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## Lessening Psychosomatic Symptoms Using Art Therapy, Mindfulness, and Yoga: Development of a Method

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Lessening Psychosomatic Symptoms Using Art Therapy, Mindfulness, and Yoga: Development  
of a Method  
Capstone Thesis  
Lesley University

5/4/20

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Art Therapy

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### **Abstract**

Psychosomatic symptoms are often misunderstood and ignored by many individuals that see those that experience them as either hypochondriacs, or not a priority due to often being unexplained by modern medicine. Mindfulness-based practices have been one of the most common proven treatment methods in various studies to support the reduction and intensity of symptoms coming from emotional distress. Both art therapy and yoga were shown in some studies to do the same, but at a lower rate. I was drawn to exploring how to lessen psychosomatic symptoms by combining these three aspects of treatment to create a mindfulness-based art therapy and yoga group of students at a therapeutic day school in Massachusetts. Research in this area focuses on psychosomatic connection in headaches rather than a broader spectrum of symptoms, which leaves much unexplored. One of the most common factors I saw as a fault in my method, as well as various methods in the literature, was too short of a time in which the level of changes were measured. Longer-term programs, particularly in skill-based utilization in symptom management, were shown to be important. Also, understanding that a lot of this research is based on self-report, and a huge portion of those with psychosomatic symptoms have gone through trauma, trust, safety, and rapport are vital to get the most accurate responses. The method I explored was seen to lessen psychosomatic symptoms in participants.

Lessening Psychosomatic Symptoms Using Art Therapy, Mindfulness, and Yoga: Development  
of a Method

### **Introduction**

Psychosomatic symptoms and the disorders that encompass them remain a mental health and medical mystery of this world that remains highly misunderstood. “People experience pain influenced by cultural ideas of pain, gender expectations of how one must cope with pain, the quality of personal relations with family or society at large, personal coping capacity, and the presence of other stressors” (Angheluta, 2011, p. 113). There are many people, professionals included, that do not believe in these disorders. They see people wanting attention or going crazy in the midst of over worrying. Meanwhile, many people remain in a grey area of struggling to understand their own experience from psychosomatic symptoms that is judged, shut down, and let go. By bringing together art therapy, mindfulness, and gentle body movement, these individuals can find some understanding, release, and connection to themselves and others that are willing to keep an open ear and mind. This thesis inquires about the efficacy of utilizing art therapy, movement, and mindfulness to lessen psychosomatic symptoms.

The concept of connection of mind and body can be a tricky piece to the puzzle when doing work with someone experiencing psychosomatic symptoms. The manifestation of psychosomatic symptoms can come from the lack of the skills to cope with the emotions individuals feel and can end up being manifested through physical, often very painful and difficult to deal with, symptoms. Therefore, some of those with psychosomatic symptoms may struggle significantly with naming, understanding, and working through their symptoms by way of making this connection because their sense of their body is associated with negative effects to their life and pain (Greeson et al., 2018; Coholic, 2010).

Many people may attempt to try and find a medical reason for the symptoms rather than a psychological one. Therefore, being labeled a hypochondriac, misdiagnosis, and improper care often is the result that leads to no significant positive change. Due to the complexity of these situations coming down to a spectrum of beliefs, there is often a lot of steps and grey area that comes with trial and error. “Pain experiences are a response to what your brain thinks is a threat...and part of treating the pain is finding out why the brain is indicating a state of danger by maintaining a pain response” (Angheluta, 2011, p. 113).

I have fibromyalgia, which is a huge reason I am passionate about this population and realm of therapy. I have experienced both ends of this work, being the therapist and being the client. This has supported my experience and inquiries into both processing my own symptoms as well as supporting others working through their symptoms. I chose the option to create a method. I co-lead a clinical group with my supervisor at a therapeutic day school in northern Massachusetts with a small group of three to seven students, depending on attendance, for a 9-week quarter on Tuesdays and Thursdays. I will further explain this experience later in this paper.

In this paper, I discuss psychosomatic symptoms, diagnosis, options and access to treatment, alternative therapies versus medical approaches, and the use of art and movement therapies compared to talk therapy. I also look into the varying theories of origination of symptoms, such as trauma, for a more holistic perspective on psychosomatic symptoms and how to best understand and support the individuals that experience them. I expected to find that the method I used would alleviate the level of symptoms that these people experience.

### **Literature Review**

At times, artmaking has not been seen for the therapeutic value that it holds, although it has been an aspect of our lives as a way to both communicate and heal across cultures, regions, age, gender, religion, socio-economic status, and other identifiers. “People have used pictures, stories, dances, and chants as healing rituals creating a lot of philosophical and anecdotal discussion about the benefits of art and healing, but less empirical research exists in literature” (Stuckey, & Nobel, 2010, p. 255). “Art and health have been at the center of human interest from the beginning of recorded history...yet we still find ourselves struggling with the “fundamentals” of art and health and their meaning in society.” (p. 254).

