WORK-LIFE BALANCE THROUGH THE ARTS AND CREATIVITY: AN INTIMATE PORTRAIT OF HEALTH PROFESSIONALS

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Maria Lupo

Drew University

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ABSTRACT

Work-Life Balance Through the Arts and
Creativity: An Intimate Portrait
of Health Professionals

Doctor of Medical Humanities Dissertation by

Maria Lupo

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Our overburdened health-care system is again faced with a shortage of nurses, physicians, and direct frontline staff. In the health professions, it is acknowledged that burn-out rates are high among staff delivering direct care. Many physicians and frontline staff are leaving direct care practices for administrative positions. This research project aims to bring to light in an intimate and personal way how health-care professionals are using the visual arts to sustain their careers in medicine while managing a work-life balance. The data for this project were collected through semi-structured interviews, observations, artwork, and individual art therapy sessions. Issues of loneliness and guilt surfaced as the process unfolded for these study participants as barriers to fully embracing a creative arts practice expanding their notions of identity. The findings indicate that changes regarding policy, licensing, and education need to be thoughtfully addressed at both the national and regional levels. The findings also support the necessity for local arts programming that fosters a sense of community regarding arts and health initiatives of healthcare professionals.

DEDICATION

To my mommy, who always believed in my artist spirit.

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Chapter 1

LET'S TAKE A LOOK!

These are the duties of a physician: First . . . to heal his mind and to give help to himself before giving it to anyone else.

From the epitaph of an Athenian doctor, 2AD [1].

In the health professions, it is acknowledged that burnout rates are high among staff delivering frontline care. Many physicians are leaving direct care practice for administrative positions. As a nation, we are again faced with a shortage of nurses coupled with a rapid rise in the turnover rates of staff delivering direct/bedside patient care. Additionally, a pandemic continues to greatly tax an overburdened health-care system. How are direct care health professionals attempting to provide optimal care to both their patients and their families while struggling to maintain a work-life balance and avoid burnout? In the end, frontline health-care professionals are abandoning their positions, further rupturing a stressed health-care system.

As a way to cope, many direct care health professionals are engaging in activities such as the creative arts to preserve their equilibrium and reduce stress. Recently, many health-care providers and organizations have implemented creative arts programming as a means to retain staff, attempting to prevent fatigue and burnout proactively to thwart staffing shortages. Institutions, for example, hospitals and medical schools, are taking steps to alleviate stress and fatigue through strategic programming, especially in the arts, with New York University's Arts & Health initiative leading the way (National Organization for Arts in Health, 2017). Recently, artists-in-residence programs and narrative medicine writing initiatives have been incorporated into the institutional health-care landscape, including medical school curricula. National and regional art programs,

including the National Arts Program, New Jersey Council for the Humanities, and the National Organization for Arts in Health, have also been established, operating as supportive resources in the field.

While many health-care professionals are engaging in the arts as witnessed by their participation in visual art exhibitions as noted by the National Arts Program, they are also joining orchestras such as the Life Sciences Orchestra at the University of Michigan Medical Center. Harvard University's Medical School Orchestra, organized and conducted by Dr. Wong, is another example of a collaborative creative endeavor engaged as a creative release from the stress of medical school. A vast number of health-care professionals are utilizing these resources, while some are autonomously seeking ways to cope independently by using the arts outside of the workplace to manage stress and form identities beyond medicine.

In this study, I explored on an individual level the correlation between engaging in the creative arts and the management of stress through an arts practice to foster resiliency within the health-care professions. To uncover the role the creative arts play in fostering resiliency and reducing burnout among health professionals, the topic was be reviewed and considered by focusing on particular members of varied health professions that are engaging in the creative arts. By interviewing long-term health-care professionals involved in the creative arts (for 10 years or more), as well as considering my own journey as both an artist and clinician, I offer close, candid portraits of a doctor, nurse, technician, therapist, and social worker. The purpose of this study is to recognize and illustrate how the arts mitigate stress and build resiliency for the health-care worker. Additionally, by providing insights and informing policy, the study can be a useful

resource to conceivably transform an overburdened health-care system strained by shortages and a limited workforce. The study's participants are clinicians, creative artists, and caregivers. The interviews focus on the medical, personal, and artistic aspects of their work and life as they strive to cope with the escalating demands and pressures of their profession. Subjects were initially interviewed prior to the pandemic and then again in the midst of the COVID-19 pandemic to check in and examine if any changes occurred in their creative practice or if they were still able to sustain their art-making activities.

The specialized issues confronting health-care professionals are often confounded by similarities to their personal lives. Family issues often mirror the endless woes of the patient and vice versa. Clinicians are often responsible and charged with critical issues and crucial decisions in multiple areas of their life for both their patients and their own families. Issues often overlap, creating transference and counter-transference, mirroring each other. This area is generally foreign to the clinical health-care professional that is not usually trained nor versed in the psychological dimensions of the patient-clinician relationship. Often this confusion causes distress in both areas, contributing to misperceptions and additional emotional strain in job performance for the clinician, frequently with unhealthy consequences. Through interviews and testimonials, this dissertation explores how frontline health-care professionals maintain and keep a work-life balance through the arts. Specifically looking at the clinician-artist as an individual and how their art has sustained and supported them in their profession focuses on their unique creative process. The participants shared their individual art practices as they maintained their professional health-care responsibilities while balancing family life. The uniqueness of each participant's art practice as well as their various positions in health-

care provide a perspective and overview of the issues and rituals that each clinician/artist experiences.

The process of interviewing and observing affords me a closer, deeper portrait of the professional caregiver as both a clinician and an artist rather than just a mere summary of statistical data. The goal of this dissertation is not to offer a comprehensive portrayal of all clinician/artists or to generalize my findings, but rather to collect a small sample, offering a deep, particularistic look into a variety of health professionals and their creative processes. Existing surveys and questionnaires only skim the surface of the interplay between the creative arts and the health professions. In contrast, in this dissertation, I approach the participants from a singular case study perspective (Abma & Stake, 2014).

Suggesting resiliency, stress relief and professional/personal fulfillment within the health-care community through the arts, the results of existing surveys consistently tout notable outcomes using the arts to reduce stress. Surveys and evaluations simply do not tell the whole story (State of the Field Committee, 2009). The genuine value of this dissertation is in the individuals' personal, revealed stories, coupled with their creative process/practice. Their stories in turn look to deliver inspiration to others that are struggling as health-care professionals. Providing background, context and a look at their practices linked to the specific pressures of the medical profession, it offers a reflective, personal view and an analysis of their creative process. The demands of care delivery in the field will be seen through the eyes of the clinician and witnessed through their artwork. My personal journey as caregiver both professionally and personally will be considered as the experience of yet another clinician who has sustained their art practice.

Offering a personal—microscopic, at times—window into the creative release that the arts offer, my work will also examine my use of personal medical equipment and supplies as part of the art-making and healing processes.

Increasingly, the arts and humanities are being used to foster the resiliency of the medical professional (Christenson, 2011). In addition, the visual arts are being employed to enhance the observational skills of medical students while developing their clinical practice as they address the emotional challenges of the profession (Shapiro et al., 2006). The arts serve as a release from the intense professional training required while providing a safe outlet for stress relief. These benefits have a secondary effect which extends to family and other non-professional caregivers within the health-care system. Artistic expression helps to set a fertile atmosphere for patient-centered care and humanistic medicine. Arts and health programs are often offered as part of a medical institution's fabric under such programs as art therapy, music therapy, healing arts, arts and medicine, population health/community health, and employee engagement. Medical systems at large benefit greatly from health-care professionals having longevity in their given professions. The gains for the organizations are in the areas of finance, patient satisfaction, and quality. Additionally, patients and their families benefit from the increased number of health-care professionals improving patient access and continuity of care.

A growing number of medical centers have an arts coordinator or director who manages a variety of arts experiences such as visiting artists, artists-in-residence, and arts programming. Some examples are New York University Medical Center, Harvard Medical School, and Johns Hopkins. Many of these programs are available to staff,

patients, and caregivers. They are often developed in partnership with community arts agencies to advance art collections and offerings. Some offer rotating art exhibits, often featuring local/regional artists and sometimes staff. A major focus of their mission is to utilize the arts to enhance the work environment and reduce the stress on professional caregivers, families, and visitors through an environmental approach. The goal is to increase staff and patient satisfaction. Slater et al. (2017), demonstrated that a hospital's use of an arts-enhanced environment is strongly associated with patients' willingness to recommend the hospital. The identification of an arts initiative as a modifiable contributor to patient satisfaction supports the continued investment in arts-based programs, activities, and experiences for hospital patients as it seems to enhance staff satisfaction. *Arts in health* and *arts in health* care are terms used to encompass these programs and initiatives in a health-care setting, while in public health it is often referred to as *arts in community health*.

Professional areas in the arts and arts and health field include medical humanities, health-care design, occupational therapy, recreational therapy, life enrichment services, creative arts therapy, and arts for people with disabilities and those with chronic diseases—this wide range illustrates the scope of the field regarding patients and caregivers. Together these disciplines work to comprise a continuum in the health-care experience that uses the arts for health and well-being. Professional caregivers (physicians and nurses) and paraprofessional caregivers (such as home health aides and certified nursing assistants [CNAs]) who are at risk for burnout are in need of these services as much as are the patients they serve. When integrated within a caring organizational culture, arts programs can provide solutions for addressing the self-care

needs of professional and paraprofessional health-care workers. Support, encouragement, and availability of arts programming provided by the medical system or medical facility can often lead the professional caregiver to build a personal practice that supports resiliency and is scaffolded by the institution's culture. This can lead to employee retention and increased customer service in some cases, plus improved patient outcomes and satisfaction. In 2009, Samaritan Health Services surveyed its employees about the value of the arts-enhanced environment for patients as well as for themselves (Slater et al., 2010). The data were used internally to guide the further development of their Arts and Health Initiative. Support for the initiative was very high. Additionally, arts and health initiatives can be effective in employee team building and morale team building. They can offer support during a collective medical crisis when there are negative patient outcomes.

The arts and humanities and the creative and expressive arts therapies are increasingly being included in health sciences education, with innovative programs designed to improve physicians' and nurses' diagnostic skills, such as visual acuity and observational ability. Empathy, resiliency, and communication skills are also an added benefit to both the employer and the health-care professional. Constantly caring for people who are facing physical, mental and emotional challenges of coping with a major illness or impending death often leads to major stress and depression in the health-care professional (Brennan, 2017). These dedicated professionals facing long hours and intense job demands are not immune to the additional stressors which we all face within our own families and in our own lives.

Currently, many arts in health and creative arts therapy programs implemented to care for the caregiver are designed specifically for professional staff members in hospitals, clinics, and hospice settings. Such programs are viewed as being highly cost effective, due to the significant cost to the institution for replacing physicians and nurses who may leave due to compassion fatigue. This attrition contributes further to a national shortage of health-care workers. According to Wong (2012), professional caregivers can greatly benefit by using the arts to mitigate compassion fatigue that they face in today's intense health-care facilities.

For professional caregivers, burnout manifests as deep physical, emotional, and spiritual exhaustion accompanied by feelings of reduced competence and loss of compassion (Khamisa et al., 2013). Nurses are especially vulnerable to compassion fatigue because of their prolonged personal contact with patients (Coetzee & Klopper, 2010). According to Potter et al. (2013), compassion fatigue, which leads to burnout, is pervasive among health-care professionals in whom stress is experienced through patients who are in the dynamic stages of illness coupled with long working hours, decision making under pressure, and changing competing priorities. Burnout has more severe ramifications than does compassion fatigue, as "burnout has a greater scope than compassion fatigue; it is defined as severe emotional exhaustion, depersonalization and feelings of worthlessness" (Alkema et al., 2008, p. 102). The consequences of burnout for the clinician manifest in poor self-care and patient care, diminished empathy, medical error, and poor physical and mental health, with a suicide rate that is double that of the general population (Beresin et al., 2016). According to Beresin et al. (2016), approximately one physician dies by suicide every day linked to high levels of stress.

The literature has cited the effectiveness of teaching professional caregivers how to use art to help lower compassion fatigue (Pauwels et al., 2014). Arts practice has been shown to help medical students sustain their own spiritual and mental health practice while in school and in their subsequent medical practice (Wong, 2012). Some medical practitioners have found that the arts can also help them better recognize the patient's strength and satisfaction through improved communication (Charon 2007). Since 2001, the Association of American Medical Colleges has directed the development of medical humanities courses by focusing on the narrative, including the visual narrative (Dittnich, 2001). It has been shown that physicians who have participated in these arts and humanities courses score more highly equipped with empathy skills at the bedside (George et al., 2013). Brennan (2017) added that empathic health-care professionals are less likely to fall victim to burnout.

The general consensus in the literature reveals that many factors, including shortages of health-care professionals, demanding caseloads, regulatory pressures, and decreased reimbursements from insurance companies, contribute to the stress of both physicians and nurses in the delivery of direct care. Compassion fatigue, according to Potter et al. (2013) is pervasive among health-care professionals. Jenkins's (2012) investigation into the concept of compassion fatigue suggests its defining precursor is continuous and repeated exposure to stress. Burnout or cumulative stress is a consequence of chronic emotional and interpersonal stressors. According to Potter et al., compassion fatigue encompasses physical, emotional, and mental exhaustion. Health-care professionals experiencing high levels of ongoing stress are particularly vulnerable to compassion fatigue. Meta-analyses of the physical and mental health effects of caregiving

have shown higher levels of depression and physical health problems in caregivers when compared with non-caregivers (Pinquart & Sorensen, 2003). Caregivers can be professionals (physicians, nurses, therapists, psychologists, or social workers) as well as paraprofessionals and informal caregivers (family and friends). Caregivers provide continuous care, including frequent assistance and all aspects of emotional and physical support (Lambert, 2016). This makes nurses and CNAs among our most vulnerable.

Research has shown that individuals suffering from compassion fatigue experience dysfunction in the executive function of the brain and have trouble with emotional regulation (Godsil et al., 2013). According to Potter et al. (2013), although not documented, there is a potential for nurses and other clinicians who experience compassion fatigue to be at risk for committing errors in problem-solving, memory, and communication, which can manifest in adverse patient care events. Further evidence according to Harmon et al. (2007) exists that employee engagement is strongly correlated with patient experience and satisfaction.

Health-care institutions are finding that visual healing elements built into the environment and innovative participatory arts programs can contribute greatly to addressing professional medical staff issues such a low productivity, high turnover, adverse patient events, job-related errors, poor service, and low patient satisfaction ratings (Khamisa et al., 2013). The key to preventing staff burnout and turnover appears to be providing a variety of self-care activities for physicians, nurses, and administrative staff (Coetzee & Klopper, 2010). Research has suggested that physicians benefit greatly when the arts are included in clinical training and available during their practice years. Demonstratable outcomes include increased empathy, improved observational skills and

diagnostic skills, enhanced communication skills, and improved ability to treat people at various stages of life from different cultures while practicing good self-care (Clift & Camic, 2016). The time constraints of the direct care clinician and reduced staffing and shortages appear to be obstacles in program implementation (Christenson, 2011).

The use of the arts and humanities in health sciences education and in professional development training programs for medical professionals is rapidly growing (Lambert, 2016). Application of the creative arts in educational initiatives for medical practitioners is expanding within the larger field of medical humanities as an interdisciplinary field of medicine that includes the humanities, social sciences, and the arts. The medical humanities are concerned with integrating the creative and intellectual strengths of numerous humanistic disciplines to provide perspective to the sciences and improve medical education. Scholarship in the field of medical humanities argues that the arts can offer diverse ways for medical professionals to think, observe, communicate, and empathize (Dolan, 2015).

Increasingly, professional artists and arts organizations are partnering with medical schools and medical systems to produce innovative and effective training for the professional caregiver. These programs focus currently on the education of physicians, yet there is an obvious absence of similar programs designed for nurses, paraprofessional caregivers, and other allied health professionals, while this group has the highest rate of contact with patients and their families. Inclusion of an arts practice in medical education helps physicians to care for their own spiritual needs and mental well-being while in school and subsequent medical practice (Puchalski et al., 2014). In addition to using the arts to improve medical professionals’ skills as physicians, nurses, and professional

caregivers, inclusion of the arts also teaches these professionals in how to use lifelong engagement in the arts to help with self-care throughout their careers (Dolan, 2015).

Due to the high consequences of employee burnout, especially in the health-care environment and medical centers, medical schools are rallying with programs to lessen stress and thwart burnout through curriculum inclusion. Programs include the development and implementation of ongoing educational programs, plus support and intervention programs for health-care staff. Depending on the setting and the resources available, medical institutions have fluctuating approaches which work around varied schedules and needs. Some support programming is even hardwired into the fabric of the health-care institution's human resources or medical affairs departments. Additionally, to combat burnout, an increasing number of health-care organizations have embraced the arts and health movement, offering programs to their health-care staff and employees in the direct care environment. Programs often include various art genres; moreover, they are offered as part of the institution's medical humanities curriculum, which is offered to allied health, attending medical, and house staff. Generally, participation is voluntary and often grant funded unless it is built into the interns' and house staff's curriculum and meetings such as morning report or noonday conferences. Some medical centers even dedicate grand rounds or have added Schwartz rounds to the mix.

Visual artists, photographers, filmmakers, poets, musicians, actors, dancers, and storytellers use the arts to provide instruction, educate about the arts, and document life experiences for enjoyment, distraction, inspiration, hope, relaxation, adding to the fabric of the community and in particular to medical environments, where emotions and stress run high. Artists in health care perform a particular service, often with a dual role serving

staff, as well as patients and caregivers. This includes creating a nurturing, expressive environment for the staff and clinicians to find comfort and transform. An example of a program in which artists have a dual role is Georgetown University Hospital's 20-year-old studio Artist-in-Residence program presented by an art therapist, which is a major component of the physician and house staff training. It was developed for both patients and staff, providing appropriate directives for each population. While creative work with patients is the most rewarding for the artist/creative or art therapist, this dissertation will journey through arts in health care, focusing on clinicians that embrace the arts to reduce stress and build resiliency to create and maintain work-life balance.

According to Pauwels et al. (2014), professional caregivers greatly benefit by using the arts to help reduce compassion fatigue which they face in today's intense health-care facilities. Health-care institutions are finding that building a healing environment and participatory arts program can contribute greatly to addressing professional medical and allied health staff issues such as low productivity, high turnover, adverse patient events, job-related errors, poor service, and low patient satisfaction rating (Hillard, 2006). Beyond the institutional programs, many health-care professionals are engaging in the arts as witnessed by their voluntary participation in visual art exhibitions as noted by the National Arts Program. In addition, clinical staff, allied health, nursing staff, and students are joining orchestras such as the Life Sciences Orchestra at the University of Michigan Medical Center. Harvard University's Medical School Orchestra includes medical students as well as attending physicians from area hospitals. Harvard also boasts a working relationship with the Boston Museum of Fine Arts in an engaging program encompassing both visual narrative and storytelling. Many

health-care professionals are utilizing these resources, while some prefer to create independently.

Numerous arts experiences can be used in designing effective wellness programs for physicians and nurses. These experiences may include painting projects, journaling, book clubs, dance/movement sessions, or staff orchestras and choirs (Morgan, 2016). To further encourage engagement by health-care professionals and paraprofessionals in the arts, health-care facilities utilize art carts to be enjoyed by staff members during breaks. Required retreats and professional development programs centered on the arts can purposefully integrate the benefits of arts participation in focused sessions, hopefully leading to the development of a sustained, fulfilling private art practice for the clinician.

Since nurses are especially vulnerable to compassion fatigue because of their prolonged personal contact with patients, it is critical for arts in health-care administrators to expand caring for the caregiver programs to nurses. They comprise the largest single group of professional hospital staff providing the primary source of direct patient care. Allotting time for nursing staff to engage in the arts during staff time poses a problem due to shortages and limited shift time; therefore, development of a personal art practice is worth encouraging. Expansion of arts programming beyond nurses for other frontline caregivers is an important concern, since CNAs are saddled with the most rigorous, exhausting frontline responsibilities while receiving the lowest pay.

