the human spirit. Humans have the instinct to survive, even when given the worst odds.

My life in a project, and experiment in art on many levels.

Namaste
Figure 28. Untitled. Shipping tape, wool and collage. 36’ x 12” x 15”.

Annie’s Artist statement

My cancer was:  
Terrifying
Faith-challenging
A crucible
Looking death in the face

My cancer is:  
A bump in the journey
Life-changing
Friend-making
Life-giving

My life is a miracle. I found myself through faith, courage tremendous support, and amazing medical treatments. I am a flying pig. Life is a death defying act.
Figure 29. Untitled. Pencil and Watercolor crayon. 18” x 24”.

Alana’s Artist Statement
I am a 58-year-old mother, grandmother, poet, artist, gold-smith, Reiki master, and “cancer survivor.”

I guess you might say I am a ‘Jill of all trades,’ I just didn’t think cancer would be one of my toughest skills to master. My cancer journey began in October ’08. I saw my doctor in October and she reminded me I was due for my yearly mammogram. I didn’t have any reason (I felt) to be concerned about cancer since I had the c125 cancer screening yearly. “WAS I MISTAKEN.” Of course the night before my mammogram I checked my breasts thoroughly, ‘a lump” – surely it was nothing – no breast cancer in the family – its just a fibroid – no need to worry. The diagnosis was given – cancer – with the extra foe of a braca gene mutation
= both breasts removed
= best chance
= chemo
= hysterectomy

Living alone, family in another state – was I going to survive? – or do I want to.

The dumbness of just doing wearing off.
“THE SKILL OF SURVIVAL BEGINS”
“Severe depression”
Counseling
Meds

I need more – more of a connectiveness – something tangible to help express my feelings.

ART THERAPY
I remember my first session I was angry, sad, feeling worthless.
When I was done with my piece – I felt better, somehow, putting it out there helped lessen what I felt I was carrying. WHEW!!!
Darla

*Figure 30. My Room. Three-Dimensional Collage. 18” x 18” x 24”.*

Darla’s artist statement

I was diagnosed at age 27. Since then I’ve had 25 major surgeries and am a cancer survivor. The morning of surgery I woke up around four o’clock and I didn’t see visions; I didn’t hear people, but I felt a real sense of peace go over me and it said it’s cancer but it’s going to be okay and it turned out to be cancer and it was okay. I believe I chose my own destiny and that I saved myself by the hands of the surgeon.

Back when I had my first surgery, St. Luke’s had sunrooms on patient floors where people would just go meet and comfort each other. I would go down there and get people talking. Now I volunteer to sit and talk with cancer patients. Prayers help. My faith is very deep I am always open; modern day miracles happen.

My art shows an extremely powerful angel coming down. It also remembers that somebody had brought a happy face to the hospital. The art reflects the potency of the happy face in my life ever since. To this day I carry happy face stickers to share with friends. Making this piece was fun. There was excitement about it because I knew what I wanted and had supportive help from my Husband and art therapist. It was my husband who thought of putting the shoes by the bed because the doll came with shoes. The two pictures are windows looking over the river walk downtown. I love water I could look at water all the time. Making this art brought resources to the surface.

I think it’s a wonderful idea to bring art into a hospital. It is tough though, it may be the last the last thing people are thinking of, but it does really help a lot of people.

Overall, you gotta take one day at a time

That’s my story and I’m sticking to it.
Kurt

Figure 31. This Unholy Illness. Pencil and Watercolor. 16” x 20”.

Kurt’s artist statement

This unholy illness...feeding on cells where only love is allowed. This word...brings fear and tears of what may be...of pain yet waiting to hoard my senses and of the lives that I love. They did not chooses this sorrow to be upon themselves...nor did they choose to host this sorrow. This sickness...that steals the future and replaces it with a breathless and a quiet terror...no words can appease.
Eileen

Figure 32. Untitled. Acrylic. 18” x 24”.

Eileen’s Artist Statement

When I found out I had cancer, I said to myself, “okay.” I did not have a bad time. Life deals some things that are good for you and some that are not. I am lucky.

In 1985, I found a lump and went to the doctor to have it removed. I was awake during the procedure and he said: “There is another one on your ribcage.” He decided to take it out. It was malignant. They removed the cancerous lump, my lymph nodes under my arm, and 1/3 of my breast. Then, I needed radiation for 10 weeks. All was well.

In 1989, I went to the doctor and he found precancerous cells on the scar tissue of my breast. So, I had my entire breast removed. I did not have to go through chemotherapy. The worst things were the stitches and the drainage. I go back to the doctor every year for a mammogram and a check-up.

When I had my breast removed, there was no help or therapy available. I felt isolated because I never had the chance to speak to any survivors and did not know what to expect.
Clara’s artist statement

Cancer diagnosis was a shock. Because the tumor was growing so fast, decisions on treatment needed to be made immediately. During that time learning about the triple negative breast cancer I felt overwhelmed. The presence of healthcare providers guiding my decisions was helpful and appreciated.