Coholic’s (2011) article entitled “Exploring the Feasibility and Benefits of Arts-Based Mindfulness-Based Practices with Young People in Need: Aiming to Improve Aspects of Self-Awareness and Resilience” gives an in-depth look at the practices in mindfulness that are used in the treatment of psychosomatic symptoms. Mindfulness based stress reduction (MBSR), mindfulness based cognitive therapy (MBCT), dialectical behavioral therapy (DBT), and acceptance and commitment therapy (ACT) are among the most chosen. A running theme in mindfulness-based work is about acceptance and being present and connected. DBT uses the balance of acceptance and change. The goal of ACT is to experience and accept thoughts and feelings in the present moment. Coholic lists ways in which these practices have been used with the population I work with, such as, school-based programs to reduce stress, nursing programs to help children deal with pain, and adolescent groups to support the search for self-awareness and life purpose and meaning (Coholic, 2011, p. 305).

## Measuring Somatic Symptoms

A variety of methods, some of which are outlined in the following, have been used in the measurement and data collection of psychosomatic symptoms for both before and after treatment and how mindfulness, art-therapy, and the use of yoga can be incorporated into the attempt to lessen the amount and severity of the symptoms that occur. Individuals that suffer from psychosomatic symptoms, at times, attempt to take control of their symptoms by withdrawing from their bodies (Kalisvaart, Van Busschbach, Van Broeckhuysen-Kloth, & Greenen, 2018, p. 46). Due to this, as well as other factors, these difficult cases create a situation where questionnaires of self-reporting may not be a sufficient way to measure the full range of experience within the body (p. 47) This is when incorporating the implicit side of the brain comes in to play. Kalisvaart, Van Busschbach, Van Broeckhuysen-Kloth, and Greenen suggest the use of non-verbal tools, such as physical tests, behavioral observations, or artistic expressions (p. 47).

Greeson et al.'s (2018) study uses multiple measurement tools, including surveys and inventories of symptoms, among others. The Cohen-Hoberman Inventory of Physical Symptoms (CHIPS) is a list of 33 common physical symptoms which includes many physical symptoms that are often viewed as psychosomatic (p. 4). The Ruminative Responses Scale (RRS) is a 22-item scale from the Response Styles Questionnaire that uses a 4-point scale to assess "ruminative coping responses to depressed mood" (p. 4). The White Bear Suppression Inventory (WBSI) is a 15-item questionnaire designed to measure thought suppression. Two subscales are generated: unwanted intrusive thoughts (UIT) and thought suppression (TS) (p. 4). The Acceptance and Action Questionnaire (AAQ-9) measures "experiential avoidance, which indicates the tendency to avoid or alter negative thoughts, feelings, and physiological sensations" (p. 4). The Emotion

Regulation Questionnaire (ERQ) is a 10-item questionnaire that is designed to assess individual differences in the habitual use of two emotion regulation strategies: cognitive reappraisal of stress and negative emotions and expressive suppression (p. 4). This study found that “bivariate correlations showed a significant, direct association between increased mindfulness and decreased stress-related physical symptoms” (p. 5) and “increased mindfulness was directly correlated with improvement in perseverative cognition and emotion regulation” (p. 5).

Broadbent, Niederhoffer Hague, Corter, and Reynolds (2009) found through an analysis of themes in drawings done previously with children, “actions and instruments causing pain, personification of pain, physiological representation of the pain, perceptual disturbance associated with pain, abstract representation of pain, and location of pain” (p. 466). The authors then conducted a cross-sectional study where participants were given a questionnaire that included the Brief Illness Perception Questionnaire (Brief IPQ). This is a “nine item scale assessing the patient’s view of the timeline of their pain, the consequences, causes, symptoms, personal control, helpfulness of treatment, concern, emotional reactions, and an understanding of their headaches” (p. 466).

The effects of a study done with a one-hour art therapy session was measured by the Edmonton Symptom Assessment Scale and the Spielberger State-Trait Anxiety Index (Stuckey & Nobel, 2010). The participants showed comfortability with the art therapy process presented to them and the desire to continue the process (p. 258).

Coholic (2011) discusses various perspectives of mindfulness and how it is incorporated into therapeutic methods and perspectives in treatment with seventeen different groups. They then look at the findings of levels of different behaviors of the participants. The most prevalent behavior listed was “lacks self-confidence and self-esteem” (p. 307). Interestingly, the design

interviewed each of the participants separately after the group experience in order to accurately gather information about how participants' experiences were in the group. Usually, most group work is done fully in the group, including asking a question about how the experience was for people, so doing it this way takes away the filter participants may have in their responses due to worry of social pressures to answer a certain way.