Medical schools and clinical programs engage the visual arts in training physicians, including house staff. At least three studies conducted over the past decade have concluded that medical students who participate in arts-based training demonstrate better visual diagnostic skills than those students who do not receive this training (Abia-

Smith, 2016). Visual arts lessons for physicians can include drawing live models, group discussions about paintings, focused observation exercises about works of art, and approaches that integrate fine arts concepts with physical diagnostic topics (Dolev et al., 2001). Opportunities have been increasing for medical schools to partner with local museums and arts organizations.

A 10-week course for medical students at the University of Washington, titled Visual Thinking: How to Observe Depth, uses detailed art observations to teach observational skills and critical thinking skills, then apply them to ambiguous and problematic medical diagnosis. Objective review of the class journal entries suggests the course helps the students maintain a broader perspective in their education, focusing not just on the disease but on the whole person (Abia-Smith, 2016). This approach has the potential to develop mental and emotional resilience, an important skill for maintaining empathy and preventing burnout during medical training and practice (Abia-Smith, 2016).

Professional development training is occurring primarily through public sector funding flowing from arts councils and from higher education arts and medical centers. Trainings often use existing artists in education as core workshop facilitators in workforce development in arts and medicine programs, especially in areas serving older adults. Initial funding efforts in workforce development have encouraged the National Endowment for the Arts (NEA) and private foundations to contract with service organizations such as the National Center for Creative Aging to produce training tools for artists who are interested in working in a medical setting including. These resources include, notably, *The Creative Caregiving Guide* (National Center for Creative Aging,

2015). State and local art councils have leveraged these investments to enhance artist training. They serve as a direct resource to medical professionals and allied health staff wishing to engage in the arts.

State arts agencies such as the Ohio Arts Council and the Pennsylvania Arts Commission are training artists, arts administrators, and health-care providers in effective ways to use the arts. Workforce development also includes using the arts in ways to strengthen health-care personnel's resilience for meeting the challenges of working in high-stress health-care settings. In 2013, Prince Charitable Trusts provided funding for ArtStream, a Maryland community arts organization, to implement arts-based activities to nursing service personnel on the Wounded Warrior Unit at Walter Reed National Military Medical Center. Retreats featured music, dance, drama, visual arts, and other art experiences which were held at a beautiful location off base. Additional art activities were held within the unit throughout the year. Due to additional funding, the program, called You Are a Work of Art, has now expanded to other nurses throughout the hospital.

Figure 1

Examples of Art and Health Initiatives in Health-care Environments

Music Performances
Visual Art Exhibitions (Staff & Community)
Theater and Dance Events
Bedside Arts Programs
Workshops
Lectures
Education
Literature & Medicine
Narrative Medicine/Reflective Writing
Caring for the Caregiver

Having noted some of the general initiatives in arts and health care, this dissertation focuses on the individual clinician/artists selected through a case study approach. Participants in this study's interviews include a psychiatrist, an emergency medical service (EMS) worker, a social worker, and a nurse. According to Morehouse (2012), interviewing is the basis of the qualitative method. The interview is essential to the process, since we live in a complex world and in-depth, experiential knowledge of phenomena or issues cannot be easily reduced to cause and effect in surveys (Morehouse, 2012).

In addition to looking at artwork by the clinicians in those disciplines in a personal way and observing their creative practices and rituals, this dissertation includes elements of my own sustained practice and creative process as I continue to work as a

mental health therapist. It compares and contrasts my creative process with those of the clinicians that I interviewed for this dissertation. I viewed the artwork of the clinicians I interviewed through the lens of Shaun McNiff (1992). According to McNiff (1992), art fundamentally heals, and it is the medicine that is buried in our souls. As McNiff (1992) stressed, it is a highly individual process, which is the reasoning for this dissertation. Art offers hope and resiliency to the health-care worker—a form of self-healing (McNiff, 1992; Malchiodi, 2020). According to Malchiodi (2020), self-regulation is a crucial competency that the expressive arts address. Malchiodi (2020) further related that the arts have the ability to modulate affective, sensory, and somatic responses that impact functioning, including emotions, somatic responses, and cognition. In general, resilient individuals are effective regulators—that is, they are able to remain calm under pressure and quickly adapt to new challenges (Malchiodi, 2020). This dissertation takes a close, personal look at these health-care professionals, as well as shares my own thoughts and feelings about their varied artistic processes to further understand the connection of the arts as it relates to work-life balance and resiliency.

Chapter 2

CREATIVITY AND SUBLIMATION, PERFECT TOGETHER

Throughout history, human beings have used the arts to share their thoughts and reach a newer or deeper level of understanding of ideas and feelings, especially the ones that are locked inside. According to Dutton (2009), art's appeal is lodged in our genes and in the genes of our ancestors who first painted on cave walls and danced, sang, and told stories around the campfire. Ellen Dissanayake (1995) argued that art can be regarded as a natural, general inclination that manifests itself in culturally learned specifics such as songs, dances, performers, visual work, and poetic speech. As Dissanayake (1992) explained:

> My palaeoanthropsychobiological view is that in order to include human history, human cultures and human psychology, art must be viewed as an inherent universal (or biological) trait of the human species, as normal and natural as language, sex, sociability, aggression, or any of the other characteristics of human nature. (p. 169)

Through the ages, art has worked to change individuals and communities to confront, challenge, and inspire by allowing us to imagine and dream to be something more.

We as individuals feel vital and effective when we create, make, build, or fix. When we are deeply absorbed in the task (making art), losing ourselves, passing the time in a contented zone, defies time, according to Davis (2017). Csilszentmihalyi (1990) defined this state as "flow," an optimal state with special motivation (p. 25). Lambert (2016) explained that when we do meaningful work with our hands, neurochemical feedback floods our brains with dopamine and serotonin. We have evolved to release

these chemicals to reward ourselves for working with our hands and in turn are motivated to do some more. This is thought to be linked to our mechanism of survival. Work which dispenses these chemicals is highly favored and linked to survival-based outcomes (Newman, 2011).

The hands of doctors, nurses and other health-care professionals are very much involved in the survival of others. These efforts, too, are rewarded with the feel-good chemicals. This could be one reason why health-care professionals are motivated to continue in these stressful professions. Rollins (2012) contended that making art is a natural fit in the continuum for the direct care health professional or paraprofessional. Perhaps this explains why many members of the various health professions often find solace in the arts.

Models of creativity and sublimation are integral in the healing process, but the specific, elusive nature and mystique of the creative process seems to rest mainly with the individual. Julian Stamm (1967) and Edith Kramer (1987) believed that true sublimation, which is the transformative, healing aspect of the creative process, occurs in the realization, acceptance, and witnessing of the final art product not solely in the process of creating. True sublimation, according to Stamm (1967) and Kramer, requires an audience or witness. Since creative practices and the art-making processes are often unique for each individual, changing from time to time, distinct models of creativity, while also considered as part of the creative process, are regarded in a fluid, individual manner. Artists and creatives often receive similar inspiration, as Stamm (1967) argued, but respond differently to the creative impulse within an ever-evolving process and cycle of creativity. The same may be true for the clinician/artist.

Poincare (1985) noted that the creative process seems to start with conscious work on a problem or issue. For the clinician/artist, the process may possibly begin with a work-related dilemma or stressor. For the artist/creative, the art process sets up problems in method and procedure that pushes the creative into complete immersion into the process. Each individual clinician/artist may have a personal ritual, a creative process that places them in the zone of creativity. Looking at the selected clinician/artists, the unique ways in which they purse their art and the art-making process, we begin to understand that their creativity is a distinct process to be explored individually. Time and place may be limited, and makeshift studios are often the rule for the clinician-artist. Due to the demands of their primary profession in medicine, they must often find stolen moments to create. For some clinician/artists, this is coupled with a secreted practice. The demands of their primary profession in medicine often pose an obstacle offering a unique model of the creative experience for this group.

In debating the key elements underlining this topic, the central issues remain regarding healing and self-care and their relationship to work-life balance regarding the health-care professional. Stamm (1975) believed that both creativity and the creative processes are strong traits derived from a form of primitive strength that is fueled by “un-neutralized, aggressive and libidinal derivations.” These qualities, according to Stamm (1975), even in the true artist/creative “inherently endowed with specific sensory modalities” sometimes can only be fully unleashed after trauma or in someone with an altered sense of reality. Stamm (1975) argued the true artist’s creation really only manifests during *primary process* which supplants the unconscious and acts upon the primitive impulses of the id.

Freud (1922) introduced the term *sublimation* to signify a provisional stage representing urges, mainly sexual and very primitive. Freud went on to give assurances that sublimation was a developmental process eventually surfacing and reforming in most people in a socially acceptable form. These acceptable forms of behavior would then be manifested in social circumstances. The observable actions would often be admired and/or applauded in public circles, thus completing the act of sublimation and permitting the client/patient to move forward. Freud's work on sublimation initially did not form a link to creative work, but creative work can certainly be included in the criteria. Later, Freud agreed. Work (art) is observable and admirable within a public forum, providing a universally accepted art form, therefore meeting the criteria.

Kramer (1987) in a clinical setting established the link to creative work especially artwork. Freud conceded that artists or creatives suffer no more or no less than the average person, but through their creative gifts they are much more equipped to remedy the conflict by resolving a situation through the creative process, therefore achieving sublimation. The artist/creative has ready access to primary process and the unconscious through their artwork and art practice (Freud, 1922). The practicing artist/creative understands the process of creation and almost at will through personal, creative rituals calls upon or induces the id, therefore entering the unconscious state. The artist/creative handily can delve into the preconscious, pre-contemplative stage and create, moving freely within each stage present in most models of creativity. The artist/creative, if trained, then can move into the conscious stage of creation, where the final stages of sublimation generally take place (Stamm, 1967). The conscious state is where training, skills, and refined images emerge to complete the process of sublimation. Stamm (1967)

outlined the final stages of sublimation as verification and reevaluation of the art product. In the final stage, the artist/creative produces the artwork or action to be witnessed for sublimation to be realized and completed.

While creativity is at the heart of matter, Stamm (1967) described the sublimation process as an open process that every artist/creative views and engages in differently. In fact, artists or creatives often alter their creative practices from time to time. All the stages may be evidenced in the artistic process, but the order might change according to the individual. Even the individual may change their own process over time guided by internal drives and external factors. These variations are often due to practical, real-world issues, such as available materials and location changes. Artists and creatives often receive inspiration or motivation to create, as Stamm (1975) argued, but respond uniquely. Each individual artist may have a personal ritual, a creative process that places them in their zone of creativity. The mature artist/creative generally has honed the creative process through many years of practice, understanding how to summon and harness the impulse to create.

As Todd Lubart (2001) noted in *Models of the Creative Process: Past, Present and Future*, the creative process according to some theorists is defined in four stages that include (a) preparation or pre-contemplative, (b) incubation, (c) illumination, and (d) verification; however, many argue the order of each phase and the notion of linear sequencing is not exact. Guilford, (1950) however, was not satisfied by the four-stage description of the creative process. Guilford (1950) felt the four-stage analysis was superficial and identified only limited, certain abilities involved in the creative process. Guilford (1950) noted that sensitivity to problems, as well as “mental fluency” and

flexibility, were essential to the creative process. Guilford (1950) also rated highly the ability to reorganize, deal with complexity, and reevaluate as key elements in the creative process. As Lubart (2001) noted, very little is known about the mental operations that actually occur within each artist.

As a practicing artist, creative, and art therapist, I set out in this dissertation to add insight to this process through my own process and the creative impulse. I regard the pre-contemplative stage of primary process as essential to my art practice. While both the primary process and the pre-contemplative stages of creativity are elusive, the artwork, symbols and sketches created during those phases are be considered in this study, since they form the inspiration for my artwork. The pre-contemplative stage for me proves to be most intangible and creative. It is a dreamlike phase, often occurring in the unconscious zone, yet it is there to be mined and explored. In an artist's or creative's work, primary process is easier to document, since it is often visible in the creative act or artwork as the stages of creation progress. Primary process embodies the rawness and primitive manipulation of materials utilized in the artwork. It is the untamed, aggressive, and sometimes the childlike expression in the artwork which many artists keep hidden from public view.

Poincare (1985) noted that the creative process seems to start with the conscious work or a problem or issue. I understand this as part of my own creative process. I feel this is part of every creative endeavor which starts with surrounding myself with a variety of materials in the studio. Additionally, I feel this is essential to my creative process as I have come to know it throughout the years, since it generally begins with the manipulation of materials, leading to images accessed from the unconscious. An

intractability or similarity between objects and or people usually catches my attention, leading to questions that need answers. Again, creativity, as Poincare (1985) expressed, is generally initiated by a question or problem that needs to be resolved. Yet, it can also begin with a curiosity to create, which shortly is followed by a problem. Skill and conscious thought involving *secondary process* then enters the picture. The problem can even be as simple as material usage or control, which can lead to discovery and eventually skill development or training, if needed. For the artist/creative, whether it concerns materials or image making, the art process sets up problems in method and procedure that push the creative into complete immersion in the art-making process. This process often involves the creative losing control, toggling between primary and secondary process.

As artist and art therapist, I agree that the real healing takes place as part of the process of creating art—not only in the final art product. Stamm (1967) and Kramer (1987) noted the process and whatever healing takes place is not necessarily the only element necessary to achieve sublimation. Sublimation and its achievement reach far beyond the creative process of making artwork or an action. They reside in the witnessing of the artwork in a form that communicates in a socially acceptable means (exhibition) to an audience even of one.

As Guilford (1950) reminded us, the theories concerning creativity and the creative process need to specify in much greater detail how the subprocesses can be identified to support the creative process. Guilford (1950) believed identification of the subprocesses should be at the heart of any creative model. I am doubtful that this identification is possible by the observer or the critic. It is at best a process that the artist

is most equipped to engage in; however, it requires the artist to be self-aware and reflective. Guilford (1950) felt that models of creativity are different between a creative project and a non-creative project, and the distinction between the two would be helpful in developing a model for the creative process, solely. Guilford (1950) also differentiated between the effectiveness in healing/resolution outcomes of handiwork/crafts and fine arts.

Lubart (2001) felt that even if creative and non-creative projects are defined and separated, creativity training or procedures may still not be easily taught. It might be an innate process, a conscious journey only truly available to some individuals. Generally, people may be able to master specific skills, but they may not be able to combine these skills in a creative manner when working on a task. Stamm (1975) believed that innate creativity is an essential element in the creative process. Stamm (1975) attested that creativity may be innate to some degree in all of us, but it is not a learned skill. Ultimately, creativity can be fostered, natured, and developed, but not learned.

Even roughly a century ago, Harlow (1868) and Wallas (1926) suggested that creativity had four components: preparation, incubation, illumination, and verification. In the first stage, preparation, an artist acquires the skills and knowledge that allows him or her to create the (art) work. While many try to define the models of creativity, this particular model does not leave a space for the process of the sublimation and primary process. This model is rigid, which is not congruent with my personal experiences, findings, and discoveries as a practicing artist and creative. Stamm (1975), a proponent of other supported theories, believed that creativity is an individual, fluid process initiated by the id in primary process. Wallas's model does not allow or acknowledge that

creativity is rooted as Kramer (1987) and Stamm (1975) believed in primary process and the pre-contemplative stage. Rigidity does not resemble what I found through my interviewing process or my own creative process, which revealed that creativity moves in a fluid manner between primary and secondary process. This has been my experience as both an artist and art therapist. Secondary process is integral in achieving sublimation, since it is the process of refining the artwork in a socially acceptable, admirable form or image. Secondary process is not always required in a creative work or act, but it is necessary for achieving sublimation, according to Kramer and Stamm (1975).

While sublimation requires both a witness and integration of secondary process, its strength rests in accessing the id and primary process by the artist/creative. Wallas (1926) designated the incubation phase as the subconscious stage, placing it as the second stage and the preparation stage as the first stage. The pre-contemplative stage, which Stamm (1975) believed weighs heavily in any model of creation, it seems to have a minor position in Wallas's concept of creativity. Wallas relied heavily on skill and preparation, which conflicts with Stamm's (1975) point of view and certainly is not necessary according to Kramer (1987). Kramer believed that skill is not necessary to engage in the process of art therapy or creativity, but access to primary process is vital.

Stamm (1975) remarked that the cornerstone of the creative process for each artist lies in their access to the preconscious state and in the ease and fluidity with which they are able to move through the preconscious to the conscious and back again. With ease the artist moves through primary process and into secondary process where the ego exists, and artistic refinement and skill can be employed to achieve sublimation. As Stamm (1975) described, the artistic or creative process is not only available to the trained artist,

but it is inborn in the naturally creative. However, an important phase, according to Stamm (1975), is the pre-contemplative stage. This stage is essential for the creative process to prevail. It is the artistic gateway, according to Stamm (1975), to primary process a stage which is easily accessible to the true creative. Stamm's (1975) findings support that this phase lasts longer in the artist/creative, existing mostly as a precursor to the contemplative stage; however, these stages do not always move forward in a linear progression. The artist/creative moves with great ease between the stages both consciously and unconsciously, marking the major distinction between the creative and non-creative.

As an artist and a longtime creative, I have personally linked my periods of severe trauma to phases of great creative output. These periods of creativity straddled the stages of creativity with great fluidity. The creative process for me is ultimately plastic and fluid. The creative process and witnessing (exhibitions) led me to achieve sublimation outside the bounds of therapy, culminating in a greater personal understanding and resolution of my trauma. It opened up a sense of healing and transformation, especially when shared and exhibited. I believed sublimation was achieved through the acceptance and ultimately the exhibition of the artwork, which included telling my story verbally and through an artist statement. My trauma was witnessed by others and shared personally with some. My trauma, at times physical and at times emotional, was somewhat resolved and healed through an awareness that my voice was heard, supported, and widely exhibited—witnessed. Yet, as all creatives and artists generally understand, the creative process is inherently personal and creates a sense of healing and sustainability. It needs to be inner driven. In addition, I align with Stamm (1967) and Kramer (1987) in the belief

that creativity alone does not support sublimation. Sublimation, to be complete, must be witnessed, documented, and shared, if possible. The witnessing and public recognition must be realized by the artist/creative to complete and achieve sublimation.

Primary process is separate from the ego; it is raw, permitting uninhibited expression of the id. Arguably, primary process is our most expressive, direct expression of creativity. It is the creative impulse manifesting the sublime in the artwork. Creatives/artists engage less in secondary process behaviors during a creative session, largely relying on the free flow of the psyche during this process phase. Stamm (1975) explained that artists do not necessarily choose primary or secondary processes; rather, artists/creatives naturally create within the space allowable by primary process within a naturally organic method. The artist/creative resides within the creative process continuum, bouncing fluidly through each stage, but relying mostly on primary process.

As the debate concerning creativity and sublimation unfolds, factors such as stress, trauma, and craft/skill are essential elements necessary for sublimation to even be considered as an outcome manifested in the art product. Stamm (1975) recounted the continuing debate regarding sublimation and how it does not necessarily connect to creativity. In fact, there is often a misuse of the term *creativity* and a misunderstanding of what really makes up the elements of a true artist/creative, according to Stamm (1975).

Stamm (1967) imparted that sublimation can occur after a period of creativity when actually the artist/creative has left the primary process (id) and moves into secondary process (ego). This allows the artist to create and complete their work. The secondary process phase permits the artist/creative to utilize their learned/trained skills to achieve universal appeal and conform as an art form. Primary process allows for the raw,

creative energy required to complete the acclaimed, socially relatable artwork to transform. In the secondary process, the artist now actually can approach sublimation while working within the realm of the conscious in tandem with the unconscious. The artist/creative is now in sync with reality connecting to their innate skill and training as they move in and out of primary process accessing the id.

According to Robbins (1987), artists have liberal access to primary process, especially if object relations has not occurred and proper connections have not been created with people and places (p. 50). With an artist/creative, when this connection is severed or not completed, sublimation (artwork/expression of the highest order) can occur, but it is necessary for the artwork to be witnessed; however, under severe trauma according to Kramer (1987) a therapist may be present.

