ART THERAPY WITH CHRONIC PHYSICALLY ILL ADOLESCENTS

ABOUT THE AUTHOR

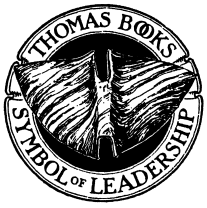
Ruth R. Luginbuehl–Oelhafen holds a medical degree from the University of Basel, Switzerland. She specialized in Pediatrics with a main interest in Developmental Pediatrics. She is a trained art therapist with a diploma from the Toronto Art Therapy Institute, where she was the recipient of the Martin Fischer Award for the best thesis. She introduced and taught the course for medical art therapy at the Toronto Art Therapy Institute. With her medical background in pediatrics, her clinical practice in art therapy has been heavily focused on the psychological impact of physical illness in children and adolescents. She is currently working in private practice in close collaboration with the department of pediatric palliative and bereavement care in a major children's hospital. As an active artist, she feels privileged to experience the healing power of her creative voice on a daily basis. In her work she focuses on the multiple facets and complexity of life.

ART THERAPY WITH CHRONIC PHYSICALLY ILL ADOLESCENTS

Exploring the Effectiveness of Medical Art Therapy as a Complementary Treatment

By

RUTH R. LUGINBUEHL-OELHAFEN, M.D., DTATI



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I wish to dedicate this book to all my patients,
who took me with them on their difficult journey and
who introduced me to the depth of their emotional struggle
in accepting and integrating their illness into their lives.

PREFACE

Improved therapeutic interventions in medicine during the last 25 years have increased the chances of survivability for children with a wide range of conditions, including those in the newborn intensive care unit. In industrialized countries today over 85 percent of children born with chronic conditions will survive until at least the age of 20 years (Blum, 1992). As noticed by Golombek et al. (1989), adolescence becomes more complex as our social system becomes more technological and industrial. This is particularly true for physically impaired adolescents. Therefore, as professionals providing services in the medical health care system, we must expect to be increasingly confronted by the difficulties faced by these adolescents.

As a pediatrician I have learned that in early childhood, where the child is in a dependent position due on the one hand to his developmental immaturity, and on the other hand to physical illness, it is important to support the caregiving system. The better my understanding of family dynamics, the more I have the parents as allies and the more I can empathize and obtain cooperation and compliance. This will, in turn, facilitate the patient's course of treatment and his prognosis for a relatively smooth development.

But when the child is older, he should be encouraged to participate in decision-making and treatment. Communication with adolescents, however, poses a particular challenge for the doctor or other caregiving professional. At this transitional stage of their lives – no longer children, not yet adults – adolescents are experiencing many internal and external changes which, even in physically healthy teenagers, are accompanied by emotional turmoil over such issues as body image and social acceptance. For the teenager with a physical illness, these struggles are even more pronounced (Neinstein, 1991 & Hofmann, 1997). To reach independence while a chronic physical condition

forces the individual back into dependence is a very difficult endeavor. In this situation it appears almost hopeless to get in control of one's own life, being constantly pushed back into the overwhelmingly controlling environment of the health care system. It seems impossible to leave the family core, when a chronic physical illness keeps the patient from socializing with peers.

Since I became a doctor I have tried various ways of reaching out to my adolescent patients. Too often, however, they choose not to communicate much and overtures about a recommended treatment or procedure evoke defiant reactions, a response typical of an age group that is striving for independence and suspicious of the expectations of anyone in a position of authority.

A communication vehicle that is potentially appropriate for this particular group is art therapy, due to its non-verbal approach (Linesch, 1988 & Riley, 1999). Art can represent a safe place in which to express and explore feelings. It may allow a person to present one's own reality when that reality is too emotionally charged to be expressed in words. Art offers an opportunity to become aware of and to observe one's own peculiar truth with more distance; it is as if the artist's product talks back to the artist. This is a kind of dialogue that takes place parallel to, and somewhat independently of, the relationship with the art therapist (Edwards, 1987).