“Illness-related research of body drawings can be evaluated through objective, quantitative scoring” (Kalisvaart, Van Busschbach, Van Broeckhuysen-Kloth, Greenen, 2018, p. 47). The Dresden Body Image Questionnaire (DBIQ-35) is a 35-item questionnaire with both positively and negatively worded items, and contains the following five subscales: body acceptance, vitality, physical contact, sexual fulfillment, and self-aggrandizement (p. 46). Higher scores equate to a more positive body image, whereas lower scores affiliate with a negative body experience.

Shella's (2018) article “Art Therapy Improves Mood and Reduces Pain and Anxiety When Offered at Bedside During Acute Hospital Treatment” looks at measuring the differences in mood, pain, and anxiety experienced by participants in acute hospital treatment for pain-based diagnosis. Roger's Happy Sad Face Scale was used to assess the levels of anxiety, mood, and pain both before and after engaging in a 50-minute art therapy session. The author states that there was “significant improvement across all ages, gender, and diagnosis” (p. 59). Yet, the discussed study has 166/195 female participants, therefore, there is a problem with this generalized statement of results. The scale used was originally made for children, but the author says that it has been proven to work with adults as well (p. 160). Even though this may be true, I wonder how many participants possibly felt that this was a childish way of reporting their experience of their symptoms. There also is nowhere in the article that discusses what pain is

being accessed when the participants scale their level of pain. This is quite a generalized concept, especially to those that have chronic pain. The way in which the art therapist decided to use various art mediums that range on the expressive therapies continuum can be helpful in including people with varying interests.

The University of Florida arts in medicine program conducted studies with patients on long term dialysis (Stucky & Nobel, 2010, p. 258). They were given the Medical Outcomes Study 36-Item Short Form Health Survey (SF-36) and the Beck Anxiety Inventory (p. 258). The participants were shown to have significant improvements in their symptoms that were listed in the SF-36, including a reduction in depressive symptoms and an improved level of social functioning. They also reported to have less pain in their body (p. 258). Walsh et al. (as cited in Stucky & Nobel, 2010) did an experimental study giving art therapy interventions to family caregivers at bedside in hospitals. The participants took the Mini-Profile of Mood States (Mini-POMS), the Beck Anxiety Inventory, and the Derogatis Affects Balance Scale. These measurements showed the result of decreased anxiety and stress as well as an increase in positive communication (p. 258).

### **Treatment of Somatic Symptoms**

Most of the literature that looked at the incorporation of an art therapy method discussed the art created by participants. For example, the children's headache drawings in Broadbent et al.'s (2009) article showed differences in types of headaches in which "children with migraines had sharp objects, those with tension headaches had compression, and those with somatoform disorders included whirls in the head" (p. 466).

Kalisvaart, Van Busschbach, Van Broeckhuysen-Kloth, Greenen (2018) found that "clinical severity, illness perception, and distress have been associated with size and details of

drawings” (p. 47). In their study, five art therapists decided which aspects of the body were significant in the assessment of somatoform disorder. Signs of disconnection or dissociation from the body consisted of “interrupted lines, incorrect proportions and disconnected or missing body parts” (p. 48). A preoccupation with a particular part of the body was considered when they were “accentuated and magnified” (p. 48). “Disconnection from other people” (p. 48) was counted when there was an “omission of senses or hiding body parts” (p. 48). When there was an “omission of gender features” (p. 48), this was seen as a potential for the presence of discomfort with these characteristics. An indicator of the level of safety perceived was assessed by “the content of surroundings” (p. 48) in the image. The position on the sheet of paper was aligned with the importance given to a particular time in the individual’s life experience: if the image was placed to the left, this symbolized the past, a centered image representing the present, and the right of the page representing the future. Body size was “an indicator of pain and/or discomfort”; “the more paper used reflected less suffering” (p. 48).

In Scott-Hoy’s (2009) article “Pain is Red, Hope is Yellow: An Autoethnographic Story of Living With Chronic Pain in Two Voices”, shows the perspective written in the participant’s words where they spoke about their experience with their psychosomatic symptoms. “As I continue to contemplate the painting, I find myself wanting to know more about what it is like to live in a body, especially a body that is demanding attention, that constantly needs placating, medicating, and negotiating because of pain” (p. 36). He states that “pain is like a drum. A drum whose rhythm is outside the ‘natural’ rhythm of your life; a rhythm that does not slow when tired, does not accelerate when excited, but relentlessly drives on” (p. 36).

“Mindfulness was developed as a holistic teaching whose purpose was to relieve human suffering, to increase compassion and loving-kindness among its practitioners, and to help

individuals attain the peace of enlightenment” (Coholic, 2011, p. 303). Mindfulness “encourages awareness to emerge through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Coholic, 2011, p. 303).