Stamm (1967) reviewed other concepts concerning the source of creativity and its relationship to sublimation. Mainly, creativity does not represent a true sublimation. For sublimation to occur, trauma must be present. For our purposes, *trauma* is defined as the daily physical or emotional trauma of the health-care professional. Foor the purposes of this study, cognitive and/or neurological impairments are excluded as a measure of trauma. Image making and creative impulses in those cases can often be distorted and not necessarily driven by the individual’s creative drives. Creativity primarily is based on many factors which can only be understood in the individual’s process, since the creative process defies universal definitions and analysis.

Stamm (1967) gave a thought-provoking overview of the themes regarding sublimation and creativity and their relationship to the creative process and to sublimation. It is critical to consider artists both individually and collectively to

determine if sublimation has occurred. Healing and achieving sublimation are beyond being the object of trauma; they require innate creativity and skill. They must be accompanied by a catharsis which embodies either a conscious or unconscious reflective inner process or a combination.

I agree with Stamm (1967) on his view concerning the departure and the divide between sublimation and creativity. They can exist independently. In fact, both processes can occur in the artist/creative and the non-artist/non-creative separately or together. Sublimation, according to Stamm (1967), can arise for both the artist/creative and the non-artist/non-creative, but in each case, it needs to be proceeded by some type of trauma. For the clinician/artist in health care, work can provide that trauma or stress which can often reactivate past trauma. I have witnessed publicly the on-the-job trauma that the health-care worker experiences daily. This trauma has accelerated greatly throughout the pandemic. The trauma that Stamm (1967) described does not necessarily require a severe or documented ordeal; in fact, it can occur through improper object relations (bonding) early in life, which can be reactivated during times of severe stress. In situations of stress that the health-care professional experiences, daily, trauma can surface. *Object relations theory* is deep-seated in the understanding and the sensitivity of each developmental level, according to Robbins (1987). Robbins clearly stated that even seemingly minor disruptions in the normal or typical developmental processes/progression of an individual can have serious manifestations in adulthood. The indicators can appear in adulthood accompanied by a wide range of behaviors and maladaptations which, can be exacerbated by periods of extreme stress. Improper connection or bonding to the mother/main caregiver can have effect on shaping the

personality and can set the stage for trauma to take root, especially if the traumatic conditions are recreated later in life. This can be activated by on-the-job stress or trauma that is often part of the health-care profession.

As Robbins (1987) related, the basis for object relations is within the mother and child and the struggle with separateness and sameness, individuation and differentiation. He explained: “The child proceeds through the sub-phases of hatching, practicing and rapprochement completes the picture relating the child’s growth—from symbiosis to separation and individuation—culminating in achieving an identity and object consistency” (p. 56). The act of making art serves to heal wounds that are caused by any shortcomings in the performance of these tasks in childhood. The initial bonding phase is fragile and can be altered by illness/hospitalization of child or parent or even such ordinary parental separations due to the normal steps of going to school. This can trigger trauma, which may be rooted in incomplete object relations. Many doctors and health professionals find during medical residency/internships they are isolated, living away from their families in lonely on-call rooms. Sometimes alone in a foreign country, they find that separation issues or incomplete bonding scenarios are often re-enacted from their childhoods, exposing a past trauma.

Object relations in an individual can be disrupted by something relatively minor and ordinary, such as separation from parent(s) or sibling(s) due to illness, which can befall even the most seemingly typical family. This circumstance occurred in my life during the ages 8 through 12, a developmentally critical maturation stage in the life of a child. This type of trauma may not even be recorded as psychic trauma, yet it can be embedded in the psyche registering as abandonment that can often be triggered in the

course of everyday life. A cathartic release can come through the art-making process in the form of sublimation, even for the non-artist/non-creative. In both the artist/creative and the non-artist/non-creative, sublimation is expressed as a universally, socially acceptable artform or creative expression, but the process of creating is essential. The artist/creative's expression is fueled by their innate creativity, often coupled with skill and training, producing a learned or even a proficient, primitive creative product, reaching a larger audience. The non-artist/non-creative's artwork or creative expression many never achieve acclaim or be publicly viewed, enjoyed by the masses, but sublimation can possibly be attained if it is witnessed even by oneself. Generally, the sublimation process requires beholding by another, not just the creator. It can successfully be witnessed by a therapist or anyone. This is adequate to complete the sublimation process.

Trauma manifests itself in incomplete object relations, which often leaves the subject experiencing conflict existing in a space of ambiguity and tension. Health care is rife with ambiguity and tension. As Robbins (1987) related, "patients have not resolved the dilemma between good and bad existing side by side in one space" (p. 88). Further, according to Robbins, "All that is good and nurturing remains on the outside, while their bad hunger and greed stay on the inside" (p. 87). As Robbins affirmed, art materials lend themselves by nature to transformation and new solutions. The art therapist is challenged to provide an art experience that makes the transition possible with the goal of keeping the therapeutic space alive (Robbins, 1987). According to Stamm (1975), an artist without severe trauma can accomplish sublimation without the assistance of a therapist; Kramer (1987) agreed but added that the work must be witnessed. Robbins further stated

that art-making is at the heart of the healing and a path to achieving sublimations through creativity: “Canned solutions related to each developmental level cannot hope to address issues of such complexity” (p. 25). The work needs to be original not derived from a kit. For severe trauma, the healing is contingent upon the “art therapist’s artistry—in using a conscious symbolic awareness of the patient’s artwork and the relationship—to keep the therapeutic process moving” (Robbins, 1987, p. 65). Winnicott’s (1971) conceptualization of creativity and play helped tie together the threads of developmental theories and the use of art as a therapeutic technique. Winnicott (1971) approached these relationships from the vantage point of how individuals handle inner and outer space and ambiguity and the tension of the unknown. This type of tension often appears during the typical workday of a health-care professional. In medicine, uncertainty and pressure between the known and the unknown are a large part of the job. Also, family relationships through caring for patients are played out day in and day out, giving way to incomplete object relations and countertransference.

Robbins (1987) saw creativity as within the context of human development and as a way to heal. Winnicott (1971) believed play is essential, since it is the gateway to creativity and the element deemed essential in the process of sublimation. As Robbins (1987) explained,

> An art experience seems to be an ideal form in which to understand the complicated interconnections of creativity, development, object relation’s pathology, and treatment technique. The nonverbal image captures the inexplicable essences of our past relationships, at the same time that it gives them shape and meaning to the present. (Robbins, 1987, p. 87)

Robbins offered the view that with the arts there is a constant possibility of the integration of opposites, as well as a synthesis of primary and secondary process drawing on man's innate creativity to fuel the process.

In *Childhood and Art Therapy*, Kramer (1987), took a clinical approach, applying the tenets of art therapy to sublimation. Kramer, an early pioneer in the field of art therapy in the United States, outlined her support of the principle of sublimation, noting both how and when it occurs. Kramer felt that sublimation was essentially an individual process, unique and different for all. Kramer continued that sublimation, including both process and art product, were available to all, even without the intervention of an art therapist. Even though Kramer cited sublimation as the primary responsibility of the client to achieve, she believed it does not have to be a solitary act. In fact, if the client does not present with the necessary ego strength to engage in the process and ultimately achieve sublimation, the therapist or a supportive individual can join the client to support the ego. An individual with proper support—not necessarily that of an art therapist—can safely move toward sublimation in hopes of integrating the id with ego by lessening aggression and primal actions of the id.

Achieving sublimation, according to Kramer (1987), is often limited to the time it occurs. This refers to the session and/or the realization of the piece (artwork). Sublimation at least initially requires reinforcement until the ego and the id integrate the process at least partially (full integration may destroy the creative process). She explained: "True sublimation is more about the unresolved and untamed id than heightened creativity" (p. 29). This continues along with Freud's (1922) original definition of sublimation as involving essentially a de-libidinization and de-aggression of

one's instinctual drives. Kramer cautioned to not always equate creativity with sublimation. Stamm (1975) countered the motives for creativity and the creative process derive their strength from primitive, un-neutralized, aggressive, and libidinal forces. Kramer stated sublimation is not a simple task: "it embraces a multitude of mechanisms including: energy drive, identification, displacement, symbolism, neutralization, and integration." Sublimation is a process that is launched by and linked to urges and tensions that are set into motion by primal and aggressive drives. As a defense mechanism, sublimation relies on the ego to temper the impulses of the id in hopes of creating a socially acceptable art form, process, or action. The artwork (product/action) does not necessarily need to be accepted or liked but requires a form that is socially appropriate and notable. The process is not dependent on creativity, yet it requires a level of mental capacity for refinement and it cannot be accomplished by clients in a psychotic state or with diminished capacity. As mentioned, the therapist or a supportive individual can join with some clients of diminished capacity. In certain circumstances, if they successfully connect, sublimation can be prompted then achieved.

Kramer (1987) believed that sublimation cannot be simplified, and oversimplification must be avoided. Art and sublimation are not identical, which Kramer stressed, just as creativity is not necessarily a part of sublimation. Kramer cautioned that premature sublimation can be as destructive as failure. Even though it is the responsibility generally of the client to complete this process, Kramer believed a therapist or a supportive individual must first acknowledge and support that sublimation is a viable route for healing and essential for emotional health. Sublimation is best assessed through observation and interaction with the individual.

Stamm's (1967) separation between creativity and sublimation also included an additional argument that creates a fuller view of the processes involved in creativity. According to Stamm (1967), sublimation of the synergies are also entangled in the progression and final creative work of art or act. To further establish his point of view, Stamm (1967) cited several acclaimed artists, including Michelangelo and DaVinci, as achieving both creativity and sublimation. Stamm's (1967) illustrations marked an awareness of sublimation and a link to both creativity and the artist/creative's innate nature coupled with skill.

Stamm (1975) claimed that artists/creatives are largely driven by an innate need to create mostly driven by primary process and the id. The artist/creative accesses primal, primary process behaviors or inclinations, directly. They unconsciously work toward achieving sublimation as they balance it with secondary process behaviors to complete the artwork or creative act to attain sublimation. Stamm's (1967) central point is that creativity alone does not represent true sublimation. Creativity is the initial spark to access primary process and begin the process of sublimation. The final journey and completion are dependent on an external audience/witness to complete the act. Creativity alone does not constitute healing and self-actualization. I am in accordance with Stamm (1967) and some art therapists who believe that the process of sublimation through the visual arts requires a community, audience, or witness to be complete.

As Stamm (1967) related, the term *sublimation* should be reserved for a final product or action; I agree with this assessment. Sublimation is the outgrowth of trauma followed by an acceptable formation or act that is witnessed by others. The creation is initiated through psychic tension (past trauma) that motivates the individual to create,

therefore providing needed conflict to create. The artist/creative is compelled through the medium to wrestle with the ambiguity, learning to tolerate the gray area that exists between the inner and outer world. Finally, creativity is influenced by many factors and must be observed, regarded individually. For the artist/creative, these factors or conditions are largely part of the pre-conscious state. The art-making process generally lives in the pre-conscious state before action is originated by the artist/creative.

Kramer's (1987) and Stamm's (1967) viewpoints and ideas are derived from different perspectives, one which is clinically based and the other which is steeped in observing creative process. However, the nature of creativity and the act of sublimation share a common ground that the responsibility for sublimation rests with the client—the artist/creative. Generally, there is more agreement than disagreement between Stamm (1967) and Kramer. Kramer and Stamm (2003) believed that creativity is not a necessary element for sublimation to occur, yet creativity can play a principal role in the sublimation process for recognized, noted artistic masters and creatives. However, "great and notable" works of art do not necessarily require earlier trauma or for the sublimation process to be achieved. They can stand on their own as masterpieces.

Sublimation occurs as an action that is an outgrowth of trauma and a primary process function; trauma is a critical element in the process of sublimation. However, according to Robbins (1987), trauma is loosely defined within object relations theory. It is mutually agreed upon by Kramer (1987) and Stamm (1967) that prior trauma, either physical or emotional, must exist to complete the process of sublimation, and for it to be a true sublimation. Primary process, according to Kramer and Stamm (1967), is also a stage needed for sublimation to occur. The naturally creative individual or artist with or

without trauma according to Stamm (1967) is adept at accessing primary process. Kramer did not argue this point, since Kramer's work as clinician and educator does not address creativity or the innately creative artist/creative. Kramer's viewpoint is that trauma brings forth in the ordinary individual an opportunity to directly access primary process. Freud (1922) noted that this practice is a defense mechanism employed by the individual to protect the individual's psyche from the direct horror of the trauma. This process is often described by Freud (1922) and others as a "regression in support of the ego" (p. 137).

The typical client, as Kramer (1987) discussed, is only after trauma (physical, emotional/developmental, or neurological) able to create and experience sublimation and achieve it. According to Kramer, this usually occurs if witnessed and supported by a therapist. Kramer essentially saw the process of sublimation as a clinical, therapeutic process, yet one that is open to community engagement outside of the therapeutic setting. The opposing viewpoint, which is mainly espoused by Stamm (1967), is that true sublimation can exist outside of the clinical, therapeutic relationship. In fact, the critical element needed is creativity and unbridled access to primary process which is the true epicenter of creativity. Kramer was in agreement with Stamm (1967) that sublimation can occur without a therapist present, if the trauma is not severe. The main difference is the natural creative or the artist possesses a level of control to move freely between primary and secondary process. The movement between primary and secondary process provides the conduit to create on some level an acclaimed work or noted action/performance for the audience.

Stamm (1967) did not address sublimation as a process in art therapy, since this was clearly not his area. Stamm (1967) cited "famous and well-known artists," including

Michelangelo and Rodin, as proof of sublimation. Extending the meaning of trauma, Stamm (1967) related that suffering within the normal or typical range is enough to establish "trauma." This differs greatly from the view of Kramer (1987) and the clinical definition of trauma, yet aligns with Robbins's object relations theory. Stamm's (1967) belief is that sublime, universally acceptable artwork can be produced without earlier clinically identified trauma. This sets up the divergence that exists between the creative and clinical realms in regard to sublimation. Its distinction between a sublime work of art and/or action/performance and the process of sublimation is based upon different measures.

Kramer (1987) and Stamm (1967), while from different disciplines, tend to overlap in key areas, yet in areas that concern their respective fields they lean toward their chosen fields to govern their perspective. Kramer addressed the basic profile and history of her clients as an important distinction to note regarding therapy and the therapeutic process, yet she clearly acknowledged the role that heightened creativity played in the process of sublimation. The foremost intersections between Kramer and Stamm (1967) are that creativity is an individual process that can exist independently from sublimation. While they described it differently, Kramer and Stamm (1967) agreed that the process and realization of sublimation involve primary process. Kramer approached this topic by differentiating between the relationship of the id and the ego in explaining the tension involved in the process of sublimation. Creativity materializes within the movement between the preconscious and the conscious—the shift from primary process to secondary process. Kramer and Stamm (1967) both understood that primary process is readily available to the creative or the artist. Concurring, Kramer and

Stamm (1967) believed that true sublimation entails producing a socially acceptable outcome, work of art, or act. Kramer and Stamm (1967) adhered to a strict definition of the defining act or outcome as a work of art or creative expression finalized and universally accepted to brand it as sublimation. The creative work is integral to the process and expression of sublimation, and both Kramer and Stamm (1967) agreed that witnessing is essential to the process.

Sublimation is a complicated process mitigated by many factors that are realized through integration of the psyche by modulation of primary and secondary process. The primary process and secondary process are both fluid and can be transitory during therapy within the creative practice throughout the lifetime of a client or of an artist/creative. While Kramer (1987) and Stamm (1967) agreed on the major principles involved in the sublimation process, one clear distinction is that Kramer believed that a supportive therapist who embraces the concept of sublimation is a needed component in cases of severe trauma. While I agree this certainly is part of the sublimation process, I do not think it is always necessary, unless clinically indicated. I do believe heightened creativity, which includes fluidity between primary and secondary process, is essential for the process of sublimation to occur. Therapy, a useful tool, is not always required to achieve sublimation and influence healing. Sublimation, in my view, rests on the individual trusting their creativity and their personal artistic/creative practice and sharing their work.

Chapter 3

METHODOLOGY: GETTING TO KNOW YOUR SUBJECTS

This chapter outlines the research process and the methodology used in this dissertation. Relying on the naturalistic case study approach, this dissertation attempts to "unravel the complexity and particular details of a certain topic of study" (Abma & Stake 2014, p. 1150). This dissertation favors a method addressed by Abma and Stake (2014) in "Science of the Particular: An Advocacy of Naturalistic Case Study in Health Research." It considers at its heart a multi-layered contextual view regarding the subject(s) from a humanistic, holistic perspective (Abma & Stake, 2014). This method relies on interviews and observations with attention to the subject's environment.

With careful attention to detail, Abma and Stake (2014) encouraged periodic check-ins to provide a view otherwise unavailable in traditional quantitative studies. The science of the particular additionally looks to identify general and universal patterns of behavior and experience through the process of the naturalistic case study with a preference for "natural conversations and participant observations above data generated from response instruments devised by the researcher, such as tests or clinical interviews" (Abma & Stake, 2014, p. 1150). This interpretive approach to inquiry also relies on observations and interviews to assist in revealing details not available through quantitative studies alone (Morehouse, 2012). Morehouse (2012) contended it is essential to integrate the observer/researcher into the world of subject. Through this method, the researcher attempts to gain direct knowledge of the subject's world by gathering patterns both general and universal. The process of including the role of the researcher in this dissertation was a strategy that served this dissertation well. It was a natural fit, since as

the researcher I am both an artist and clinician with direct health-care experience for over the past 30 years. This approach assists the researcher through alignment, access, and trust with the subjects. An interpretive perspective as regarded by Morehouse views the subject and the observer as situated in a practice or activity within a lived world.

Morehouse (2012) explained that "Interpretative inquiry strives to understand the constructive, dynamic and culturally embedded ways that people act as they organize or pattern activities" (p. 26). Morehouse further asserted that the "task of interpretative inquiry is to detect and describe patterns of variability and to propose models to account for data patterns that reflect both stability and variability" (p. 26). Data analysis is a reflective process according to Meide et al (2018) that can be understood as "thinking movements" leading to lived experiences; composing textual portrayals, phenomenological thematization; reflective writing (p. 3). Morehouse viewed data analysis as a process that simultaneously occurs during the data collection process.

The qualitative case study approach provides details outlining similarities and obstacles within an area of study. The goal is to grasp the meaning of the experience to provide a holistic view of the participant's world (Gadamer, 1975). According to Abma and Stake (2014), as a gateway to understanding the participant, the conversation is the foundation of this holistic approach, to which they referred as the "dialogical engagement" (p. 1152). Mainly, the conversation is necessary to understand the case and "generate an account that is faithful to the complexity and meanings of the case" (Abma & Stake 2014, p. 1151). Additionally, the data acquired can later assist an organization in developing policies specific to the areas being studied, serving as an operational resource for implementing change and creating programming. It can also be a launching point for

further studies. Its usefulness is in educating policy makers by supplying necessary details and guidance to incorporate needed, meaningful change.

Additionally, this chapter offers information regarding the methods that were employed in undertaking this research, including individual art therapy sessions for each participant. The art therapy sessions were designed to uncover both conscious and unconscious, verbal and non-verbal elements locked inside of each participant. Art therapy seeks to uncover veiled meanings and metaphors by incorporating a holistic approach that is attentive to both the process and product. In defining a *holistic understanding*, Morehouse (2012) explained: “Holistic understanding implies we are not satisfied with a list of unrelated, decontextualized issues” (p. 36). In conducting this study, I sought to preserve a holistic perspective by regarding mind, body, and spirit; this approach was strongly supported by the art therapy sessions. Art therapy supports the participant as a witness, allowing them to tell their story (visually and verbally) through both process and product. Morehouse believed the orientation toward interpretative inquiry emphasizes understanding process over product. This is a key tenet in art therapy. Naturalistic case research includes a variety of perspectives in their study of a particular case according to Morehouse. Additionally, “The decision to include multiple perspectives derives from the ontological notion that reality is constructed, and that experiences gain different meanings in context of different biographies, disciplinary frameworks, and positions” (Morehouse, 2012, p. 25). Morehouse further stated that to achieve a holistic approach, “we rely on ourselves as instruments; watching, listening, questioning, probing and interpreting the case” (p. 32).

Finally, this chapter concludes with a discussion of validity and reliability of the qualitative research in this study and if the two were met.