As a pediatrician I am increasingly confronted with chronic physical illness in adolescence and its impact on the adolescent's future life. With my background in art therapy I am wondering whether this therapeutic approach can be helpful to this population in expressing and exploring its issues. During my search I found a great deal of literature about so-called medical art therapy with children and adults, but only a few case reports about adolescents. So I decided to focus more on this specific age group. For this work I have chosen a "client-centered" therapy approach, offering the client a non-threatening and non-judgmental environment rarely using directives. This therapeutic process is paced by the client and his actual needs, and therefore, gives him as much freedom and control as possible (Wadeson, 1980).

As a theoretical foundation for the case studies I used Erik Erikson's theory of Psychosocial Ego Development, since according to him development and maturation are based on resolving life crisis (Berzoff, 1996). I further consulted Neinstein (1991) and Hofmann (1997) concerning the issues of chronic physical illness in adolescence. Fi-

nally I included Wadeson's approach (1980) to art therapy in general, Linesch's (1988) and Riley's (1999) approach to art therapy specifically with adolescents, and Malchiodi's approach (1999) to medical art therapy.

The purpose of this book is to explore the effectiveness of art therapy as a primary intervention with an adolescent population with chronic physical illness – in this particular case, with adolescents in chronic renal failure either on hemodialysis, peritoneal dialysis or after kidney transplantation. The hypothesis is that art therapy (1) facilitates expression of emotions through artwork, ideally including verbal expression; (2) enhances self-esteem and identity; (3) helps them cope with their chronic physical illness; and (4) finally, offers an opportunity to vent anger and frustration (catharsis). By obtaining a safe place to explore issues related not only to the developmental stage but also to the conditions of chronic physical illness, these teenagers may begin to discover their individual strengths through art therapy, rather than dwell primarily on their individual weaknesses. In other words, the book will explore whether art therapy can be a means by which this population could be helped to accept and integrate their chronic physical conditions into their lives and to find an appropriate place in our society. In addition, this book will investigate whether art therapy could become a sanctuary, one in which the patient is allowed to keep control, to make his own decisions and to explore and develop a sense of freedom in an overwhelming controlling environment.

This book consists of four chapters with Chapter 1 providing an in-depth perspective on literature review and adolescence as a developmental stage. The psychological impact of chronic physical illness in adolescence, creativity and art therapy, medical art therapy, and the creative process is discussed. Chapter 2 studies methodology, independent variables, settings, procedures, materials used, and the gathering of data. Chapter 3 addresses case histories, their artwork, the short-term treatment group, and the long-term treatment group. Seven clients and examples of their artwork are presented. Chapter 4 discusses results, conclusions, and ideas for further studies.

R.R.L-O.

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Chapter 1

LITERATURE REVIEW

A. ADOLESCENCE AS DEVELOPMENTAL STAGE

In talking about adolescence, the first thing to keep in mind is this: we are not talking about a homogeneous group, but rather a group that displays "wide variability in biological and emotional growth. Each adolescent responds to life's demands and opportunities in a unique and personal way" (Neinstein, 1991, p. 39). According to Neinstein, adolescence has been described as "a period of extreme instability" or "normal psychosis" (Neinstein, 1991, p. 39).

According to Anna Freud, "struggles of the ego to master the tensions and pressures arising from the Id lead in the normal case to character formation" (Freud, 1958, p. 257). She described "this battle between ego and Id as terminated by a first truce at the beginning of the latency period and breaking out once more with the first approach to puberty" (Freud, 1958, p. 257). "The individual recapitulates and expands in the second decennium of life the development he passed through during the first five years" (Freud, 1958, p. 256).

To further understand the developmental tasks of adolescence, I will use the theoretical framework of Erik Erikson's theory of Psycho-social Ego Development. I will have a look at his study of the developmental tasks starting from birth and leading to adolescence.

According to Erikson (1950/1963), the ego is shaped and transformed not only by biological and psychological forces, but by sociocultural forces as well. Erikson identified the ego strengths as well as the vulnerabilities that a person has to face during each stage of development. He stated that at each stage of psychosocial development

there is the potential for the emergence of a unique kind of ego strength, as long as the individual faced and mastered the age-specific crisis with an age-specific concern at an age-specific time (Berzoff, 1996). It is important to understand that these stages are not sharply demarcated. They may overlap, regress, stagnate and catch up again, depending on an individual's life circumstances and his capability to cope. Childhood failures to master the age-appropriate developmental task limit the adolescent's ability to deal with the challenges of physical maturation, vocational search and self-definition. The result is a psychopathologic identity confusion in adolescence, which may even persist into adulthood (Jaffe, 1991).