“There is evidence that engagement with artistic activities can enhance one’s moods, emotions, and other psychological states as well as have a salient impact on important physiological parameters” (Stuckey & Nobel, 2010, p. 254). In the article “The Connection Between Art, Healing, and Public Health: A Review of Current Literature”, Stuckey and Nobel (2010) state the following,

Engagement with creative activities has the potential to contribute toward reducing stress and depression and can serve as a vehicle for alleviating the burden of chronic disease.

Over the past decade, health psychologists have cautiously begun looking at how the arts might be used in a variety of ways to heal emotional injuries, increase understanding of oneself and others, develop a capacity for self-reflection, reduce symptoms, and alter behaviors and thinking patterns (p. 254).

Stuckey and Nobel (2010) excluded evaluation of relationship of creative expression with the following areas: major mental disorders such as schizophrenia or dementia, severe developmental disorders, end-of-life issues, incarcerated populations, or the impact of religion on health outcomes (p. 255). Using different art mediums “helped in 4 major ways: a focus on positive life experiences and relieving preoccupation with cancer, enhanced self-worth and identity,...-it enabled them to maintain a social identity outside of cancer,...[-and] it allowed them to express their feelings in a symbolic manner” (p. 257).

“Art therapy has been shown to help unaddressed psychosocial in hospitalized patients and to promote better management of physical symptoms, overall well-being, and socialization”

(Shella, 2018, p. 59). Stucky. and Nobel (2010) looked at the benefit of expressive arts therapy use in hospital settings. The first was the conduction of a study done at the Chelsea and Westminster Hospital in various units of the hospital comparing using art interventions. The groups that received the art-based interventions had “improved clinical outcomes, including better vital signs, diminished cortisol related to stress, and less medication needed to induce sleep” (p. 257). Another study showed that use of art and music reduced hospital stays. There was a decreased need for pain medication seen in surgery and critical care patients that had either participated in guided imagery or had an image of a landscape on their wall (p. 257).

A study by Garland et al. (as cited in Stuckey & Nobel, 2010) combined visual, music, movement, and expressive writing that examined the positive outcomes of psychosocial interventions for two groups of cancer patients. The interventions included mindfulness and healing arts, with respect to post traumatic growth, spiritual well-being, stress, and mood. Both groups’ participants improved significantly over time in terms of overall posttraumatic growth, but participants in the mindfulness therapy group showed improvement on measures of anxiety, anger, overall stress symptoms, mood disturbance, and spirituality (pp. 260-261).

A quantitative trial of mindfulness art therapy that was targeted toward women with cancer concluded that those who engaged in art making were seen to have a statistically significant decrease of both emotional stress as well as physical symptoms (p. 257). This study involved the women creating pictures of themselves, engaging in yoga and meditation, and being introduced to self-care through guided imagery (p. 257). Another study looked at the efficacy of art therapy interventions in order to increase the level of emotional expression, spirituality, and psychological well-being in those that had received a breast cancer diagnosis (p. 257). Picard

conducted a study that showed “creative movement was shown to support self-awareness” (p. 258).

### **Elements Guiding My Method**

**Trauma.** The presence of a trauma history came up in much of the literature about those that experience psychosomatic symptoms. Rubin (2005) states that

various studies document physiologic changes in the brains of those with a history of abuse and in those with a fibromyalgia diagnosis. These studies suggest that abuse may physiologically and developmentally increase a person's susceptibility to pain and that some organic changes may be associated with psychogenic disease. (p. 1099)

Rubin then discusses some of these studies that support my inclinations that trauma may, in fact, be the source of many of the psychosomatic symptoms that people experience. This is particularly due to the amount of participants in the study being a high number, in various settings, and with multiple populations, which allows for the ability of the results of the studies to be applicable to a wider range of people.

Rubin (2005) found that “a history of abuse has been identified in more than 40% of women and 20% of men with chronic pain, which is 2-4 times the amount of the general population” (p. 1099). Another study that Rubin examined found that

91 outpatients with chronic pain showed the following rates of abuse: 64.7% of those with a fibromyalgia diagnosis, 61.9% with myofascial pain, 50.0% with facial pain, and 48.3% with other pain disorders...sexual and physical abuses during childhood have also been linked to other conflicting and complex disorders such as chronic pelvic pain and chemical intolerance. (p. 1101)

As far as the specific psychosomatic symptoms themselves, Rubin (2005) also discusses a large scale study with 5,877 college students that found a correlation “between abuse and pain symptoms” (p. 1101) where females sexually abused during childhood had the following diagnoses: “somatization and dissociation, substance abuse, psychogenic seizures, chronic fatigue, posttraumatic stress disorder, bladder dysfunction, headaches, asthma, diabetes, heart disease, and depression” (p. 1101). This was the primary source that encompassed a range of symptoms other than headaches and migraines that were the focal symptom in most of the research I came across about psychosomatics.