Qualitative Approach

Over a period of about 14 months, I observed and interviewed in person four clinicians/artists in their "studio" settings, offices, and homes, relying on Zoom for only one participant due to distance. I conducted qualitative research using a conversational interview style, allowing for the open-ended nature of the questions defined by the topic under investigation to provide opportunities for both interviewer and interviewee to discuss some of the topics in more detail. In some instances, I let the interviewee guide the process. McNamara (1999) explained: "Interviews are particularly useful for getting the story behind a participant's experiences. The interviewer can pursue in-depth information around the topic. Interviews may be useful as follow-up to certain respondents to further investigate their responses."

I initially relied on standardized, open-ended interview questions, allowing participants to share some basic information and settle into the process. The core questions were then followed by an informal, conversational interview in which no predetermined questions were asked. This allowed me to remain as open and adaptable as possible to each interviewee's nature and priorities. To be open to the process, according to Morehouse (2012), for the design to be effective the questions must open ended and flexible. In *interpretive inquiry*, the methods tend to be conducted in "messy situations," leaving the researcher to explore multiple facts of a case. It will include "social interactions directed toward developing a profile that is constructed, but modified through

engagement with participants in a co-creative approach (Schoenfeld, 2009, p. 195). Morehouse referred to this as *evolving design* (p. 50).

Recruitment and Selection of Participants

Using the *convenience sampling method*, also known as *haphazard sampling* or *accidental sampling*, participants were chosen from the medical field who were also making art for at least 5 years and were maintaining a clinical practice for at least 10 years. However, following the protocol of Etikan et al. (2016), this study also relied on *homogeneous sampling* as a subset of the *convenience sampling method*, since specific criteria, such as position in the health-care field, years of service, and art practice, were essential to the core questions of the study. I recruited participants directly or pursued referrals from colleagues in the field, selecting a limited cross section of various members of the health professions. This process proved effective, since as both a clinician and artist myself for over 30 years I had access and many contacts. The basic criteria for selection rested on two main areas: (a) 10 years or more of direct patient care (b) engaged in a creative arts practice for at least 5 of those years. Participants did not have to be artists or consider themselves to be artists prior to taking on their clinical roles; however, development as an artist during clinical practice was essential for at least a period of five years. The total number of participants of the study was limited to five, including myself. The next chapter presents the characteristics of these study participants that I studied, following a singular case study approach to each participant.

Data Collection

My having a unique perspective on medical administration, clinical practice, and the rigors of caregiving on both a professional level and a personal level played a large

part in the participants' willingness to welcome me into their worlds. The interview process began with the psychiatrist. As with all the selected clinician/artists, and in line with the IRB, they requested their names and location identifiers be withheld in respect for their clients/patients. Some of the artwork and exchanges referenced general, basic aspects of their cases. Identifying details have been omitted. While the initial interviews were taken in order noted and for the most part formal and structured, subsequent contacts and exchanges were guided by wherever our conversations led or when I or the clinician/artist felt was a good time to check in. Our interactions became organic and familiar, leading to rich, rewarding discourses on art, creativity, health care, and life, as well as our personal concerns and relationships as we were all striving for integration and balance in life.

My data collection process involved summarizing each of the participants' interviews while noting and recording specific quotes by the participants. A qualitative research interview seeks to cover both a factual and a meaning level, though it is usually more difficult to interview on a meaning level (Kvale, 1996). The art therapy sessions for each participant sought to reach for that deeper level of meaning. Primarily, my candid, open approach and willingness to share my work, feelings, process, and professional issues in both fields created a space where a mutual, collegial exchange took root and genuine sharing occurred. Our exchanges and "drop-in" sessions continued well after the official interviewing period ended.

There were three formal on-site/studio interviews for each artist, including the art therapy session. For each artist, there were approximately six observations and check-ins, generally less formal. These methods were the main data collection techniques for this

study. One clinician/artist, due to extreme distance, required Zoom meetings; otherwise, formal interviews and observations were in person. Secondary data sources included documents/artwork review provided by participants that pertained to the study. In addition, individual art therapy sessions that I facilitated with each participant were conducted as a concluding interview/meeting. During the session each participant was asked to respond to my directive and create an art piece that reflected our process and journey, together. Additionally, I created a response art piece. I responded to the entire process, which I included in the data collection as well.

Initially, interviews were conducted based on the core questions listed in the following paragraph. However, participants were allowed the freedom to talk about their experiences in a way in which they were comfortable following or while I asked the core questions. Participants were also informed of the following concerning the interview process: Interviews were confidential and would last approximately 1 hour in person or via Zoom. I would also be taking notes during the interview.

All participants were asked the following core questions:

1. How long have you been practicing?
2. How many years in direct patient care?
3. Are you currently providing direct patient care?
4. What type of art you engaged in?
5. When did you begin your creating art?

The procedure began formally by interviewing participants using five core questions and then relying on the snowball method of interviewing. After the set questions were answered, participants were invited to share any other reflections they felt

were relevant. In most cases, a lively conversation ensued as I shared my background, setting the groundwork for collegial dialogues to develop with deep sharing. The qualitative research interview seeks to understand and then describe the meaning of the central themes in the life and world of the subjects. The main task in interviewing is to understand the meaning of what the interviewees say (Kvale, 1996).

The interviews were followed with frequent check-ins. During the check-ins, I would offer insights gained through the process so far, plus the names of the many useful references that were foundational to this dissertation. This provided a conversational, collegial atmosphere of sharing, offering the participants a view of their work within a larger context. When possible, I attended showings of their work or visited their "studios" for updates and additional observations. With some of the clinician/artists I was even able to shadow their primary health-care work environments, observing directly stolen creative moments and their unusual studio space. I often witnessed the participants creating artwork on work breaks during downtimes whenever possible in their ad-hoc studio spaces. Initially, they were reluctant to share. Artists, in general, are very frequently protective of their creative process, often viewing their studio space/time as sacred.

Qualitative Findings

Meide et al. (2018) explained: "The goal of phenomenological analysis is opening up the meanings" (p. 3). It is a reflective process which involves reviewing interviews, notes/observations, artwork. As Meide et al. reported, analysis is a fourfold process including "composing textual portrayals, phenomenological thematization, reflective writing and immersion in lived experiences" (p. 3). Morehouse (2012), when

addressing data analysis, highly recommended a visual approach for all researchers. This process is followed and reviewed later in this dissertation under Findings. Analysis and Discussion.

Ethical Considerations

Confidentially and researcher bias were the main ethical considerations and concerns of this study. The participants, being in the medical field, had both personal and professional considerations regarding privacy. Their concerns were not limited to the patient's rights regarding protected health information (HIPPA), since they participated in art therapy sessions and were the subjects of confidential interviews. The participants sought a guarantee that only I would be privy to the session notes and details concerning their own identity. The study was reviewed and registered with the university's Institutional Review Board (IRB), indicating that I would preserve anonymity exclusively as part of my role as the researcher. Participants were given full disclosure of the study and personally walked through the study parameters and their expected participation requirements. Full confidentiality was assured in their release of information packets, which reinforced that names, images, or locations in any shape or form would not be used unless they specially granted permission. This was also the case regarding the artwork created during the art therapy sessions.

Issues regarding researcher bias, especially in unstructured qualitative interviews, are particularly challenging when personally and professionally the interviewer aligns in many ways with the subjects, as I did. My professional training as a therapist included transference and countertransference, which was particularly useful during this process. I candidly verbalized in the dissertation when I personally felt the lines were beginning

to blur and sought professional supervision as needed, a practice used by many therapists. To guard against this becoming an issue, I approached these interviews as I would a therapy session, knowing full well that there was a strong potential for transference/countertransference. This risk is especially worth noting when the therapist actually can identify specific issues prior to a session that maybe problematic. To head off this potential problem, as I do with any therapy session, I engaged supervision from a consulting therapist to review and discuss the case, as needed. The supervisor signed a business agreement regarding patient/client confidentiality. While I did not consult supervision on a structured basis, I availed myself of the service a few times during the course of the study. It provided the feedback I needed to keep my focus as an interviewer, permitting me fully to discuss conflicts or bias, confidentially.

Quality Criteria

Credibility and reliability in qualitative research using an open, conversational interview rest mainly on the honorability and the truthfulness of the participants. The interviewer additionally plays a significant role in both credibility and reliability, through objectivity in reporting. My approach using interviewing techniques, as well as an art therapy session for each participant, was helpful in assessing credibility of the participants and reliability in their responses. The strategy for this two-step process was to tap conscious thoughts through the interview process, while the individual art therapy sessions were designed to explore the unconscious. By comparing both processes, a general comparison could be made to verify credibility and reliability, individually. Observing the larger context of their working life and the reliability of their responses,

the process was also tested through site visits, including their studios and their professional workplace environments.

Qualitative research using open-ended interviews often raises a few concerns regarding transferability. In this case, the identity and credentials of the interviewer played a significant role in the interview process. My identity as both an artist and a clinician granted me access, providing an immediate bond and a collegial rapport with the participants. I also relied on my skills as an art therapist to probe the unconscious, as well as on my knowledge to advise professionally in many art-related areas. For complete transferability to be achieved, the interviewer needs to align with clinician/artists professionally, as well as have experience and knowledge of both fields. Additionally, the researcher should involve an art therapist to engage the participants in a creative arts therapy session. It is critical for the principal interviewer to be at least an artist, in addition to having some knowledge of the medical field. The interviewer may rely on the subjects to address the workings of their medical careers. The interviewer’s knowledge of the medical field and background as an artist provided the most basic measure needed for effective transferability.

Chapter 4

TRUST THE PROCESS? OR NOT

Whether an artist trusts that process as Shaun McNiff (1998) encouraged and embraced in his seminal book *Trust the Process*, or is simply in the midst of developing their own personal practice, art is a process that grows and develops over time. Developing one's identity as an artist is shaped by the environment and nurtured from within. The participants in this study may have varied medical practices, yet they are looking toward art, attempting to strike a balance between work and home life and express themselves. The clinicians that are the focus of this dissertation for innumerable reasons have embraced the arts as a means not only to cope but also to prevent dis-ease.

The clinician/artists highlighted in this dissertation did not necessarily see themselves as artists. In fact, the clinician/artists in this group often kept their art practice and their artwork a secret even from immediate family and close friends. Actually, the clinician/artists were conscious to carefully avoid sharing their creative endeavors with their patients and colleagues. Conscientiously, they all tended to their creative endeavors with devotion, continued engagement, and great effort. They clearly rise well beyond the narrow definition of what our society dubs as being an artist, often creating in isolation without artistic peer support or even an audience.

Their individual art expressions are distinct and unique from each other in both image and materials. Often creating in diverse, transitory environments at the oddest hours imaginable, they stalwartly continue to produce art while remaining true to caring for their patients as dedicated clinicians. Their materials are sometimes non-traditional, as they utilize medical/office supplies that are random and discarded. Their impulse to

create even during a deadly pandemic prevailed in spite of a lack of time, space, and sleep.

The major common thread surging through and binding this select group together is that they have long-standing careers in health care, accompanied by an artistic practice. They are first and foremost professional caregivers serving on the front lines, balancing professional responsibilities to patients, families of patients, colleagues, and administrators. They must be mindful of and comply with regulations/policies, ethical concerns, and safety—especially with respect to the danger posed by exposure to disease, which heightened during the pandemic. The participants are dedicated and duty bound to serve. Showing up every day, they try to care for themselves and their families as they shoulder the responsibilities that are a part of their professional service in health care. It is a 24/7 job. The four selected clinician/artists embrace the visual arts as a refuge within the complex storm of caregiving as professional caregivers and caregivers for their families.

> Maria: *As a practicing clinician/artist, I am bound to this group in many ways. I have sustained a 30-year career in health-care service as I continued to work as both an artist and a clinician. However, in my particular circumstance, my identity as an artist was fully formed flourishing before I entered health-care service as a practitioner. As an artist and art therapist, I understood the healing properties of art for both myself and my clients. In a larger sense, I was also aware of the healing properties of the arts for the entire health-care community and beyond. As I interviewed my fellow clinician/artists, I swiftly understood that my practice and my sensitivity aligned closely with this group rather than with*

fellow artists and my art world colleagues. The impulse to create, to make sense of the often daunting workloads in health care and the basic human need for self-survival through the pathway of self-care came together for me as an inclusive, non-traditional artist.

Health care as a profession encompasses one's life fully, just as art does when pursued creatively. As a personal practice, art for myself and the selected clinician/artists seemed to coexist with our medical careers, ebbing and flowing throughout our daily lives. Art and medicine compete for our time, begging for balance while they learn from each other. Time demands, limited space, and fatigue are the constant stressors facing the clinician/artist.

Five Clinician/Artists: Setting the Scene

The study participants all self-identify as a clinician and an artist. They include a psychiatrist, a nurse, a social worker and an emergency medical technician (EMT). All have at least ten years' experience as a frontline health-care professional. I will now introduce each participant.

Psychiatrist

The psychiatrist's main responsibility centers on a robust private practice which is located in a discrete extended area of his home with a separate entrance in a pleasant suburban location. Additionally, the psychiatrist is a member of the medical staff at a few local hospitals and medical centers with crisis centers and emergency services. His duties also include emergency room on-call coverage, which included a once-a-month rotation, plus a few committee assignments to set and review policy. The psychiatrist is essentially in a stand-alone solo practice, rarely following patients or clients even if or when they

were admitted to the hospital due to a psychiatric emergency. The patient, once admitted to the psychiatric unit, would then be attended to by the psychiatric staff of the hospital, similar to the practice in many hospital medical units today. Hospitalists employed by the hospital take over the case, consulting with the attending on an as-needed basis, creating a dilemma for both the physician and the patient—a disconnect.

His hospital emergency room privileges are mainly to admit crisis patients, providing an initial assessment. This detachment seems to exacerbate an already tense situation for the psychiatrist, as well as for the patients and their families. The abrupt break in therapy proved jarring for both parties (clinician and client). For mental health providers and therapists, termination of treatment is a discrete process that every mental health provider faces in one form or another. The process immediately starts at the onset of therapy for the clinician to prepare the client for an eventual transition of care. An essential role of the clinician is to prepare the client at least mentally for termination in the early stages of therapy. However, when hospitalization occurs due to a crisis, ending treatment with a specific therapist or mental health clinician, it is keenly felt by all involved parties, even the family of the patient. COVID-19 added a disturbing layer on to the therapeutic relationship between the psychiatrist and his clients. Some patients lost medical care (insurance); new patients were on waiting lists due to excessive demands as a result of isolation and other stressors that the pandemic revealed. Families were now home 24/7, which added layers of stress to everyone's day. Added issues of medication renewals faced the psychiatrist, as did digital access for their clients. Some clients had limited access to secure digital devices, if any. This was a significant factor, since during

the pandemic sessions were and for the most part still are virtual, with some in-office visits having resumed in the fall of 2021.

The psychiatrist has held steady through it all to both his practice of medicine and his art ritual following each patient/client. Taking a step back to our first meeting, the psychiatrist was referred to me by a colleague in the arts and health field who wasn't quite sure of his art practice, but recalled that during his residency he was always "scribbling or doodling something." I was intrigued to learn more, since we shared both fields as mental health practitioners and creatives. The psychiatrist would sketch very elaborate, colorful detailed portraits of each of his clients post session, carefully reflecting feelings and emotions that surfaced during the session. In fact, as the psychiatrist's obsession grew over the years, he allotted additional time between each client/patient to afford more time for the artwork between visits. His process is quite basic and in fact portable. No elaborate studio or space is required—only time—and he savored and pursued with a passion. Originally, the client/patient portraits began during residency with a simple No. 2 pencil or ball-point pen. He sketched on small scraps of paper or tiny notebooks/pads that could easily fit in his lab coat. The renderings even in the early days had depth, detail, and emotional complexity. The insightful expressions of these portrait sketches were evident from the beginning. They were reactions to the sessions, noting mood, transference/countertransference and other elements of a therapy session that resisted written expression. The intangibles of a session that were not easily definable were captured in the portraits. The observations, whether expressed verbally or nonverbally, were often too personal and subjective for the medical records. Expressing confusion and empathy on the part of the psychiatrist, the portraits as they evolved over

the years ranged in size from monotone thumbnail sketches to full color, highly developed, detailed color pencil renderings as large as 11” x 14”.

They were a release for the doctor, a way to unburden, emote without betraying his clients to another to unburden himself. The psychiatrist felt they eased his transition between each patient. They served to create a fresh, clean slate for the next patient.

> Maria: *In fact, this is similar to a method I utilized especially during my time as a private practitioner and caring for many groups during the day. Already having an established art practice, I needed another way to create a healthy boundary between each client and my personal art practice. I consciously employed this process specifically to destress and open my mind to the next patient/client. Between sessions it added a layer of protection for my own practice as a successful, exhibiting fine artist. It turned into my mandala practice. I kept handy a simple, small (5” x 5”) square journal and a few colored pencils in my portable art kit. With pre-drawn circles in the mandala journal, I would immediately begin to create a mandala after each session (individual and group), giving myself 5-10 minutes, sometimes fewer, between clients to create.*

Nurse

The nurse, while her role and responsibilities during her hectic workday at a 600-bed medical center differs in many ways from that of the psychiatrist, is also dedicated health-care professional that embraces art. She is well regarded by her colleagues, receiving many rewards of recognition for her long years of service and care. She is a professional, accomplished nurse with well over 10 years of service and training. Providing mostly direct bedside patient care in a general medical/surgical unit in a

suburban medical center, she has resisted many promotions and transfers in order to remain at the bedside. Her shift usually (7 a.m.-3 p.m.) rarely concludes at the designated time. There always seem to be impediments to leaving on time, such as end-of-shift report, second shift does not report, or a call-out (sick or weather-related emergencies). Holidays and vacations are meteed out on a rotating basis. However, unlike the psychiatrist, when she finally leaves the medical center, her day is through. Exhausted and tired, she does not have to work again until 5 a.m. the next morning.

Her work at the medical center is physically as well as emotionally and mentally demanding. There are no stolen creative art moments while on duty, no breaks or even time for the bathroom or lunch. In fact, lunch is never timely and often on the run, if at all. Bathroom breaks often take a herculean effort. Quick, before the next call bell rings or a code is called. Time is scarce, tension runs high, and the task at hand is the rule of the day, only to be upended by an emergency or crisis. Yet, our nurse finds time to create, share, and display her work even if it is just for family and close friends. She often says, “It’s no big deal—just something I do!”

Bright pastel-colored flowers are the focus of her work, which she believes is an extension of her gardening. She is ambivalent about whether her art practice or her gardening is more rewarding. She tells me she loves them both. She really does not consider herself to be an artist. She chooses to work in watercolor (a medium from her past), which is readily at hand and very portable. She now has a dedicated studio space which she refers to as “my room.” She has some fundamental training in watercolor painting from her college days, having attended a few art courses as her humanities

requirement. She enjoyed the classes very much. She recalls fondly that it gave her a break from the exhausting, tedious nursing classes.

Her delicate pastel flowers are gentle, bright compositions. She told me she likes to keep her art simple. While the paintings lack any sort of complexity, she feels they were welcomed breathers from the rigors of her daily decision making. As a nurse, holding life and death in her hands minute by minute with every procedure or decision, she feels deciding among eight pastels colors is effortless. “No mistakes. No judgments. Only beauty!” she would often say, releasing a deep breath. When asked about this, she replied in a sort of vague, playful way, “I wanted to concentrate on the colorful, pretty parts of the flower really—it is no big deal.” She added that she feels at peace while creating them and she was proud of her knack for painting flowers. She expressed that sharing her artwork is important to her, as is sharing her garden flowers. The nurse’s way of sharing her work is quite practical. She often paints her flowers on greeting cards and bookmarks, distributing them to family and friends. She called them “little gifts/little flowers—favors to brighten their day.”

She often collages dried flowers from her garden into the composition and is quite proud to point this out to all around. While she is not anxious to share with her patients that she is an artist, feeling that it would distract from the care issues at hand for the patient, she would often anonymously hang a small watercolor flower on a patient’s bulletin board to “brighten up the room.” The images she shared with her patients were no larger than 8” x 10” and generally 4” x 6”. She never mentioned it to her colleagues, but they happened to discover her postings. They were happy to play along with her secret.