According to Erikson, the first stage "Basic Trust vs. Basic Mistrust" (infancy, ages 0 to 18 months) – the oral stage according to Freud – is about establishing a basic trust between the child and the primary caregiver; therefore, the trust is to overcome "basic mistrust which is an inborn discomfort caused by the immaturity of homeostasis" (Erikson, 1950/1963, p. 247). The accomplishment of the "nuclear crisis leads to a general state of trust, which implies not only that one has learned to reply on the sameness and continuity of the outer provider, but also that one may trust oneself and the capability of one's own organs to cope with urges" (Erikson, 1950/1963, p. 248). "Consistency, continuity and sameness of experience provide a rudimentary sense of ego-identity" (Erikson, 1950/1963, p. 248) – of trustworthiness.

Erikson's second stage (early childhood, age 18 months to 3 years) – parallel to Freud's anal stage – is about "Autonomy vs. Shame and Doubt." Due to growing muscular maturation, this stage is one of ambivalence between "two sets of social modalities: holding on and letting go" (Erikson, 1950/1963, p. 251). Children at this stage need to achieve some sense of independence over their own body, including some sort of control over what is inside and outside of it. If a child comes to feel that his wish to have a choice and his urge for autonomy does not jeopardize his newly achieved "basic trust," he will gain some confidence and pride (Berzoff, 1996). At this stage the child's main struggles are control issues. He has to gain some sense of having the right to have control, but he also has to accept the fact that he will be controlled by outer forces as well. The child will have to confront first boundary issues. He will have to learn that within his social environment his freedom will end where his neighbor's (in this case his caregiver's) freedom begins. For the first time he will be confronted with differentiation between his and another's privacy (Erikson, 1968).

> This stage, therefore, becomes decisive for the ratio of love and hate, cooperation and willfulness, freedom of self-expression and its suppression. From a sense of self-control without loss of self-esteem comes a lasting sense of good will and pride; from a sense of loss of self-control and of foreign overcontrol comes a lasting propensity of doubt and shame. (Erikson, 1950/1963, p. 254)

Erikson's third stage, "Initiative vs. Guilt" (play stage, ages 3 to 6 years), corresponds to Freud's Oedipal stage. The child enters a period rich in imagination and creativity, and begins to differentiate between concepts of the self and others. He faces the task of how to identify with his parents' and their society's values. The child now starts to develop an "'inner voice' of self-observation, self-guidance and self-punishment" (Erikson, 1968, p. 119) – the conscience as the cornerstone of morality (Erikson, 1968). "Initiative adds to autonomy the quality of undertaking, planning and attacking a task for the sake of being active and on the move, where before self-will more often than not, inspired acts of defiance or protested independence" (Erikson, 1950/1963, p. 255). Whereas in earlier stages the struggle for auto-nomy had concentrated on keeping rivals out, initiative in this stage leads to anticipation and challenge of rivalry in order to reach a superior position. Competition adds to creativity for initiative (Erikson, 1968). If the child encounters too little appreciation or even opposition to his endeavor, he will develop feelings of guilt, and will react with withdrawal and loss of self-confidence.

The fourth stage, which is termed "latency" according to Freud (school ages, age 6 to 11 years), Erikson has described as the stage of "Industry vs. Inferiority." The child now moves beyond the family nucleus and dives into social life, developing cognitive skills, play skills and social skills, including the ability to express and integrate his own feelings (Berzoff, 1996). It is the time to go to school, to learn, to develop competence, new physical and mental capabilities and to promote self-confidence. Children now are eager to make things together, to share responsibility and, therefore, to develop team skills, including the acceptance of rules. Through interaction with his peers, the child evolves ways to maintain self-esteem, developing increased ability to tolerate frustration. If for any reason the child is deprived of participating in social life and/or of developing a sense of achievement, he will grow feelings of inferiority.

Adolescence (ages 11 to 19 years), according to Erikson, is the stage with the psychosocial task of "Identity vs. Role Confusion." Adoles-