Rubin (2005) then takes the research to the next step in looking at the treatment of the individuals who struggle with psychosomatic symptoms. He found that “individuals who have written about their own traumatic experiences exhibit statistically significant improvements in various measures of physical health, reductions in visits to physicians, and better immune system functioning” (Stuckey & Nobel, 2010, p. 259) as well as control over a depressive mood and pain severity. Pennebaker, who often writes on the topic of expressive writing, points to there being no known reason for the results seen, but that it is most likely attributed to cognitive, emotional, social, and biological levels of the brain all being accessed in the process (p. 259). These results have been shown to hold true across diverse samples, including, but not limited to, age and culture (p. 259). Graham et al. conducted an anger-expression group with 102 chronic pain resulting in a higher level of control over and severity of pain as well as a decrease in depression (p. 259).

**Mindfulness and thoughts.** Coholic (2010) points out various examples of how researchers talk about mindfulness and it’s uses, looking at how different people conceptualize its purpose and ways in which to incorporate it. “There is increased evidence that mindfulness-

based cognitive-behavioral interventions effective with problems such as anxiety, chronic pain, grief, mood disturbance, and stress” (p. 304). With that said, some of these researchers make the point to remind ourselves that mindfulness is not to be used to “simply seized upon as the next promising cognitive behavioral technique...decontextualized, and plugged into a behaviorist paradigm with the aim of driving desirable change” (p. 304), but that it is rooted in a holistic manner. By this point, when contemplating whether or not to incorporate mindfulness practices into a therapeutic context, it must encompass more than just the simplicity and surface level that it is often used at to support genuine healing.

“The BodyMind Approach (TBMA) inter-relationship between physical and mental health for the treatment of patients with persistent medically unexplained symptoms (MUS), which started at the University of Hertfordshire” (Payne, 2015, p 19), is a “mindful, kinetic practice that integrates mental and physical health in people with medically unexplained symptoms (MUS)” (p. 20). TBMA uses research from both attachment theory and neuroscience (p.20). The elements of neuroscience are particularly vital to strengthen the ability of those that need to see scientific proof to believe in a given way of healing. Attachment Theory, although coming from a psychology lineage, has been extensively studied over time prove significance in one common understanding of the human experience.

Payne (2015) discusses a process called assisted meditation, which is where the patient enters a process of becoming engaged in a state of inner mindfulness as she or he moves in the presence of a witness/facilitator. The patient directs attention to embodied, inner experiences of self, actively reflecting and commenting on bodily sensations as they are raised into awareness. Patients showed “improved wellbeing and activity levels as well as and heightened ability to self-manage their symptoms, and a decrease in stress, anxiety, and depression levels” (p. 20).

Much of the psychosomatic research that mentions particular symptoms focuses on headaches. Broadbent et al. (2009) states that “the most common attribute for chronic daily headaches are psychological, such as stress or being overworked” (p. 466). They then point to the strength of our thoughts in stating that “headache patients who believe that their condition will last a long time and that it has a severe personal consequence are more likely to be depressed” (p. 466). In other research, it is then named that “evidence-based complementary and alternative medicine (CAM) are needed to reduce the burden of stress on health. Mind-body medicine interventions, such as meditation and yoga, represent a participatory medicine approach that integrates behavioral, self-care practices with ongoing conventional care” (Greeson et al., 2018, p. 2).

Greeson et al. (2018) discuss various ways in which our thought processes and patterns can be extremely harmful if not noticed, interfered with, and then remolded into healthier patterns; these include over engagement “with negative emotions and intrusive thoughts,” and under engagement “with unpleasant thoughts, emotions, or physical sensations by engaging in avoidance or suppression” (p. 2). Greeson et al. further state that cognitive perseveration takes multiple forms, including worry, rumination, catastrophizing, or repetitive, negative, self-focused thoughts, whether it be conscious or unconscious (p. 2) and is linked to ongoing emotional reactions that progress to stress-related chronic disease” (p. 2). Greeson et al. also discuss “Transdiagnostic” (p. 2) processes, which refer to pathological forms of perseverative cognition and maladaptive emotion regulation. Mindfulness meditation has been

proposed as a “trans therapeutic” approach to transdiagnostic mental processes. Together, the theories of perseverative cognition and mindful emotion regulation provide a

conceptual framework for how to understand the clinical outcomes of MBSR, as well as the processes underlying therapeutic change. (p. 2)

By far, the most common psychosomatic symptom mentioned in the research was headaches and migraine. “Pain was reported as more frequent and intense among headache sufferers with higher psychological-distress scores” (Vick & Sexton-Radek, 2009, p. 116). Those that had a fear of pain and a tendency to avoid activities associated with pain had a higher predisposition “to a cycle of disability” (p. 116). There was a rise in the “use of alternative and complementary therapeutic approaches” to address “pain management with biofeedback, imagery, EMDR, relaxation, meditation, and hypnosis” (p. 116).