The buildings on the left side of this painting represent the hospitals and clinics at which I sought treatment. Through these places I always found something to strive for, a light at the end of the tunnel.

Moving forward into the blue skies I have found things to be thankful for. I have found a new realization of my path in life. My life may be different, but it is not over. I have found so many things to be thankful for and appreciate. Through this art I have gained a sense of vision and new awareness of my surroundings.

The coy pond is a tribute to the gift of serenity my friend brings to me. We are fighting cancer together.

*Figure 33. Before and After. Acrylic. 18” x 24”.*
Monica

Figures 34. Untitled. Acrylic and Mixed Media. (2) 16” x 20”.

Monica’s artist statement

When I was diagnosed, it was like my whole world ended and I didn’t know which way to go. When I was told there was no one with me and I remember I could hardly find my way home. I felt like nobody wanted me. Cause I felt broken.

I didn’t die, figure it all, God had something else for me to do.

Art therapy is healing for the first time. I think it’s the best thing that ever happened to me because I think it was acceptance. The art therapist could accept me for who I was.

What I learned from art therapy is learning to trust even to this day with all the things I went through. I think it really healed the trust and I think there are gifts. I was trusted to put whatever I could on canvas. That’s how my artwork started coming together and that’s why I keep saying we hurt but we heal.
Sophia

Figure 35. Life Gives You Lemons. Acrylic and Mixed Media. 16” x 20”.

Sophia’s artist statement

I have been dealt some very sour situations in my life. In situations where you feel you have no control, you are powerless, you realize something. The realization that I have come to is that I have power and the ability to smile with the lemons life gave me. It is all about attitude. I knew if I had a positive attitude I could overcome any trial or tribulation.
Figura 36. Sin título. Acrílico. 16” x 20”.

No hay declaración del artista.
Margie

As I lay in the hospital getting ready for my second surgery in seven months, I am overwhelmed with a state of trepidation. Knowing that my world could change from what I knew it to be. As my doctor enters the room and his calming effect on me, I know that no matter what he can handle this... Whether I can I’m not sure. He tells me he is worried and is going to rush the results. Fear replaces all thoughts. Finally my fear was confirmed you have Endometrial Cancer. I went to find out what’s next? My doctor compassionately sat with me answering every question and follow up question. Even though in my heart I already knew what I had to do, the questions were still there. Knowing I was too young to have a hysterectomy. Many factors challenged my decision. Because I knew that I had to make the judgment call that would take my choices away. I was too young to have this happen but it was my hope to STOP The Cancer - The Bleed - The Tears - The Pain Today I can say I am Stronger - I am handling it - I made it - I found myself - I AM CANCER FREE

Figure 37. Cancer Free. White Pencil on black board with Shrinki Dink. 14” x 20”.

Artist Statement Included.
Figure 38. A Thing of Beauty. Watercolor. 14” x 20”.

No artist statement.
APPENDIX C

COLLAGE SUMMARY I
Reflections on this collage summary led to recognition of a spiral pattern that emerged followed by a generalized story of the cancer experience. On the left edge of the page, a dark eye of an orange fish came to represent the early cells of cancer. Below the eye is a turkey fight that quickly represented the initial stress and struggle of diagnosis. The swift circular movement of this image led into an image of oil riggers shutting down a pipe spraying oil. The image came to represent the teamwork of medical staff and caregivers available for the cancer patient. The chaos of this two images is enhanced by the skeletal image that emerged to reiterate the death defying act of cancer survival.

Located directly beneath the oil riggers, an image of a person floating supported in the water speaks to the process of letting go and an element of faith. To the right of this image is a host of candle carriers representing prayer and hope. Above the candles are two images, to the left is a large shadow figure and to the right, an alligator peering just
above the water. The lingering threats of cancer return are undoubtedly a factor in the lives of cancer survivors. Above the shadow images, the circular movement shifts and starts to cycle clockwise instead of the counter-clockwise pattern so far. The image of a jumping deer shifts the directions suddenly not unlike a leap of faith. The image that follows appears as a storehouse of barrels and is lit by a distant yellow light that reflects the brightness of prayer candles and the fish eye surrounding the original cancer cell.

After the trajectory was realized there was seen the masked figure without a position in the story. The masked witness to this journey grew in significance as the research unfolded. The figure became the patient as witness to their own cancer journey. Filtered by the mask of experience, the cancer appears differently to each person.
APPENDIX D

COLLAGE SUMMARY II
Reflections on this as the second of two summary collages found related themes.

Notably, the mask was discovered to hold the same position. In the first summary collage, the figure is behind the mask and experienced the cancer in real time. In this one, the figure has moved to the lower right corner and reflects upon the experience of cancer in retrospect.
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