Maria: *This clinician/artist was the most difficult of the four to interview. While she was very giving and invited me to her home, sharing her garden and her artwork and she is genuinely likeable, she really was evasive and deflected many challenging questions about her career and training, including the care issues and concerns that confronted her daily. Her separation and compartmentalization was quite bewildering, since it was extreme and far beyond what I encountered with the other clinician/artists. I quickly realized that the differences were not so much in our type of artwork or approaches, but in our training as clinicians. While the psychiatrist and I shared similar backgrounds as mental health practitioners with specific training in transference/countertransference including the art of language and emotion, our nurse lived and dealt with the here and now. No grays, no in-betweens.*

In her own way, she successfully processed her emotions through an artistic, therapeutic practice which she carefully protected by keeping it separate and distinct. Quite independent of her nursing career, her flowers (garden and watercolors) were her special place of retreat. She told me the flowers were "her place of comfort and her refuge." She was about bringing beauty into her life and sharing it with others. The horrors and the demands of her daily job were exacerbated during the height of the COVID crisis. She would often say, "Why dwell on that. Life is short . . . way too short."

Maria: *Well, it appeared to me to be the "Scarlett O'Hara" approach to psychic pain, which I rejected on so many levels. As a therapist, I believed in owning our stories moving toward integration as the goal. Initially, I was very critical, feeling*

it was denial. However, I came to appreciate and respect it over time, understanding it was her well-honed coping strategy.

My respect for the nurse and her art practice did not change overnight; it evolved strenuously, taking much work on my part. I came to realize that it was me using a one-dimensional lens to view these selected clinician/artists. While the EMT was also not a mental health professional, his process and career resonated with me. It reminded me of my earlier career as a medical photographer, always attuned to the action in either the emergency or surgery departments often riding in a rig myself. The element of immediacy, intimacy. Every minute adrenaline pumping, life and death palpable. So, for the nurse, there were no continued intimate, personal care issues; our nurse was alone. Her art practice needed a different space and energy. She knew this on a gut level. I needed to step back to allow and respect her process as both an artist and clinician.

Unlike the psychiatrist and the social worker, the nurse lived her life in the practical world, caring for patients and their families, responsible for their most basic needs and bodily functions daily, often in an intimate, personal way. Her world is very different from all of our, yet, she has continued to create to produce art throughout her career. It gives her pleasure, purpose, and identity.

Maria: *Why was I challenging this? I needed to align or at least give her space to create and express herself. I needed to understand her better. I started to bridge the gap by sharing myself as I did with the others despite what I perceived as her causal, flip regard for her artwork or process. I needed to take her process seriously. I realized I had been holding back. After all, she was producing. I*

needed to give her the space and reverence to continue if the process was to be meaningful and parallel to the other clinician/artists, as well as true to myself. I stepped aside and began to trust the process.

From what I observed, her method worked: she was able to sustain a successful career at the bedside while others in her profession certainly have not been able to make that claim.

Maria: *Unlike the nurse's, my own experience for the most part was not black and white. I lived in the grays of feelings and emotions. In fact, I often witnessed recovery, resolution or healing in my clients, even if only in small steps. I often felt I made a difference, by sharing my art with a client or a family, which she did not. She also did not have the indulgence of time and space to work with a patient or to process the many phases and stages of their healing. It was always on to the next new admission.*

The nurse faced a daily routine of orders, schedules and hands-on care that required skill, stamina, and exactness that was critical for the safety and protection of both the patient and the caregiver. The only relief offered to her was the abrupt, immediate transitioning from patient to patient. These are the dictates and demands of her profession.

Social Worker

The social worker also works at a major medical center, yet her daily schedule is less hectic. Largely predictable and manageable within a regular schedule, the social worker's day is unlike the psychiatrist's and the nurse's. The length of her workday and time off for holidays are standard, affording a quality of life that neither the psychiatrist

nor especially the nurse enjoys. The department of social work, where she works within the medical center, largely focuses on discharge planning, with far fewer emergencies then our other clinician/artists face. The social worker has her own office with a standard lunch hour and takes breaks generally as needed. Occasionally, she will indulge in much-needed rejuvenating art breaks during her workday, closing her office door. While she dabbles in many types of crafts, her main area is needlepoint, focusing on vines and floral designs intermingled with uplifting sayings that she feels have sustained her through some of her toughest days. Often, she invites colleagues in for a needed break giving them solace from the hectic, hustle of the nursing floors.

She creates pillows, wall art, and mini-samplers often toting her half-finished samplers between work and home. She is known to bring her handiwork to office meetings with her colleagues (peers and supervisors), crafting throughout the meeting. Due to her longevity as a trusted staff member, her behavior is accepted. She noted that “the artwork keeps her calm.” This is a testament to her sustainability and lengthy career in a high-pressure position. She really does not feel her work is art at all. Yet, she admits it’s beautiful, but not in the same way as a “DaVinci, Michelangelo, or Van Gogh.” She would often screech and laugh when she would say this. I took the opportunity to share my work with her, especially my Healing Quilt series (all hand sewn, crafted from discarded tea bags). She was aware of my status as an artist/art therapist. She wanted to hear more. We discussed how I used sewing in many of my pieces and often extended this option to clients/patients. This conversation surfaced many times as she slowly grasped the concept of fine art, crafts, and art therapy, understanding their similarities and

differences. She was part of the mental health profession and enjoyed her crafting, needlework, very much.

The artwork was mainly embroidered throw pillows and a few framed quotes which were displayed in her office. It was a private area, except for a few colleagues who would visit. This area patients/families never see. The largest grouping of her handiwork was displayed at home, which is open to only close friends and family. Only when they are noticed, she will then talk about her craft, but will never bring them up unsolicited. Here are some of the quotes that were displayed on the pillows and samplers, giving credit to the author.

"Live life to the fullest, and focus on the positive." - Matt Cameron

"He who has a why to live can bear almost any how." - Friedrich Nietzsche

"No one is perfect - that's why pencils have erasers." - Wolfgang Riebe

"It always seems impossible until it is done." - Nelson Mandela

"You are never too old to set another goal or dream a new dream." - Les Brown

"You're braver than you believe, and stronger than you seem, and smarter than you think."- A.A. Milne

After sharing the quotes, she reflected on the power of the written word. Again, the conversation centered on the artistic merits of her artwork and its value. She revealed they possessed a great deal of personal meaning, and that she cherished every piece. Vividly, she was able to recount when she crafted each piece. She clearly recalled her life circumstances and feelings/emotions at the time. She believed using words in her work prohibited it from being true art. She thought crafting and sewing were not a respected art medium in the traditional sense. It was craft, handiwork.

We discussed the use of words in fine art. I noted artists who have incorporated words successfully into their work. I referenced my own recent healing quilt where participants added their own words or saying on to the artwork. I described my piece as more of a community art therapy project. Art therapy seemed to appeal to her and pique her interest. The topics of our talks going forward moved toward therapy as art and how it worked for both the clinician and the client. She was intrigued by the notion of using art and music to heal. Art therapy intuitively made sense to her as a clinician. She felt no longer content to have this split in her life. She thought integration of the arts into her practice could prove beneficial to all.

The social worker, unlike our other clinician/artists, is an active member of her town's historical society (arts group), giving her an annual outlet to display her craft publicly in the annual county fair. This activity she very much enjoys, operating her booth-display and demonstrating her skills for the public. She often donates her work to charity raffles. Art for her is about sharing: "it's like being a good cook—you share with others," she declared.

> Maria: *While we shared similar professional goals, responsibilities, and education/training, connecting with this clinician/artist I found particularly challenging until she moved toward an understanding of art as a way of healing. Originally, I could not connect with her art and her works bland positivity. However, it changed quickly when I shared my background, training, and experiences, particularly as an art therapist and community eco-artist.*

She was thirsty for a new, creative way to work with her clients. She was interested in all the studies published showing support for the creative art therapies. She

was looking forward to plugging into the healing power of the arts and bringing it into her work, both personally and professionally. From that point on our discussions became engaging, and we often created art together. Together, we explored watercolor painting and clay, affording her the opportunity to be creative using art therapy directives to reduce anxiety while exploring personal growth and goals.

EMT

The other clinician/artists highlighted in this dissertation did not use objects or materials from their workplace in their artwork, except for maybe a generic scrap of paper or a pencil; however, the EMT directly used materials and discarded medical supplies. His work resonated most closely with me, since my work is material driven. Additionally, I have often used personal, discarded medical supplies in my work—these materials have included such x-rays, CT scans, tubing, etc. His artwork feeds straight from his work as an EMT. It feels direct and immediate. In fact, he felt one was not possible without the other. He believed he would not be making art objects if he were not an EMT.

Before his work as an EMT which began about 15 years ago as a volunteer with the local first aid squad, the notion of even looking at art was foreign and totally un-relatable. Art was not an element of his world. He felt making art for him just sort of happened. It stemmed from his sense of not wasting anything and his regard for the environment. The EMT started to collect the discarded unused medical materials. Tubing, O2 masks, gauze, caps . . . sometimes the items were just not needed, or they were the wrong size, or a patient died before needing them. Yet, the packages were opened; therefore, the materials were unusable. His hodge-podge collection was beginning to

evolve with every shift he covered. Odd pieces, random and strange—but not to him and his world. They all had a purpose and told a story of a person or family. He remembered them all. This was a world that he could not fully share with others, since very few could relate to his daily perils which were fraught with much anxiety and risk. The risk increased as COVID crept into our lives. He kept all the stories to himself . . . his observations, feelings, and questions. He let it out through his artwork assemblages.

The EMT would share only with a select few his unique creations that marked his experiences and life as an EMT: a daily routine wrought with anxiety, emotion, and all too much uncertainty. Reluctant to show or share his work, he was cautious, being very careful that others would understand he did not steal the materials. The supplies were all discarded, clean trash. He was a collector, similar in many ways to my own collection and gathering methods. My supply, a repository of recycled materials, rests next to more traditional art materials in my studio, offering a range of materials, options, and ideas.

When someone would remark on one of the elements in his “medical materials assemblage” rather that discuss the rigors of life as an EMT or the particulars of a case, he would rebound with an explanation of its use as an object. “I do not want to relive even a minute on that rig.” He often blurted out. We reached a common ground, since for some of my art pieces I also used discarded medical equipment. Mine were personal, discarded elements from my mom’s care and treatment. My approach seemed far too personal for our EMT. He would not even consider using family or personal medical equipment or tests as an art material, but he understood and respected my reasoning.

While COVID-19 affected us all, the selected clinician/artists’ stress levels ran higher. They were all on the frontlines and could not seek refuge remotely—except

partially, for our psychiatrist and social worker. For them as frontline caregivers, there were many changes in the way they worked; the hours allotted for art-making also changed, radically. Mostly, it had a real practical effect on the EMT and his art-making process. His materials and supplies were now in jeopardy. With COVID-19, even discarded "clean medical materials" were to be discarded immediately. Anything that was on the rig needed to be discarded after each patient. This safety practice continues today. Nothing is to leave the rig or enter your home . . . not even your own clothes. Safety precautions were and are very strict. So, of the artwork of all the clinician/artists, the EMT's demonstrated the most change, visually. It stemmed from a necessary, basic change in materials. To replicate IV tubing, the EMT discovered it could be purchased by the yard in local hardware stores. Even though medical equipment could no longer be used, the process of creating artwork and securing materials remained the same. It still included scavenger hunts, discarded materials, and recycling, but now they were not only relics of his life as an EMT on the rig; rather, they comprised everyday materials. His materials were relatable to all—a new, added dimension to his artwork. Now, the EMT could share his work and not worry if someone thought that the materials were stolen. The work did not necessarily relate to life on the rig. The work was no longer about reliving the horrors of the day. A new identity was beginning to emerge for him. He was now using traditional art supplies integrated into his recyclables. This formed the basis of some of our conversations on identity.

Summary

In general, my selected group of clinician/artists were similar in many ways to other artists and myself. Straightforward. Complex. Open. Guarded. All different and

always changing. Never linear or static regarding process. Their moods and accessibility rested on workday issues; sometimes extreme stress provoked a restrained, cautious mood, while other times it inspired an almost jovial, playful mood. Changing moods—sometimes rather suddenly within a studio visit or call—often guided our time together. As artists we all agreed, we are often not always comfortable sharing our work, especially during the creative phase.

Initially, there was an awkwardness, uneasiness regarding the clinician/artists' studio visits whether they were in person or via Zoom. I sensed that they felt I was solely interested in the final product. Like most people they felt that success rested with the finished art piece. This is a natural concern, since they did not consider themselves artists at all. It took a while to assure them that as an art therapist, I was interested in the process, not the product.

The psychiatrist never planned to exhibit his work, even though he clearly understood its value in terms of his skill and mastery. He was well aware of his natural talent reinforced and encouraged through some early college art classes and early exhibition success of non-patient-related artwork. He knew his work was masterful and aesthetically pleasing, and he alone was quite comfortable with our initial visit. Besides his prowess as an artist which he acknowledged, he clearly appreciated my training as an art therapist and artist. While our creative work products were very different, we were aligned in thought and spirit professionally as mental health clinicians. In fact, he was very interested in the field of art therapy—mainly how I diagnose, assess, and treat.

The nurse's and the social worker's self-effacing attitudes, I felt, were disturbing. They clearly invested time and some expense in materials even shared their work on a

limited basis, yet it was a struggle to get the conversation at least initially beyond denial. The nurse claimed, "It is just something to do—I do it for fun." As our time together progressed, I shared with them a few articles on creativity and its value in healing. A change occurred within the nurse and the social worker; our conversations deepened.

The EMT, while very pragmatic and down to earth, simply stated, "I make things." He was easy to talk to and genuinely open, yet getting the conversation to move beyond materials again presented a struggle. Imagery was also difficult for the other participants to discuss, except the psychiatrist. The EMT began to ask me about why I used medical supplies as materials in my artwork. I explained it was to lessen the pain of my mother's illness and passing and to process her death to make sense of the unsensible. My candor seemed to offer an opportunity for him to feel comfortable sharing his feelings, and eventually the others also responded to my frankness.

I visited the clinician/artists' studios all in person except for the psychiatrist. The psychiatrist was at an extreme distance, so we relied on Zoom. Immediately, it became quite clear that while there were similarities between the clinician/artists, they also possessed a unique richness that was fashioned by their past, families, and environment. Discovering that distinctiveness, singularity of each clinician/artist ultimately revealed that there are many layers inside of each. The lushness and depth of each clinician/artist is embedded in the individual's story and journey. As we move toward the individuals' stories and practices, our clinician/artists, caregivers on multiple fronts, expressed they were in search of work-life balance. Herein lie their stories.

Chapter 5

TRANSITIONS AND CHANGES

A creative process, if it is authentic, resides in change. Over time each clinician/artist unlocked the walled-off creative parts of their life. Striving for integration, they were willing to share their creative process. For each clinician/artist, it was wrought through trust and measured by time as our relationships developed and grew. I was also a willing participant in the process, readily sharing my craft, training, and experience. For the most part, it redefined each clinician/artist's role as an artist and clinician, permitting new growth and sharing on many levels. The route for each clinician/artist was as individual as their artistic expressions, careers, and lives.

Closer Look

I asked each clinician/artist to discuss their process and to share some elements that evolved from our time together through the progression of our interview sessions. I planned each interview as an open interview session designed for each clinician/artist to take the lead. I invited each clinician/artist to participate individually with me in an art therapy session as we were concluding our time together, affording the space for a closer, deeper glimpse into their identities as both an artist and clinician.

Psychiatrist

The psychiatrist created portraits as a tool for the personal processing of client emotions after each session. They were his way of coping after each client session, especially when emotions overwhelmed him and needed processing. Often, there was no time to seek out a colleague for a peer review session. Transference and

countertransference flooded in with no dams or levees to hold the emotions back. Art was his refuge; his sand bag; his dune on the lonely beach, always there when needed.

The psychiatrist's practice as an artist began the earliest of the artistic practices of all the clinician/artists—while he was in medical residency, with an even earlier casual start in college after he took a drawing class. His formal training in the arts seemed to give him the confidence needed to discuss his work regarding content, practice, and process, which was similar to my experience as an artist. Our first Zoom visit centered on the formal qualities of art so visible in his work: line quality, composition, mastery of materials, chiaroscuro, texture, surface, etc. Since he worked in isolation and did not show his work, he was genuinely interested in me giving a formal critique of the work. I have the credentials and professional background to partake in a professional critique; however, I did not feel that was necessary to this project. I quickly decided differently with the psychiatrist. Ultimately, it was my way to establish a relationship with the psychiatrist. With each artist my goal was to gain a better understanding of their creative processes and their personal and professional lives. My training as an art therapist necessitates that I form a therapeutic relationship with each client/patient, requiring transparency, communication, and understanding. Additionally, I practice art therapy in the humanistic tradition, which is steeped in a patient-centered care approach, and I believe that the client/patient is always the primary authority on his or her own care. The client/patient knows what they need. I as the therapist function as the facilitator. I used my skills as an art therapist while interviewing.

So, we began our critique with an amazing assortment of about 50 portraits varying in size from 4" x 6" through 11" x 14" and textures including various media:

charcoal, conté crayon, ballpoint pen, charcoal pencils, and No. 2 pencils with an occasional marker or office highlighter. It truly amounted to a skilled grouping of portraits consummate in execution, yet expressively loaded with emotion and brimming with client/patient case histories that could be gleaned in a glance. Ten portraits the psychiatrist selected were the center of the first visit. He also shared their case studies. Mary was a patient of particular interest, since for the psychiatrist it posed a challenge that is still with him today after many years.

So, we started at the beginning reviewing all of his portraits of Mary while I listened to his intention and meaning for each. We also noted his growth and skill as an artist over the past 10 years. While I thought the formal aspects of his artwork would be a large part of the session, since they were in our initial meetings, this session was about content and imagery. Initially, the psychiatrist was interested in my life as an artist and my rigorous training as a MFA student and life in New York City. Now, he was eager to discuss his work and his patient, Mary.

Mary, a current female patient for the past 10 years, originally diagnosed with generalized anxiety and mild depression, was a case he wanted to share with me, since she was an artist. Her sessions started when she was 26 years old, varying from once a week to sometimes every other week. At times, Mary refrained from treatment with, gaps resulting from childcare issues, minor illnesses (colds, flu), vacations, and issues regarding insurance coverage. He was nearing the point that he wanted to bring artwork into his practice and was intrigued by art therapy. He admitted until recently he understood art therapy to be only a form of recreational or occupational therapy, not so

much as a credentialed metal health profession. He felt that in certain cases art therapy perhaps could help remove blocks and holes in the therapeutic process.

Feeling that Mary was a good candidate for introduce art into the therapy process, he wanted to know where to begin. However, he wanted to discuss it with me first, knowing that to actually practice art therapy even with his advanced mental health credentials he still would need to be certified and trained. We discussed the power of the art product and the responsibility and ethics involved in introducing art therapy into his practice. Training was critical and required for doing no harm and practicing ethically. Tabling additional training for the moment, he wanted to discuss what it would look like in his practice. He wondered if in fact his portraits of Mary could be a useful tool to introduce in Mary's sessions as a self-reflective tool for her journey. Each of his patient portraits were basically personal session notes which he would never share with a client. The portraits were intended for private and personal reference only by the doctor. It was important, I felt, to never blur or cross those lines for the safety of the client. The psychiatrist after some discussion agreed.

Many more questions followed, and most of them were not immediately answerable. He needed time, training, and a gestation period after some formal training in the creative art therapies which I highly recommended. So, together, we took a few steps back and reviewed his portraits of Mary and their evolution and their emotional impact. He craved the psychological aspects of art therapy as a tool in therapy. He saw his work and its possible use as a reflective tool for the client to unblock stalled sessions, deepening the conversation. He wanted to learn more and very quickly. I was clear that

he would need additional training in art therapy. Our time together was a brief introduction to art therapy—not a substitute for training and his own journey.