Vick and Sexton-Radek’s (2009) article “Art and Migraine: Researching the Relationship Between Artmaking and Pain Experience” examines data that was taken from surveys given to those that entered a “migraine art” competition. The “Migraine Art” competition and correlating research was done that was composed of 562 works of art visually expressing the experience of suffering from migraines. “Suggested presence of visual loss, distortions, other illusory phenomena, out-of-body experiences, visual splitting, disturbances in body schema, mosaic vision, corona phenomenon, and split body image” (p. 117) were themes that were seen in these competitions. Although there is a question of ethical integrity of placing these pieces of art in a competition, the focus of incorporating this journal into my thesis would be to focus on the relationship of causal, effect, and change of the migraine pain experienced by the participants after making artwork to process it. The author brings up a particularly important part to this work when thinking about the type of materials used when working with those that suffer from migraines, as many art materials produce fumes that worsen migraines.

**Psychosomatic pain versus medically explained pain.** The World Health Organization (WHO) 1946 preamble, defines health as “a state of complete physical, mental, and social well-being rather than merely the absence of disease or infirmity” (Stuckey & Nobel, 2010, p. 254). “In the U.S.A...16% of the presenting symptoms had organic cause, 10% had a cause related to psychological variables, which leaves three out of four complaints medically unexplained” (Payne, 2015, p. 19). In outpatient clinics “52% of physical symptoms were medically unexplained” (p. 19).

Medically unexplained symptoms (MUS) include a broad spectrum of presentations where there is difficulty in finding a pathology to symptoms (Payne, 2015, p. 19).

Somatoform disorder, the precursor to the diagnostic category of somatic symptom and related disorders in DSM 5, consists of physical symptoms that suggest a medical condition, yet not explained by this condition or by the direct effects of a substance or other mental disorder. (Kalisvaart, et al., 2018, p. 46)

MUS account for up to one in five of all general practitioner consultations, 30% of which had an associated psychiatric disorder (Hills, Lees, Freshwater & Cahill, 2018, p. 135). “Controversy and confusion surround terms such as ‘psychosomatic’ and ‘psychogenic’, with existing evidence suggesting that these terms still imply that symptoms are ‘all in the mind’ and thus that ‘there’s nothing wrong with you’” (p. 135).

Rubin (2005) divides pain into four diagnostic categories:

1) pain with anatomic features and objective findings, 2) pain with anatomic features and without objective findings 3) pain with nonanatomic features associated with stress and somatization and 4) pain with nonanatomic features associated with perceived physical injury and symptom magnification. (p. 1100)

Rubin explains the differences of each category in the following manner,

The first type is supported by the physical examination and test results. Some examples include lumbosacral radiculopathy, carpal tunnel syndrome, and shingles diagnosed with characteristic skin lesions. The second type of diagnosis is made primarily through clinical impression, rather than test results. Some examples include classic migraines, trigeminal neuralgia, and shingles when diagnosed without skin lesions. The third diagnostic category is suggested by a constellation of symptoms, psychosocial history, limited or absent objective abnormalities, inconsistent details obtained during the history and/or examination, or bizarre findings on physical examination. The symptoms present are primarily "subconscious" or unintentional. These include a variety of musculoskeletal disorders such as fibromyalgia syndrome, tension headaches, chronic neck or back pain, or conversion disorder. Lastly, the fourth diagnostic category are those diagnosis that have perceived physical injury and symptom magnification, often involving secondary gain. These types of pain symptoms are often numerous, inconsistent, contrary to normal physiologic principles, and/or disproportionate to the objective findings (p. 1100).

The symptoms that related to stress, such as chronic musculoskeletal pain, sleep problems, lethargy and fatigue, depression, anxiety, headache, gastrointestinal complaints, and cardiovascular symptoms, account for the majority of doctor visits (Greeson et al., 2018, p. 2).

Kalisvaart et al. (2018) did their study in tertiary mental health center specializing in psychosomatic medicine. Half of the participants, which consisted of 75% female, had a comorbid diagnosis of a mood disorder, anxiety, or personality disorder (p. 46). A multidisciplinary approach of body-related mentalization, acceptance and commitment therapy, cognitive-behavioral modulation, and the dynamic family environment therapy was used (p. 47).