The initial portraits of Mary by the psychiatrist were mostly ballpoint pen and ink (blue ink on lined paper), as were most of the portraits during that time. Some were also cross-hatched and shaded using No. 2 pencils. While the materials were whatever was easily available, there was nothing haphazard about their execution. The psychiatrist's clinical, artistic works were balanced compositions with appropriate proportions; the formal qualities of the artwork were respected, even if the works were created on a notepad scrap. Emotionally, they summed up the intensity or lack of intensity in each session. As we compared each to its corresponding session note, the portraits truly were a snapshot, telling the story of each session. They were powerful and potent; however, I felt they were not suitable for client viewing without very careful consideration of the client and culling of certain images. More than one at time could be overwhelming, taking a client back to a time and place they were not ready to address or re-address. I cautioned that the client did not create these, and they possibly would cut through the client's defense mechanism at a time or in way that the client did not choose.

As we reviewed his other client portraits and further discussed his process and art therapy, our discussion moved toward what would be the most therapeutic use of art in therapy. He realized that by using his own artwork in a client session, showing his artwork to a client, he was actually moving away from a client-centered approach and elevating himself to be the epicenter of the session. We processed together the true therapeutic value and that the client needs to be the true beneficiary of the session. The

therapist is the facilitator/healer, not the focus of the session. Our session then moved quickly toward professional ethics and next steps as developing a practice as an artist.

We agreed art therapy is for the client; it is their process. Professionals are facilitators, holders of their space. We embrace and keep their space safe for them as their ego strength slowly grows stronger. Art as a means in therapy really involves the full engagement of the client in the process. It is their tool for creating their space of healing, not ours.

Feeling a greater connection to his artwork after our many sessions, he felt he would greatly benefit by having an art therapist as a personal, clinical supervisor and therapist—someone to create a space for him to cope and grow as both an artist and clinician.

> Maria: *I naturally declined when he offered me this role, explaining that yes, we would keep in touch, but ethically I would not be able to be his therapist. He understood that ethically I was prohibited from taking on a dual role. The duality would pose a conflict, yet we could maintain our collegial friendship. So, the exploration into the world of art and healing was ready for him to take his step through that door for training and discovery. The next step: participation in an individual art therapy session in which I would facilitate attempting to unlock his unconscious to reveal his present identity symbol to serve as a metaphor for his recent reflections and observations.*

Nurse

Now, open to the process, the nurse was ready to move on. Her openness surprised me with her question: "Why do I hide my beautiful artwork?" While I did not

have an answer for her directly, I expanded the conversation to share with her the concept of healing arts and artwork and its long, steady tradition in nursing. Looking to reframe both professions, I started with a simple story about Florence Nightingale, Queen Victoria, and the Crimean War. Florence Nightingale believed care extended well beyond the physical, and she petitioned Queen Victoria to ship original masterpieces from Buckingham Palace to the frontline. Florence Nightingale believed in the healing power of art: a tradition that would find a home in nursing in the years to come.

The British soldiers were not doing well physically or mentally; morale was at a low. Sickness, disease, and infection had a hold on the troops. In a particularly bloody, intense war, Florence Nightingale believed that art treasures were needed in the recovery tents on the battlefield—not in the dusty, stale palace hallways. Florence persisted and in turn enlarged the concept of patient care to encompass body, mind, and spirit. This resonated with the nursing profession and started a tradition that continues today.

I shared that most of the healing arts literature was really from the nursing profession, particularly in the fields of oncology and cardiology. Medical/surgical nursing areas generally lacked the time and space to initiate mindful practices in their units. We discussed some of those projects that I could easily recall from the literature. Next, we discussed her career choices in light of reviewing some of the nursing healing arts projects. We looked at how the nurses would incorporate art with their patients, even at the bedside. While she was not ready for any type of career change into either a cardiology or oncology unit, she still wanted to share her artwork. Her original impulse was to "brighten up the patients' days and their room." Clearly, she felt she could do this. She could at least donate the artwork to the medical center.

We circled back to the idea that maybe other nurses would like to help, since the literature supported that nurses embraced and encouraged the arts. Having a hospital background, I suggested forming a nursing arts committee. With a committee, more was possible. More artwork. More awareness. She liked the idea of giving back and doing more, more, more. I also suggested some local and national arts and healing organizations as jumping off points to possibly meet some like-minded nurses. I encouraged her to tap the office of volunteers, a major resource in any hospital. Her journey began within the next two weeks with some baby steps. Nevertheless, it was moving forward. The nurse was excited just picturing the possibilities.

Social Worker

The social worker appreciated her craft, understanding how at each juncture of her life/career it saved her. It was her personal refuge. Each quote she crafted into her needlework embodied times when she endured many personal and professional challenges. Entertaining a possible career change, she sought to move forward, bringing craft into her practice. A fiercely independent old soul, she embraced the idea of being an art therapist.

I received a call late one Friday night, as she wanted to know what would it take for her to become an art therapist. I quickly responded: “30 credits.” Building on her MSW (Master of Social Work), she could obtain certification after completing the 30 credits plus an additional thesis-level case study, including intern hours under the mentorship of a board-certified art therapist. Further down the road, she could obtain registration and board certification, which are not initially required to practice. I directed her to the American Art Therapy Association website and Caldwell University’s

accredited art therapy program—both excellent resources. After I encouraged her to meet with a school counselor, we agreed to follow up on Monday to talk about the details.

By Monday when we touched base, she already had an appointment and was planning to register for the fall. Determined and dedicated, we discussed my experience in the program and possible career redirection. I suggested she change the focus of her position as a social worker, moving into direct patient care with a specific client population. Now, as a social worker, she was employed as a case manager with little or no client contact. Her concerns were placement, aftercare, medical resource usage, and insurance. In these tasks, there was no room for art, healing, or emotions. She wanted more and was willing to put in the time, energy, and finances to realize her new vision.

While I could not directly be her mentor of record or serve in a professional capacity, since we already had a prior relationship, we agreed to maintain a close, collegial relationship as she entered the program. We would often speaking as much as once a week, and she could not contain her passion. She wanted to share her discoveries, immediately.

The program required her to seek independent, professional internships with a board-certified registered art therapist. Next, she plotted out her courses carefully. Feeling it would take a couple of years if she cut back her hours at work, she was not discouraged. She did. She was off and running. So, while she still continued to make art as she studied, her focus was on the program which encouraged art-making, journaling, and case studies and research. It also broadened her scope of materials, as she believed that an art therapist should be conversant and knowledgeable about all art materials and media.

EMT

A dramatic transformation arose within the EMT. Process, identity, and imagery were a part of his development. A new identity evolved gradually over the course of the pandemic. Sparked by COVID-19 protocols and shortages, medical supplies were just no longer available. His common “palette” was no longer available to him. He was at a loss. All rig materials were to be properly discarded or left on the rig for disinfecting. Initially, he was blocked. Not really aligning as an artist, he was unable to move forward or move at all due to the scarcity of available materials. This brought forth a deeper level of conversation regarding my work, processes, and materials, since I use mostly non-traditional and often recycled materials. Underneath his use of medical materials there was a keen sense of “no waste” in his use of mostly discarded supplies. This is the underlying theme of my work, as well. This attention to waste and using recycled materials became the focus of our future sessions.

Unique and unlike my studio visits with the other clinician/artists, it was time for the EMT to visit my studio, which is laden with discarded, recycled materials waiting to be repurposed into art projects. The other clinician/artists were not invited to my studio. My latest pieces are 100% recyclable, largely composed of “used teabags” saved and collected to be sewn into a healing quilt. This project began simply by collecting the teabags (thousands) until months later their purpose occurred to me: I would create a Healing Quilt: Tea & Sympathy. I shared with him how materials inspired my work. My process was material driven. I felt he needed to experience my studio/approach.

I shared my method of first collecting materials. I then explained that I let the image(s) spring forth from my random collection of recyclables and other materials in my

studio. I collect toys, notions, and other oddities. My ritual also includes garage saling, and trolling hardware stores and thrift shops, looking for whatever piqued my curiosity or caught my eye. My studio is filled with large and small bins of my treasures, and I always leave them open and visible to speak their images to me in their own time. Items were purchased, collected, or saved, often with no immediate project or image in mind.

He liked my “free and open” process. He told me he felt “inspired and energized” by just visiting my studio. We discussed using non-work-related materials so he could openly show and share his work without having to justify the source of the materials, which had been an identity issue for him in the past. He had felt he would be accused of stealing work supplies. Now, he was free and feeling ready to begin to assume the identity of an artist.

After visiting my studio, he started to make a studio space in his parents’ garage, collecting tools and interesting, inspiring materials. I was invited to his studio visit about three weeks later. We discussed materials, methods, and the process of becoming an artist. He was slowly creating small sculptures, which appeared to be maquettes for larger pieces that may or may not be developed. On my most recent check-in, I found his identity as an artist deepening, plus, a very used studio space. He was accepted into a small members show. Having recently joined a local community arts group, he felt it provided a sense of purpose and an outlet to show and share. For him, this was a very new experience.

For myself as an artist, witnessing his creative awakening and transition from clinician/artist to artist was inspirational. I had a newfound colleague and fellow artist

that vibrated with me unlike the other clinician/artists. We continued to stay in touch, sharing tips and exhibition leads and materials.

Transition to the Next Phase

While the goal of these interviews and check-ins were meant as a touchstones to mark their progress and process, the sessions were limited by language. They were an imperfect snapshot from time limited sessions, controlled by one's ability to selectively mute their thoughts and their voice.

My own practice as an art therapist is to create a safe space for clients to share safely, freely. The creative arts therapies are often used to access the unconscious. We needed to further break down our boundaries and tear down our walls as researcher and participant. So, our final conversations would be an individual art therapy session for each participant, designed with a directive or prompt to uncover inner thoughts and desires. Through symbols expressed in the session, each participant would be challenged to investigate its meaning. This was a process we would do together. My role primarily would be that of a facilitator. In the Jungian tradition, we would explore the symbols and meanings created: personal, cultural, and universal.

Chapter 6

EVERY PICTURE TELLS A STORY; OR, OPENING TO THE PROCESS

Art is not confined to a small coterie of geniuses, visionaries, cranks and charlatans—indistinguishable from one another—but is instead a fundamental human species characteristic that demands and deserves to be promoted and nourished . . . art is a normal and necessary behavior of human beings that like talking, exercising, playing, working socializing, learning, loving and nurturing should be encouraged and developed in everyone.

(Dissanayake, 1992, p. 175)

I sought to open up the dialogue between myself and each of the clinician/artists. My principal resource, my personal tool kit, is art therapy. It is the mainstay of my beliefs. Images are closer to the truth/unconscious than is language. In my studio, I would create an art piece to summarize, reflect upon the impact of the sessions and entire process. I planned in a separate session to share my reflective art piece individually with each of the clinician/artists.

All the clinician/artists readily agreed to participate in an art therapy session that I would facilitate. My goal for the session was to loosen or unlock their unconscious to freely tap into their motiving forces and internal drives regarding our time together while glimpsing at their creative process in action. Leaving each clinician/artist with a better understanding of their work and a symbol of our time together guided me in composing the directive for the sessions.

A directive is the prompt that an art therapist gives the client at the beginning of the session. The directive is generally guided by the goals for the session, which are informed by the needs of the client. My goal for the session is to have each clinician/artist create a symbol or image to reveal their creative process, as well as to reflect upon their art and careers and our time together. Such a symbol or image created individually by

each clinician/artist would allow for a point of reflection to process our time and look toward the future, together. The artwork gives us doorway or portal to the unconscious, unfettered by words or editing by our conscious mind. We often fight to express our reactions and feelings that are often kept suppressed. Art therapy transcends and frees our unending loop of conscious thought, allowing our unconscious to come forward.

Each clinician/artist was given the same directive and materials. The sessions were 90 minutes as follows: 5 minutes to explain the directive, 35 minutes to respond to the directive by creating their image or symbol with the materials provided (No music. It can influence the response to the directive.). The remainder of the time was used together to process the image created in session. Time limits were given to ensure responses were quick and spontaneous and to standardize the process for all participants.

Directive:

With the materials provided please make a s symbol or an image that reflects your time working with me over the past year. One that you feel represents you and your art practice as it is today.

Materials:

1 ¼ ounce of Model Magic white air-drying, basic watercolor set with brush
Colors (Brown, Purple, Blue, Green Yellow, Orange, Red, Black)
Plastic Knife

The Sessions

Psychiatrist

Figure 2

Mandala/Target

Psychiatrist
Image/Symbol: Mandala/Target
Model Magic, Watercolor
3.50” dia.
Date: July 10, 2021, 2 p.m. EST
Location: Client’s Home Office

Overview of Session (Zoom)

After a brief introduction to the session, the psychiatrist began the session by opening the Model Magic and squishing it around in his hands. Exploring its properties and searching for inspiration, he commented that he never used it before today. He hummed as he manipulated it, twisting it around. It seemed to resemble playtime for him. It seemed to be a freeing experience.

After about 5 minutes he settled down to work and began forming a round, disk-like object. He reached for a lid of a plastic container on his desk to use as a form, a mold. Even though I stipulated before the session to use only the materials provided

which were mailed to this clinician/artist, I decided to overlook his use of the lid. My approach in general is client-centered in my practice. I believe the client knows exactly what they need. I made no attempt to comment on this during the session.

He seemed a bit awkward with the shapelessness and unstructured qualities of the clay. I would later see the plastic lid gave him structure and definition. His uncomfortableness with materials later played out with the watercolors. In his own work he always used pencils and pens. Keeping this in mind when it came time for painting his symbol/object, I interjected a few tips on watercolor painting, especially how to control liquidity and tone/intensity. As the session continued, he remained on camera as I observed quietly without interference excepted as noted. As customary during a session, I would give periodic updates on time.

He was awkward while painting with watercolor, trying to determine the consistency that would work well with his art piece. He used a scrap of paper to briefly experiment with amounts of water/paint needed for the brush. Even though I was available to ask, he did not ask for assistance or even gesture that it would be welcomed. As he painted his disk-like symbol using only three colors (blue, yellow, red) in concentric circles, he commented that it reminded him of a Jasper Johns target painting from the late 1950s. He later told me he was one of his favorite artists.

Processing With Client (Excerpts)

> **M: "Tell me about your piece."** *(This gives the client the opportunity to address process, materials, or image—whatever is on their mind.)*
>
> **P: "I wasn't sure what I was doing. I really thought we could choose our own materials."**
>
> *I explained how directives are structed and why. Standardization is key and certain materials provoke certain things in certain individuals. It's partially about*

my observations of the client noting those challenges. How would the client solve them? Yet, giving a certain amount of freedom of choice within the directive to the client is critical . . . Proceeding to redirect . . . .

M: "Tell me about your art piece. The image itself. . . during the session you referred to it as a target."

P: "You mean Jasper Johns's work from the late '50s?

M: "If you like?"

P: "They always fascinated me . . . in fact they were the first real art objects that I ever saw in a museum. . . . He actually added private body parts to the edges of those paintings. The sculpted objects were part of the target. Very bold!

M: "If you had more time or materials would you have added the body parts?"

P: "No . . . not really. . . . I really did not like the clay. I could not achieve the details I like. Not like my drawings."

M: "Let's return to the directive and consider your image through that lens."
Directive: *Please make a symbol or an image that reflects your time working with me over the past year. One that you feel represents you and your art practice as it is today.*

In a typical session, I rarely so quickly redirect a client. I maintain they are their own experts and know what they need. In this case, since it was not a genuine psychotherapeutic session and the clinician/artists are not clients, I needed to steer it to the question at hand. This session was more like a visual interview/conversation.

P: "I'm not sure."

M: "Let's look at the image itself. What do you see immediately when you look at it?"

P: "Actually a Mandala. I was intrigued how this was your de-stress ritual. Plus Jungian psychoanalysis is a large part of my practice. . . . Have you ever seen his Red Book?"

M: "Yes." *I went silent. Again, he was deflecting and I wanted to return to the original directive. (a good few minutes)*

> **P: "It may seem rather small, but I feel I made huge changes, since we began. At least in my mind. I had been frozen. Working and practicing the same way for years. This process opened up creative possibilities for me. Now, I'm considering sharing work with selected patients and also having them engage in art and image making as part of their healing process. Breaking down the walls in my practice.**
>
> **Mandalas are about focus and integration of the whole. A place I want to be. My process for necessary reasons has been very secretive. In some ways, I would like to bring my arts forward . . . maybe even show . . . . I really don't think I would show patient portraits . . . . After all we take an ethics oath. There are guidelines. Beyond this session can we look at that? . . . You do it. You show your work. Yet, your work is largely symbolic. I'm sure you are constantly making reference to past/present clients."**

For the remainder of the session we discussed integration of the whole person as an artist and clinician. Until this session, I really did not appreciate how the psychiatrist was struggling with a public vs. private identity as an artist—his need to be seen, to step outside of the box. The walls he carefully built to protect himself were crumbling. I was surprised to find this fragility. Yet, it may be necessary for him to move forward and open up to a new identity. I ended this session on time, making sure to leave him in a safe place. He seemed curious about his future as an artist. He may be taking some art classes, but we agreed that working with an art therapist would be essential to his development. I promised a referral. Plus, as a professional colleague, I would keep in touch. I felt pleased that he was able to voice doubts that were undoubtedly buried for a long time.

Nurse

Figure 3

Flower

Nurse
Image/Symbol: Flowers
Model Magic, Watercolor
2.75" dia. & 1.75" dia.
Date: July 10, 2021, 7 p.m. EST
Location: Client's Family Room

After a brief introduction to the session, the nurse started molding the clay with a few brief remarks. First, she asked me if I would like an iced tea. She remarked. "Once a mom always a mom!" She commented she was happy to see her medium, watercolors, on the table for the session. As she started to use them, she was surprised at the absorbency of the clay. I could see that she was working hard to get it exactly a certain way, possibly to match the watercolors in her painting. After a while, she moved on and worked on her second piece. Unlike the other artists, the nurse actually created two images—both flowers. Initially, she divided the clay into two lumps. One lump was a little larger than the other. Later, she incorporated different color schemes for each flower.

During our session, her family was home. There were a few knocks at the door, barking dogs, lawn mowers and leaf blowers, yet she kept on working. She made a laughing remark about her life. *"This is the place I create. This is my life."*

Processing With Client (Excerpts)

M: "Tell me about your image/symbols."

N: "Duh . . . they're flowers?"

M: "Humor me . . . tell me more." *I imitated the popular song from the musical* Grease.

N: "Well . . . surprising myself, I struggled with the watercolor?"

M: "In what way?"

N: "Uncontrollable and much too light?"

M: "Ahh, the importance of the right materials. I noticed you got right to work." *I wanted to direct her to process, since she really is focused on product. Take her out of her comfort zone. In her own work she only painted in watercolor the images of flowers, They were beautiful. My goal for her was to own and value her work or to begin to explore the creative process—to get closer to who she really was as an artist.*

N: "Yup, no time to waste. Two Kids, two dogs, cats, goldfish . . . not sure if the hamsters are still alive. I got a zoo!"

M: "Yet, you find the time even to take classes."

N: "Yes!"

M: "Let's get back to the images/symbols."

N: "Flowers . . . well I just love them. It's kinda fun to grow them then paint them. I love giving both away. At work I'm known as the Flower Lady."

M: "It sounds like you are letting folks know about your painting. How does that feel?"

N: "Pretty cool. Look, it is such an intense place—so much pain. Maybe I can change that just a little."

M: "How? Any plans"?

N: "Yes!" *smiling broadly*. **"Well, I started that volunteer group with some of my nursing friends and a few of the nursing students. We are Nurses Who Paint! (NWP). The hospital even gave us free meeting room space."**

M: "Tell me about your group."

N: "We are all volunteers. We create artwork for patient rooms and then hospital volunteers bring a few around to the rooms and let the patients pick out a painting for their room. Actually, no big deal."

M: "What makes you say that? No big deal."

N: "Well, we all enjoy doing it. It's just a little something to brighten those dingy rooms up, especially in the older parts of the hospital."

M: "How many members?"

N: "Five steady and a few that drop in once in a while. We are thinking of having a spring sale and donating proceeds to our Charity Care fund."

M: "It sounds like you are doing a lot. Let's look back to when we met."

N: "I was hiding my artwork at work . . . never signing a piece. Now, I'm actually leading an art group."

M: "How does it feel?"

N: "Right. Just right . . . fine."

While this session was not rich with imagery, meaning, and symbols, it was loaded with action. The nurse certainly has made a commitment in addition to blazing a trail at the hospital. From the beginning, making a difference and doing good was very important to her. Prior to our time together this year, she remained by choice in the background with her art. Now, she was boldly coming forward. Even within the session she was not satisfied with pale colors that were available for her flowers. She wanted to make a statement. Shout it out!

Her growth during this period, as with the EMT especially, had to do with identity. Their public image, which certainly will grow and change over time, was important. Public vs. private and integration of both has always been something I thought about often especially in my early days. I was so afraid to jeopardize my day job. When

do you come out of the closest? It's certainly different for everyone, but one thing is true: it takes courage. Sometimes it means putting ourselves and jobs on the line, but sometimes it makes the difference between life and living.

Social Worker

Figure 4

Stairway

Social Worker
Image Symbol: Stairway
Model Magic, Watercolor
1.25"x 2.25"x 2.50"
Date: July 9, 2021, 1 p.m. EST
Location: Client's Home Office

Overview of Session

After a brief introduction to the session, the social worker quickly started. Nodding politely, quietly she opened the package of Model Magic. Prior to the session she had already cleared a spot on her desk, set up a protective covering, and had water and paper towels to clean the brushes. Donning an old shirt/smock, she was prepared and ready to work. I reminded her of the allotted time for the session. She nodded. I attributed her conformity and comfort to the simple fact that she had been reading about the field of art therapy preparing to enter a certificated post-master's program in the fall. She

understood the basic elements of an art therapy session. The session started immediately without interruption.

She plunged right into image making in a very procedural, organized way. It was clear that prior to the session she had been reflecting on the past year. She was already considering her life changes and the impact of the art-making process.

Processing With Client (Excerpts)

> **M: "Tell me about your image/symbol."** *It was clearly a stairway, but I wanted her to name it to be clear on her intent.*
>
> **SW: "A Stairway, my future."**
>
> **M: "Let's back up a bit. Tell me about the process, the materials."** *I wanted to slow her down a bit to give her the fullness of a session, since she already had clarity on her image. I wanted to explore the shadows or gray areas, if any were present.*
>
> **SW: "Well I could not get the watercolors dark enough. I wanted a dense, thick black."**
>
> **M: "Almost like thread?"** *I wanted to bring her back a bit to consider her own practice. She was accustomed to using thread, which intrinsically has darker hues/tones. I wanted her to grasp that even though she worked efficiently she was outside her comfort zone, much the way an art therapist works with a client. Yet, despite her unfamiliarity with materials her symbol came through loud and clear.*
>
> **SW: "YES, I can see that."**
> **M: "Our process is about making connections, tapping the unconscious. How did the clay feel?"**
>
> **SW: "Actually, OK! I really thought it would be messy. As you can see, I overly protected my desk."** *We both laughed.*
>
> **M: "Let's get back to your image. The stairway. To the future . . . "** *I made some spooky sound effects. Again, we both laughed.*
>
> **SW: "Yes, it's a stairway, my path into the future. While it's scary, dark, . . . uncertain, it actually has a direction—a path. I'm going up the staircase. I'm really excited about it. It will change my practice and maybe my life."**
>
> **M: "How? In what way?"**

SW: "I'm really looking forward to starting classes . . . art therapy is, well, exciting! Bringing art into my practice. Thank you!"

M: "For what?"

SW: "Introducing me to art therapy and letting me know at my age it was doable. I can actually get certified. Thank you! I'm so excited."

M: "Back to the staircase. Let's talk about the color. It is black. Did you really want to make it darker? Why?"

SW: "Because I truly cannot envision all the possibilities and changes. Even though I wanted it darker . . . I don't really feel it's [the future] that scary, scary. Your own path has been so unpredictable. Yet, you seemed like you landed on all fours every time." Generally, *with a client I would not share personal information about my journey/life; however, in this instance, a traditional client relationship did not exist. The sessions were basically an extension of the interviews.*

M: "Did you notice that your staircase dried even lighter"?

SW: "Yes, it initially bothered me . . . but time was over. The session ended." *laughing*

M: "Thoughts?"

SW: "Trusting the Process!" *laughing* **"or learning!"**

M: "In what way?"

SW: "Well maybe it was meant to be" *smiling* **"the unconscious at work . . . cue the spooky music!"** *makes spooky sound.*

M: "What did it tell you ?"

SW: "Well, the final piece was lighter than expected. Much lighter!" *smiling* **"The future may not be that scary or as unknown. It's actually more logical than not."**

The remainder of the session we discussed integration of the whole person as an artist and clinician, which seemed to be a theme running through all of the clinician/artists' sessions. For some of the clinician/artists this was a particular interest. In

her case, we also discussed career options. The social worker seemed to be making the boldest move in that direction. She seriously was planning for a career change, altering her practice to be patient focused with direct client contact. Accompanying this change, she was committing to further education, internships, and board certification. She was all in! Ready to start an art therapy post-master's program in the fall.

For me there was a bit of countertransference with the social worker. She was actually taking steps to convert her passion for art into a mental health profession. She wanted to make a difference and have the credentials to do just that. I'm excited about it for her. I'm looking forward to having a colleague in the field.

This client above all made me long for more client contact to embrace the field of art therapy by sharing it within a practice. She helped me remember who I truly am within the arts and health field. What were my dreams? Am I still pursuing them, fully? She rekindled an excitement about this specialized field (art therapy) rather than the generic area of arts and health which seemed to consume me over the past few years. I was rediscovering art therapy. It offers so much more.

EMT

Figure 5

Chrysalis/Cocoon

EMT
Image/Symbol: Chrysalis/Cocoon
Model Magic, Watercolor
1”x 3” x 1”
Date: July 9, 2021, 4 p.m. EST
Location: Client’s Garage Workshop

Overview of Session

After a brief introduction to the session, the EMT had a few questions. He really wanted a studio visit to talk shop. With a little redirection he settled into the session. I thought it was important to remind him about the structure of the session, including that the artwork for the session was limited to only the materials provided. His workshop was a fully loaded sculpture/tool shop offering more distractions than space. Without any further discussion the session proceeded.

Processing With Client (Excerpts)

M: “Tell me about your image/symbol.”

EMT: “What do you want to know?”

M: “Anything you feel like.”

EMT: “I did not like it.”

M: "Image?"

EMT: "No, the clay thing and watercolor? I don't use added color in my work." *Interesting, ownership of his creative work. A major step in claiming his identity as an artist.*

M: "Tell me about the image." *I wanted to move away from a discussion about materials and the art therapy process. We could get lost in that debate for hours, essentially it would become a studio visit. Generally, with a client I would not share personal information about my journey/life; however, in this instance a traditional client relationship did not exist. The sessions were basically an extension of the interviews.*

EMT: "Chrysalis."

M: "Why?" *He expressed himself using very few words, so I was mirroring his behavior. Sometimes this works and the client will move toward more descriptive phrases, feeling frustrated by the silence and emptiness of the session. Clients tend to fill space with artwork or conversation to self-soothe.*

EMT: "Well, I'm changing."

M: "In what way?"

EMT: "I think about art all the time. Always in my studio. Do you like it?"

M: "It seems to have everything. Do you?"

EMT: "Yeah."

M: "Tell me about the changes . . . . what does the Chrysalis tell you?"

EMT: "Changes are unfolding!" *I wanted to redirect the session back to the concrete for him to look at the changes he foresees or is working toward in the future. I wanted him to verbalize so he would get in sync with where he is in the process.*

M: "What changes besides the studio have occurred?"

EMT: "Well, I joined an arts collective. I actually entered shows. I tell everyone I'm an artist!"

M: "How does that feel?"

EMT: "GREAT. I may take a workshop."

M: "In art? Sculpture, welding?"

EMT: "No, the business of art, like marketing for artists. I want to sell my work."

M: "This is a big change. No longer hiding your work."

EMT: "I have a ways to go, but I'm going. It's freeing; besides, I'm meeting some really cool people." *If he were a client I would have pursued the part about meeting people to assess his current relationships and/or possibilities of isolation in his life.*

M: "Good . . .so, tell me, what is the next thing you will do after this session?" *Again, going back to the concrete to see how dedicated he is to his new identity—or is he saying what he thinks I want to hear?*

EMT: "First, dinner and a beer . . . this creative stuff makes me hungry! Then I'm photographing two pieces to enter into a show with the collective."

M: "Good Luck. Am I invited to the opening?" *We both laughed, ending the session.*

I found this session in some ways a struggle, since verbally he was so restrained. Yet, it felt peer like—especially with his equipped studio. Also, this clinician/artist was ready to claim his identity as an artist. He was clearly looking and working toward his newly identified goal as a fine artist. I identified and admired his plunge into the world of fine arts without regard for merging it with his role in health care. Time will reveal the sustainability of his path. Will it be a butterfly? Or will it be an empty, dry cocoon?

While he is sure of some things, he still needs time to mature and develop, of which he is very aware. It reminded me—fine arts are my roots. While the process of the dissertation is my current focus and arts and health my love, fine arts are my true passion. This session brought me back to my beginnings.

My Response

Figure 6

Owl

Researcher
Image/Symbol: Owl
Paper (back of a calendar), watercolors, No. 2 pencil
1”x 3” x 1”
Date: July 14, 2021, 7-8 p.m. EST
Location: My Studio

Overview of Session

My response to the relationships, sessions with the clinician/artists over the past year was well beyond words. The only logical response for me would be in an artistic expression. I wanted my response to be fresh and uncensored, so I set up a quiet time in my studio, limiting the session to an hour. I scattered a few basic materials around as listed and set out to work. My response was immediate, using the whole time allotted.

I chose to not use the same materials that I prescribed to my clinician/artists in their session. I wanted to have the control of familiar materials to directly express my feelings. While in the clinician/artist sessions, I wanted them to experience the

unpredictable, uncountable feelings of unfamiliar materials to elicit buried responses to find their images to probe and poke at their unconscious, for myself, I simply wanted my feelings and response to be recorded to take on a visual form by tapping into my own visual, symbolic language.

Artist's Response (The Work)

My response is rough, almost crude compared to my other finished works employing owl imagery. It's raw, expressing the entire process of entering the clinician/artists' intimate spaces and lives. I was exploring their lives probing for any kernel of creativity I could find. I was looking for that crack, that opening to reveal their true nature and creative impulses.

Looking at my response, its darkness yet halo of yellow seems to surround the owl, binding together the artwork in a nebulous storm. While the clinician/artists seem to be settling into their newfound identities as they stretch their limits to attain new goals, I feel I am in the midst of a murky storm. Just as every piece of art in some way is a self-portrait, my response to the clinician/artists is about me regarding their response and the entire process over the year. Personally, through the process I have re-aligned my goals and personal mission, which I will address in my concluding summary as I review the highlights of the past year.

Imagery

The work is fluid with a serious, brooding owl collaged in what at first glance appears to be a tree, but in actuality it is free floating in foggy haze. The owl is surrounded by a yellow halo/aura suspended in what appears to be the eye of a storm, which in reality is a calm protected space within a hurricane. The owl is pensively

observing, waiting while small patches of light blue and blasts of yellow pierce through the storm or dark fog. The darkness clearly holds no visible form or image. This imagery speaks for the clinician/artists and myself while huddled in our safe space, waiting and calculating when to move forward, wondering: What does the future hold? Are we willing to move forward? When?

Yet the owl, a metaphor for wisdom, is stalwart, unwavering in its stance. This is pretty much the way I see us all. We are a little uncertain of the future, the unknown. Yet, we are hopeful even in a small way about the future and what it holds, imagined as bursts of blue and yellow. The intense gaze of the owl speaks of the unfaltering determination of this group, including myself, to focus forward and keep in touch. We are held together by the art. My collage is simple, direct, and loaded with strength while searching for a direction. The future. The hope.

Preliminary Insights of the Combined Case Studies:

Before I move on to analyzing the data, it is important to note that each participant is navigating uncharted territories. All are venturing into the unknown, looking for that which has been repressed or strategically hidden. Their artistic spark is an integral part of their lives as professionals, but boundaries between their private and public identities seemed blurred. Yet, the drive to move forward for each clinician/artist was real. Carefully navigating the process, they considered both the risks and rewards of deepening their artistic practice and connecting it to their professional identity.

The goal for each clinician/artist seemed to be further integration of the full self. They acknowledged the importance of full integration and the life-saving qualities of art. Full integration, however, could pose personal and professional risks. These could

include career changes, professional interruption, and realignment of personal/family time; however, despite these challenges, the clinician/artists were ready to explore the journey in their own personal way.

Table 1

Summarized Participant Experiences

Participant's Journey	Purpose/Drivers Why?	Formation/ Transitioning Toward Identity	Identity
Psychiatrist	emotional exchange, skill, refuge	integration, exhibiting, healing	private. considering public integration
Nurse	beauty, sharing, supportive	integration, sharing work/craft publicly	caregiver, mother moving toward beauty/sharing publicly
Social Worker	need to help, professional development	becoming an art therapist	career change
EMT	materials, process, ecology/environment	becoming an artist	integration, changing

Maria: *The process of working with each clinician/artist reminded me of my roots as an art therapist. I had forgotten. My passion for the arts and their healing power never seemed to wane, yet my respect for art therapy and its contribution to arts and health had been pushed aside. It was swept up in the global embrace of the arts and health movement.*

The power of art therapy was in my hands a discipline I sacrificed much to practice. I was called to action to do more than just embrace the field through advocacy. I was making strides to practice again as an art therapist. I have actually reached out to resume practicing as an art therapist rather than as arts and health practitioner or administrator. While the rigors and demands of this

disciple are much more challenging, through this process I have uncovered my hidden truth. I was meant to be an art therapist, honoring the discipline and traditions of art therapy.

Chapter 7

ANALYSIS, FINDINGS, AND DISCUSSION

Kasriel-Alexander (2015) observed: "The process of art making has transitioned into the public domain as a self-initiated activity to improve psychological well-being" (para. 10). Available data continually suggest that the arts assist in reducing stress when practiced by the general population or within an art therapy session. This has held true for quantitative studies regarding health-care professionals as published by the National Organization of Arts in Health (National Organization for Arts in Health, 2017). Further, more generally, "art making can help people overcome their feelings of existential emptiness and loss of soul or identity" (Malchiodi, 1998, p. 85). This also held true for the clinician/artists as self-reported during the interviews conducted for this dissertation. The psychological benefits of creating art are rooted in physiology and brain chemistry: "The actual process of art making can also alleviate emotional stress and anxiety by creating a physiological response of relaxation or by altering mood. Creative activities can actually increase brain levels of serotonin, the chemical linked to depression" (Malchiodi, 1998, p. 87). According to Kaimal et al. (2016), art-making resulted in a statically significant lowering of cortisol levels which also included the participants self-reporting that the art-making experience was "relaxing, enjoyable, helpful for learning about new aspects of self, freeing from constraints."

"After a long day or if there is a break in-between seeing families, I get to my craft projects with anticipation—It is my time," reflected the social worker in this study. The social worker also acknowledged that "even when it is not possible to actually make something, just thinking about a piece or my next project gives me great pleasure—

feeling I can finally breathe for a while." She continued, "Just searching for the perfect quote for my samplers or pillows gives me a special, personal way to express my hopes for my patients."

Westermann and Steen (2007) argued that in order to properly understand an individual's behavior one must see it in the context of others' behavior. We may seem to act as individuals, but our action are often in concert with those of others (Fischer & Bidwell, 1998). Westermann and Steen continued, the observer's engagement with the process or behaviors helps in gaining knowledge of the activity. This allowed for an interpretative approach which was adhered to in this dissertation. While the clinician/artists created in different ways, they maintained their skilled, frontline practices as health-care professionals for 10 years or more. They even sustained their primary family and social relationships effectively, maintaining work-life balance as observed by this researcher and reported by the participants. "Art, my flowers, are the bridge that balances the chaos between family, work and life," exclaimed the nurse during this study. The nurse concluded smiling with pride, "It's my special place—a way to contribute pretty to the world and my family."

It has been long established that the creative arts reduce stress as utilized by creative art therapists in the fields of behavioral health and rehabilitation medicine. Art delivers a medium through which addicts may begin to express feelings, according to Morris and Willis-Rauch (2014). Addicts are often reluctant to discuss and to experience, but art is a natural process that is accessible during times when words are not (Morris & Willis-Rauch, 2014).

The distinctions and implications revealed by this dissertation for health-care professionals using art as a self-practice gave way to other themes which surfaced through observations, interviews, and an individual art therapy session with the participants. Their individual journeys remained as unique as their art, yet themes emerged particular to health-care professionals not generally noted in the general population. Their individual stories revealed how the arts sustained them throughout their frontline professional health-care practices as they maintained a balance between work and home life. The main goal for this study was to understand the meaning of their arts practice for a healthy work-life balance, and how they experienced the relationship between their art practice and work as a health professional.

The four main themes that provided us with that insight and that emerged from the data analysis are: identity, loneliness, guilt, and creativity. Each generated sub-themes that are reviewed in this dissertation and outlined in Figure 7.

Figure 7

Themes and Subthemes

Identity
Duality of Self
Security Job/Career
Perceived Dedication to Health-care Profession
Loneliness/Isolation
Creating in Secret
Longing to Belong
Sharing Craft
Guilt
Time away from Family and Patients
Self-Sacrifice/Self-Care
Creativity
Natural Urge to Create

The clinician/artists were interested in growing their arts practice while indecision of exactly the best route was a common thread in all the interviews. “I need to process my client’s sessions. So much responsibility—hearing their stories and no one to share my feelings with,” the psychiatrist sighed. “It is a lot of pressure.” This dilemma was readily expressed by the psychiatrist during the interview. “Making portraits of my clients sustained me throughout my residency all those lonely nights on call in the psych ward,” he continued. “It was lonely, cold—always waiting for the next crisis in the ED.”

The participants in this study no longer desired to create in secret, yet for the most part they were ambivalent regarding the use of arts within their practice, except for the social worker, who was planning for her future as an art therapist. However, they were ready to claim their dual identities as both artists and clinicians. They were all committed to exploring future possibilities using art personally and possibly professionally. I will now describe the outcomes of the analysis.

Identity

Identity is a broad category and one in particular that the creative arts therapies address when patients are transitioning from one state to another in regard to a change in health status and abilities. As Malchiodi (1998) explained,

> While art may help us express fear, anxiety, and other stressful emotions, it also touches the soul or spirit. While family, work and other parts of life may fulfill us, creative experiences with art making can help us express or contact parts of ourselves that other activities and interactions cannot. (p. 15).

In particular, the EMT struggled with identity. He really felt stifled by the endless routine of being on the rig. The lack of closeness with his transport patients and colleagues contributed to his loneliness. The arts offered him a connection to himself and the community—a way to express his thoughts and feelings. “Making art for me is at the very least half of who I am,” the EMT remarked.

The clinician/artists were in the midst of developing their own practices as artists in their own right. The EMT’s excitement grew as he developed his craft and relationships with the local arts community. He proudly shared his recent

accomplishments: exhibits, studio space, and growth as an artist with me as our time together grew.

The leading characteristic of identity that plagued these clinician/artists was duality of self—namely, their hidden selves as artists. "It was like living in two worlds sometimes three, clinician, artist, father. It wasn't healthy and I knew it," lamented the psychiatrist. "He continued, "but I felt boxed in a corner, no way out." Allen (2005), writing about the same phenomenon, asserted:

> In the studio I witness artists re-creating themselves and returning to balance by dialoguing with images. The art process seems to provide a bridge to the laws of Nature, which we can easily lose touch with in our busy efforts to achieve and produce. (p. 55).

The arts are a profession or advocation that one normally enjoys sharing with others. This impacted the clinician/artists greatly. It further exacerbated their issue of identity, contributing to loneliness and isolation. Loneliness and isolation will be addressed distinctly in its own category. Issues of loneliness and isolation are highly problematic in both fields: art and medicine.