These participants then received diagnosis of the following: undifferentiated somatoform disorder (33%), conversion disorder (19%), pain disorder (11%), other primary diagnosis (17%), unknown (21%) (p. 47). Rubin (2005) points to the connection with psychosomatic symptoms and trauma when he says that “these symptoms and behaviors that are dysfunctional may arise as these patients seek attention and validation while repressing painful memories of trauma” (p. 1099). “Even when chronic pain is associated with significant psychopathology, improved treatment outcomes may be achieved by accepting the patient's symptoms as real and by providing empathy, validation, and multidisciplinary therapies” (p. 1099).

### **Methods**

The method I created was to explore how to lessen psychosomatic symptoms by combining the three aspects of art therapy, mindfulness, and gentle movement in treatment. I did this by implementing a mindfulness-based art therapy and yoga group.

### **Population**

Members of the group consisted of seven students at a therapeutic day school, five females and two males, aged 13 to 18. Each student exhibited psychosomatic symptoms regularly to varying degrees and had an interest in art therapy and/or yoga. Both cofacilitators picked the students based on these criteria. The psychosomatic symptoms that these students mostly exhibited were headaches, stomachaches and nausea, fatigue, heart palpitations, and sweating. All of the students have at least one mental health diagnosis. Some of them have diagnoses that identify the presence of their psychosomatic symptoms, and others just have the symptoms as secondary to their mental health diagnosis. The most common psychological diagnostic presence was anxiety and depression.

The cofacilitators also tried to think about group dynamics when choosing group members, as this topic can be extremely vulnerable for some people. The present group dynamics changed to an extent from session to session, as every student was not present for every session due to absenteeism or by choice to skip clinical group, which is when the sessions were held. All students were able to understand that there is a connection between their mental health to their physical symptoms, yet to a varying degree. Some of them had regular treatment goals around managing these symptoms. One student in particular who had a history of pseudo seizures before attending this school had a very difficult time understanding the connect and was quite avoidant of working through processing this concept. The students also each had a varying level of how much they previously were aware of where their symptoms originated and coping skills or techniques to lessen them by severity and multiplicity.

### **Process**

Originally, the group was to run for a length of nine weeks, twice per week on Tuesdays and Thursdays. Due to a school vacation running in the middle of the group, as well as a snow day, four days were cut from the scheduled meetings. Tuesday sessions were primarily led by me while my cofacilitator was present and co-leading, and Thursday sessions were run by my cofacilitator alone. All sessions took place in the living room. All members of the group removed their shoes before entering the room. They then preceded to their position in the room.

Each session incorporated mindfulness practices, Tuesdays included art and Thursday included yoga. Each session started with a 5 to 10-minute guided meditative practice that focused on a different topic each week. It was followed by 20 minutes to create an artistic response on Tuesdays and 20 minutes of guided yoga on Thursdays. There was then 5 to 10

minutes for a closing of inviting anyone who wanted to share their final thoughts or what they experienced or created during the session.

Mindful visualization and body scan were the two most common practices used. I played instrumental, relaxing music in the background of the guided practices. The topics explored consisted of various ways in which we relate to our bodies and the experience within them, such as gratitude, self-awareness, connection, and so forth. Then, members were asked to reflect about their experience during the meditation, whether it be by creating a visual image or a written response. This often included a specific guiding question to reflect on how the mindfulness practice affected their current symptoms. After this was finished, members were invited to share any thoughts or reflections they had. After each session, the cofacilitators debriefed about how they felt the group went that day, what worked, and what did not.

The first day of the group began with the facilitators explaining what the group would be like. The rest of the first session and the second day consisted of the group members and facilitators creating a list of rules for the group. The rules ended up being the following: be respectful of all group members, be mindful of the space, be open-minded, participate, and keep confidentiality of what is said between group members.

Week two began with the following question: What is your experience/understanding of your psychosomatic symptoms? The second week's mindfulness practice was a guided meditation chosen by me about being present with yourself and taking your symptoms as they are in the given moment. The art direction was as follows: Create a visual representation or written response to this concept.

Week three began with the following question: What does your safe space look like? Do you still experience symptoms here? The third week's mindfulness practice was a guided

visualization chosen by me about imagining yourself in a version of your safe space. What do you see, hear, and smell? The art direction was as follows: Create a visual representation or written response of what you saw as your safe space.

Week four began with the following question: What is your relationship with your symptoms? The fourth week's mindfulness practice was a guided meditation chosen by me about the relationships we have to different parts of ourselves. The art direction was as follows: Create a visual representation or written response to express this relationship.

Week five began with the following: Pick one area of your body to focus on that needs some support. What do you need? What is an area of your body that you do not struggle with? Can you remember a time or experience that changed your symptoms, whether it be better or worse? The fifth week's mindfulness practice was a guided body scan chosen by me about being aware of your symptoms as they are in the given moment. The art direction was as follows: create a visual representation or written response to your current experience of symptoms.

Week six began with the following question: Is there anything good about your symptoms? Do they serve a function? The sixth week's mindfulness practice was a guided meditation chosen by me about being present with yourself and taking your symptoms as they are in the given moment. The art direction was as follows: Create a visual representation or written response to this concept.

Week seven began with the following question: Has anything changed regarding your psychosomatic symptoms over the course of this clinical group experience? If so, what part of the experience do you think caused the change? The seventh week's mindfulness practice was a guided meditation chosen by me about compassion and self-love. The art direction was as

follows: Create a visual representation or written response about what accepting your experience feels or looks like.

Throughout the entire process, I knew I was going to have to be very aware of not projecting my own experience in relation to what the method was trying to provide and examine. Unfortunately, of all times, the very last session was difficult for me. I was having a really painful day where my own symptoms were so heightened it was quite difficult to remain present. I also felt as if the inconsistency of attendance in the group, although it was anticipated, inhibited the overall quality of genuinely seeing how the method worked for these individuals. There was also quite a range in the understanding of their symptoms due to the limited education around psychosomatic symptoms.

### **Materials**

Facilitators set up the environment to include a circle-like shape of yoga mats and one couch. Group participants were invited to bring in a pillow or blanket to support comfort. Participants used the same yoga mat each session. Each member had the choice of picking a small or medium sized art journal for a place to hold their art work and processing throughout the group. Members had the choice of doing their response with markers, colored pencils, pen, pencil, watercolor paint, or oil pastels for each artistic reflection.

### **Results**

I had the pleasure of co-facilitating the clinical group with my supervisor. It was a reminder that this is definitely an area of work that I want to continue to practice with both the population of those experiencing psychosomatic symptoms, as well as the methods we utilized. It was helpful to go through this process with the students as they were at various stages of understanding of how their psychosomatic symptoms work, including students that were resistant

to acceptance of the origin of their symptoms and their ability to support the alleviation of them. This resistance appears to mirror the resistance seen by some people that are unwilling or unable to understand psychosomatic phenomena (citation), and therefore it is important to incorporate these resistant individuals with psychosomatic symptoms in the application of the method.

The students had varying responses to the sessions. The strongest response of the group was to the mindfulness portion of the sessions, where each member agreed that it was relaxing and usually allowed them to become less focused on both mental and physical stressors in the moment as well as pay attention to what was going on for them in their body. This was also the portion where the students were most invested. Some of the students had a difficult time with processing their experience of mindfulness through art.

The last session of group that we held allowed for time to reflect on the process and to give me and my co-facilitator feedback on how participants felt that the group worked and what might help it become further successful if the group was to be run again. The response from participants included a positive reaction to the group, including that it helped them think about their symptoms and coping skills to deal with them in a more positive and helpful way.

The first thing I would change, is to have it run longer and more consistently. For this kind of method to be fully successful for the participants, there must be a certain level of trust, as well as both comfortability and vulnerability to coexist. Due to the nature of the sight being a therapeutic day school, attendance was not consistent, and therefore the group dynamics changed each day. This response was consistent with the members as well as my cofacilitator.

### **Discussion**

There needs to be more research in examining a wider array of psychosomatic symptoms than just headaches. When there is a specific focus in research, there leaves a whole realm of

questions unanswered. This particular area of psychosomatic symptoms needs more answers particularly due to the level of uncertainty and the lack of understanding. There are many links between stress and headaches seen in some research presented, such as in Broadbent, Niederhoffer, Hague, Corter, and Reynolds (2009); but there is no conclusion that stress is the root cause of psychosomatic symptoms, and to say this would be a generalization that could lead to misinformation. Rubin (2005) discussed a significant link between trauma and psychosomatic symptoms, but this research is limited and could be taken much further. For example, to examine the link between the symptoms of post-traumatic stress disorder (PTSD) and psychosomatic symptoms, could allow for a whole new lens on understanding of the experience of those having a difficulty understanding and communicating about their internal experience.

My first recommendation for anyone exploring this topic is that there is no part of this work that is quick or clear. You need to have a patient, understanding, and compassionate mind in relating to those that experience psychosomatic symptoms, because their experience has primarily resulted in countless people not understanding or believing that their pain is legitimate. Also, as the research I reviewed shows, there is both empirical and scientific research out there that has been done to show that this pain is truly happening and that many of these individuals even have the evidence in differences of their brain compared to those that do not have these psychosomatic symptoms (Rubin, 2005, p. 1099). Even if you think you have a grasp on understanding psychosomatic symptoms, you potentially could be very wrong, as each person's experience is so different.

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***THESIS APPROVAL FORM***

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**Student's Name: Breanna Washburn**

**Type of Project: Thesis**

**Title: Lessening Psychosomatic Symptoms Using Art Therapy, Mindfulness, and Yoga: Development of a Method**

**Date of Graduation: May 16, 2020**

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

**Thesis Advisor: Donna C. Owens**