Questions of how to establish, justify, and maintain a new integrated, holistic identity as both an artist and clinician was the continuing thread throughout the interviews. Even the clinician/artist that charted a solid path forward (the social worker who was committed to furthering her credentials as an art therapist) still felt an uncertainty over the future. She had a direct plan for integrating the arts into her professional life by becoming an art therapist. Yet, it was mixed with anxiety and similar to what the other participants who were not on a specific path were feeling. Their

excitement and hesitation were palpable; still, they all were committed to further developing art in their lives. All of the interviewed clinician/artists sought to incorporate their identities as an artist into their public/personal images. “They [my patient portraits] connect me with my patients—they actively helped me during morning report,” recalled they psychiatrist. “I quickly could recall each case just looking at my thumbnail client portraits—they reflected my patients’ journeys/dilemmas as well as my own feelings towards them—much like session notes,” he concluded. The psychiatrist seems to be embracing his profession in a new way, understanding that his strength as a therapist lies in his visual acuity and observational skills regarding his patients.

Toll and Scanlon Melfi’s (2017) community tile painting project, “Let’s Just Start, generated much community engagement revealing a project that offered much in the way of self-esteem” (p. 1101). “Many participants made comments such as, ‘I can’t believe you thought my tile was good enough to hang on the walls of the clinic’ or ‘Displaying my picture makes me feel like you really care for me as a person not just a patient’” (Toll & Scanlon Melfi, 2017, p. 1102).

Another matter relating to identity specific to this group is job security. Having a dual identity myself, earlier in my career prior to my becoming an art therapist, I managed a media department in a medical center. I felt that if my employer knew of my artistic practice and aspiration, they would not view me as part of the dedicated workforce. I was dedicated to my work at the hospital in the media department, yet I felt that if they actually knew that I was an awarding-winning, nationally exhibiting artist, I would be perceived as just biding my time until my “big break.” I would not be taken seriously as an employee or considered for advancement, placing my livelihood in

jeopardy. This is a myth that outsiders to the art world generally believe. This was voiced by the nurse in this study, as this dual identity caused tension and anxiety for her on the job during work hours. "Since some of my colleagues knew that I studied art and once in while I would show them a print or something, they would often just say out loud at the [nurses] station 'Well, someday she will be too good for us. I will just say I knew you when,'" she explained. The nurse continued, "I noticed my colleague would say this when our manager was around; then, there would be looks. It made it very uncomfortable for me, and at the time I was planning to apply for the position of lead nurse on the unit."

This leads into the next subcategory: dedication to the field of medicine. Employers are often uncomfortable with diversity in employees and atypical ways another spends their free time. "I understood I was different at least from the other EMTs," the EMT revealed. The EMT further shared, "I was not just content to get through the day and have a beer or go to the beach. I needed more. I found making art or making things—as where I wanted to be—that is now how I spend my free time. I felt uncomfortable sharing this with the other med-techs on the rig. I kept to myself." The clinician/artists have trained long and hard, persevering in their medical fields. Yet, they found respite in the creative arts. This duality is not generally understood, the participants expressed. These dedicated professionals have no desire to leave their chosen medical professions for personal, professional, or financial reasons. They were also concerned that their patients would perceive their duality as showing a lack of dedication to their medical fields. The psychiatrist explained: "While I know my portraits are very good and worthy of an exhibition, I feel to exhibit these would breach the privacy of our sessions in a very real way." He continued, "Even if I changed my subject matter, just revealing I

was an accomplished artist with shows and exhibitions . . . would be disruptive to the therapeutic relationship. My patients would view my dual profession as competing for their time." Even later in my career as an art therapist when I needed a day or two off to install a show, I always reported it as a vacation day. I was very insecure to reveal I was participating in a personal art project even though I was asking for vacation time off that I was due. Just like the participants of my study, I felt my loyalty and dedication would come under question. I felt as though I did not fit in with my colleagues.

Generally, all the clinician/artists were concerned with their transition from being known only as professional clinicians publicly to being known also as artists. Identity, career concerns, and future implications of a new identity at their present place of employment were the main themes that surfaced during our time together.

Loneliness/Isolation

Moon explained:

> In relation to art, perhaps the longing for human response partially explains why prehistoric humans stained walls of caves, and why Rouault painted and Rodin sculpted. The act of making is an invitation to relate. By making, the artist takes visual images from within and gives them visual form in the world. In a sense, art-making is an act of acknowledgement of one another beyond the boundaries of self. (p. 148)

Loneliness and isolation as we understand them today are debilitating societal issues leading to a number of co-morbid diseases that also coincide with many issues relating to job performance and the medical field, such as substance abuse, depression, and anxiety, to name a few. For the participants of this study, loneliness was often the

most difficult topic; they would often deflect my questions about it. Eventually, they trusted the interview process enough, uttering their deepest feelings to the researcher. “In general, my life is one of isolation as a solo psychiatric practitioner. From the beginning, I studied alone. I am on call alone—just alone all the time. It’s hard, very hard,” lamented the psychiatrist. “I thought I was okay with that—I mean, I understood that was my profession.” The psychiatrist continued,

> but with art, even though I could not share—being patient related, it really tugged at my heart. Now, I had something I did want and need to share—a newfound language that transcended my medical practice. It is about me and my healing process. My family and closest friends are even excluded, since my work is directly patient related.

The nurse does share her work somewhat with her busy family who, according to her, “frankly do not care—look, the kids are into their own thing and my husband works hard. They just considered it something I do once in a while—a hobby or pastime.” The nurse continued, “I do feel lonely as both an artist and a nurse. It is just how it goes—work [nursing] gets bottled up inside—I guess that is how we cope; healthy or not, that is what we do. I really wish I could be more out there as an artist especially with my colleagues; we share so much daily—life and death—but I just don’t feel this would be wise, since they may misunderstand my professional loyalty.”

The burden of loneliness and isolation can be heavy on the general population, and particularly on those in particular groups. Goldbard (2018) explained: “People who are isolated by age, illness or a change in life that sets them apart are much more susceptible to mental and physical illness then those who participate in networks of

relationships" (p. 14). Goldbard continued: "Under isolated circumstances, it can be easy to subside into a depression that perpetuates itself, especially in the absence of powerful energy, will and/or information to reach out" (p. 55). Isolation/loneliness also weighs heavy on the medical profession, since by nature it is practiced solely with little time or encouragement to share and reflect with colleagues. An art practice parallels this model, since much time is spent in isolation creating our crafts. "Few things are more painful to the psyche than loneliness," expressed Yalom (2005, p. 75). The burden upon the clinician/artists group is even greater. A self-imposed veil of secrecy is laced over their work as both a clinician and an artist. Secrecy contributed to the loneliness and isolation that the clinician/artists deeply felt. This was keenly experienced by the EMT and the psychiatrist. The psychiatrist's concern over violating patient confidentiality by revealing his realistic patient portraits documenting patient sessions certainly was real. The EMT was also concerned about his use of discarded medical supplies being misunderstood as a use of stolen items. As health-care professionals who felt the need to maintain extreme secrecy in their art practice, both of them experienced situations that proved to be the most isolating. In addition, their positions in medicine did not make them part of a team. Their co-workers/associates rotated daily on different shifts. The social worker and the nurse found small ways to share some of their artwork with their co-workers and families, which they expressed was enjoyable, but certainly not enough.

Showing one's craft is in our nature. It is reminiscent of our childhoods when we would proudly show our accomplishments. For the clinician/artists, this is an activity they are excluded. They are unable to fully share their complete themselves. "The community must respond to the artist's work for the process to be complete," Moon (2008, p. 131)

asserted. According to Moon, the type of reaction is inconsequential; all that matters is the witnessing of the creative work. "It is the way I can express myself, but for now it is hidden deep inside of me," lamented the EMT. Our urge to create is a natural, biological need that will be addressed as an independent theme later. Our need to be whole and authentic is essential to our well-being. As part of health and well-being, social prescribing as advocated by health-care professionals is taking root in Europe (Goldbard, 2018). Its main focus is participation in the arts and cultural activities. It recognizes the arts as a need for human socialization to fully experience well-being and health (Goldbard, 2018).

Guilt

Guilt weighs heavily on the participants of my study. They worry about their artwork or crafting resulting in time away from both family and patients. The nurse, having a big family with responsibilities and an intense schedule as a full-time bedside medical surgical nurse, often questions the time it takes away from her family. "The patients will always be there. I go in do my job—hopefully clock out on time, but when I get home, I'm so exhausted. I can barely move," lamented the nurse. She continued, "When I'm home, I fear sometimes I'm not really there. I feel empty—nothing to give." In fact, any self-care routine amounts to self-sacrifice, often resulting in guilt for many health-care professionals.

Medical professionals are a high-performing group and reluctant to practice self-care. It is often viewed as either an indulgence that is not a necessity or one that there is no time in the day to enjoy. Resistance to openness and change, according to Gustafsson et al. (2010), largely contributed to reluctance to engage in self-care and contributed

greatly to burnout within this group. The high burnout group in the Gustafsson et al. study resisted change and largely felt they were misunderstood, this coupled with other traits demonstrated a group that would not engage in any creative, new endeavors. This is pervasive across the spectrum of medical professionals. In fact, on a daily basis, basic needs are often delayed or even denied such as food, sleep, and bathroom needs during working hours. Institutions often look the other way. Organizations are aware of the workforce shortages exacerbated by the COVID pandemic; however, health-care workers are expected to compromise their needs and perform. Labor laws and policies enacted to protect their rights are blatantly ignored. It is a broken system. Finding time in the daily workday is a challenge. So, guilt for these professionals is high as they struggle to meet their professional and personal demands. The social worker voiced her feelings about time away from her patients and time making crafts/art:

> I sit here and stich these inspirational quotes while there are patients and families that need much more attention than I can give them. It is an endless cycle. I orchestrate their smooth discharge, but in reality I have no idea of their reality.

She paused and looked away, saying:

> Is it good or bad. I just don't know . . . but training as an art therapist might just give me the connection to my patients that I'm searching for—I would be involved setting goals and care plans with them—totally involved in their case from beginning to end.

Creativity

The participants in this dissertation expressed a need to create. Mankind's natural urge to create is part of who we are and is embedded in our biology, as expressed by

Dissanayake (1992). Dissanayake (1992) continued, “It fulfils a need that gives us our sense of identity as well as distinguishing our individuality. It establishes our wholeness. Bringing our humanity and the fullness of ourselves into focus” (p. 171). She explained:

> My palaeoanthropsychobiological view is that in order to include human history, human cultures and human psychology, art must be viewed as an inherent universal (or biological) trait of the human species, as normal and natural as language, sex, sociability aggression or any of the other characteristics of human nature. (Dissanayake, 1992, p. 169)

The psychiatrist, having the longest art practice of the group, clearly understood his need to create: “My art talent, which I discovered early on, was a lifeline.” He continued, “I’m not so sure I would still be in practice without that creative release.” Art binds us to our community, letting us share who we are with our community: “Art therapy supports the belief that all individuals have the capacity to express themselves creatively and that their product is less important than the therapeutic process involved” (Malchiodi, 2012, p. 1). The EMT summed up his need to create in the most basic terms: “I realized no matter what—even on the most unbearable, endless days with the roughest cases imaginable—the school bus crash, at the height of COVID—I must get to my studio for even a minute—then I can put it all together—get up and do it all again.” Dissanayake (1992) identified the centrality of the creative process to the ability of humans to carry out tasks that are specifically human: “Art making is an innate human tendency, so much so that it has been argued that, like speech and tool making, this activity could be used to define our species” (p. 171).

Discussion

The literature review on burnout and resiliency touched on themes that surfaced regularly on a deeper and more personal level in this dissertation, revealing the participants' views on identity, loneliness and isolation, guilt, and the innate healing properties of art. This dissertation confirms, as the literature supports, that humans in general as well as the participants in this study have an innate need to create. It is a biological need which is present in every human. This is stressed emphatically by Dissanayake (1995) in her fundamental article "Art for Life's Sake." This idea was also emphasized by Stamm (1975) and Kramer (1987). Stamm (1975) and Kramer believed that the arts clearly express who we are—our true selves. Stamm (1967) and Kramer postulated that through sublimation our inner balance is achieved, making us whole while bridging the gap between the conscious and unconscious. Sublimation, Stamm (1967) and Kramer attested, can be achieved through the art-making process. This can be accomplished with or without the facilitation of an art therapist as they both agreed; however, sublimation to be true and transformative, requires a witness.

The participants in this dissertation have a desire to share their artwork. In sharing their artwork, they will complete the process of sublimation, fulfilling the most basic need to be accepted and communicate. The healing takes place through the witnessing of their creations, according to Kramer (1987) and Stamm (1975). Witnessing outside of therapy is enough to heal undeveloped traumas that occur and erupt within the context of daily life. As defined earlier by Robbins (1987) in object relations theory, trauma can be defined as any disruption in attachment that has not been healed earlier. Our lives are

confronted by this type of trauma daily within the context of living. This is especially true in high stress health-care environments.

Self-identity is a core issue facing the participants in this study. It is a major issue for the professional caregivers. It manifests within many disciplines, surfacing as confusion, denial, and burnout, leading to depression in the health-care professional (Alkema et al., 2008). The arts, accordingly, seem to have a remedy for the ailing, burned-out physician, nurse, or other health-care professional. Studies by Lambert (2016) and Malchiodi (2012) confirm that art-making relieves depression as well as effects a reduction in stress and cortisol levels. They affirm that art-making positively affects dopamine and serotonin levels, which are both major factors in depression. Malchiodi (2020) further asserted that the creative arts therapies are instrumental in self-regulation and stabilization.

Stamm (1975) saw the arts as a reflective process, guiding the artist through an inner process that embodies the conscious and unconscious. This is supported by leading art therapists such Kramer (1987), Robbins (1987), Allen (2005), and McNiff (1992). Mc Niff (1992) and Allen (2008) viewed the arts as medicine that is deep within our souls. The arts connect us to ourselves and community and our inner processes. As McNiff (1992) concluded, the arts "offer . . . hope and resiliency to the healthcare worker-a form of self-healing."

In sum, the arts offer a self-reflective time away from our daily lives, supporting us in our healing and repairing trauma (Malchiodi, 2012). As Robbins (1987) succinctly stated, the life-affirming activity of making art is healing, and by nature the process of creating is transformative, leading to new solutions. New solutions, either personal or

universal, are welcomed and desperately needed as we enter an era of continued health-care personnel shortages and the looming consequences of this and other pandemics.

Policy: A Look Ahead

According to publication *Art and Well-being: Toward a Culture of Health* (Goldbard, 2018), health-care administrators have been greatly influenced by a movement called *Triple Aim*. This movement is an approach to optimizing health system performance simultaneously along three dimensions: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care (Bisognano & Kenny, 2012). According to Sadler and Ridenour (2009), insightful health-care administrators discovered that arts programs can address these goals and enhance the patient experience. Initial research makes the case that an arts-based patient-centered care approach, which is to provide care in a more personalized, humanized, and demystified manner, can actually meet these goals (Sadler & Ridenour, 2009). Arts-based care, focusing on the patient, indirectly supports caregivers, both lay and professional. It lays the groundwork that the arts are acceptable in health care, as well as for health practitioners. Additionally, it provides a positive work environment for the staff. The arts need to be encouraged in the health-care setting for the health of the patient, caregiver, and staff (Goldbard, 2018). According to HCAHPS (Slater et al., 2017), scores based on patient surveys distributed by Medicare equally deliver the good news that high patient satisfaction scores shaped by an enhanced arts environment correlate to increased revenue through the likelihood of more patient referrals and increased patient satisfaction.

Patient satisfaction within the health-care experience is informed by patients' interactions with all members of the staff, primarily physicians and nurses (Coetzee &

Klopper, 2010). According to Coetzee and Klopper (2010), it is critical to expand caring for the caregiver programs to nurses, because they comprise the single largest group of hospital staff and are the primary providers of hospital patient care. My recommendation is to extend arts/humanities programs within teaching hospitals. Art-related caregiver programs should also include medical residents, interns, and medical/nursing students as part of their training. It can be folded in their lunchtime conferences and medical grand rounds. Adding Schwartz rounds to their course of study can further humanize and personalize the patient care experience.

"As we understand burnout, it relates to the depersonalization that the clinician experiences with each patient encounter leaving them empty," as explained by Potter et al. (2013, p. 336). Additionally, it is important to note that medical residents, interns, and medical/nursing students are in the early, formative years of developing a personal medical practice model. Humanistic training during this time can have an even greater impact rather than later in their careers. The house staff as well as nurses are especially vulnerable to compassion fatigue because of their prolonged personal contact with patients and their families. Goldbard (2018) advocated for the extension of provision of arts programs for those in all caregiving roles:

> Professional caregivers (physicians and nurses), paraprofessional caregivers (such as home health aides), and informal caregivers (family and friends) face constant stress and at an ongoing risk for compassion fatigue. When integrated within a caring organizational culture, arts programs can provide cost-effect solutions to addressing the self-care needs of caregivers. (p. 16)

In looking toward the future, acknowledging that the arts are contributing to people's health and well-being is significant in promoting cultural transformation. The professionals working within the arts and health field recognize that the arts offer a dynamic common denominator in strategic collaborations to influence medical practice. This can lead to innovation and transformation, both of which are greatly needed, now more than ever.

Increasing demand for care, the aging of society (baby boomers), and a diminished work force which includes lack of staff due to increased burnout and supply is at a crisis point. These areas necessitate further exploration, since they play an essential role in staff retention and burnout. Policy and practice are supported and informed by research. It is especially helpful when the research supports cost-saving measures, making the business case that addresses staff retention and turnover rates.

Education for our health-care professionals and paraprofessionals focusing on arts and self-care practices needs to be standardized so it can be easily applied and widely practiced. Research is critical if we as arts and health supporters wish to incorporate sustainability as well as create a legacy. A humanistic medical education which incorporates the arts must be required curriculum in nursing training programs and medical schools. Not only will it enhance behavior by teaching and modeling creative self-care practices, but it will also assist the practitioner in providing an enhanced and family-patient-centered approach. Some medical practitioners have found that the use of the arts can also help them better recognize the patient's strength and satisfaction through improved communication (Charon, 2007). George et al. (2013) explained the practical effects that humanistic education has on medical practice: "Since the Association of

Medical Colleges directed development of medical humanities courses focusing on the narrative, it has been shown that physicians who have participated in these arts and humanities courses score more highly on empathy skills at the bedside." The arts and humanistic training must be included as an acceptable form of Continuing Medical Education (CME) credits. CME credits are a requirement for medical professionals to maintain their credentials. To further assist the clinician/artists who participated in this study, I highly recommended that each clinician/artist follow up with an independent art therapist to explore the issues that surfaced.

Another essential consideration regards policy and licensure on a national level. Having arts training and implementation tied to reimbursements and facility credentialing would be a key strategy. Policy on a national level generally begins with Medicare, which then filters down to private insurance. Senior care initiatives, which include nursing homes, and skilled nursing facilities, which also serve younger adults and children, are required through credentialing programs to provide programs for the patient that focus on body, mind, and spirit. These programs, which are mandated for licensure, also must include the arts. This structure can be extended to staff at hospitals and medical centers. It can be mandated just as annual safety and OSHA training is for the health-care staff on a regular basis.

On a local, grassroots level, health institutions can develop an arts and health program by utilizing local artists, students, and creative arts therapists in training. To be successful, the program should be designed in conjunction with a medical humanities specialist or a practicing artist with a deep knowledge of health care.

Implementing policy, creating sustainable programs, and delivering arts programs takes professional champions in the field—namely, medical and health humanists. Their skills and advocacy are needed to advance the field. Partnerships between medical and health humanities programs with medical centers and medical/nursing training programs would be a way to utilize existing resources to further make arts and health resources available to the health community. As recommended earlier, partnerships with artists, art programs, creative arts training programs, arts councils, and museums can offer a pathway to incorporate arts programming in a cost-effective manner for health-care institutions.

In summary, advancement of the arts and health-care field, to be sustainable and reach the individual practitioner, must include education and research, which needs to be hardwired into the system through policy and regulations by credentialing bodies. Clift and Camic (2016) asserted: "Efforts to develop consistent services across the arts and health-care field will need to include both the complex system of institutional partnerships as well as the intimate networks of original indigenous manifestations of the work" (p. 56). As Dissanayake (1992) reminded us, "human beings are programed to be aesthetic beings, finding creative expression important to successfully reaching developmental goals intellectually, spiritually and physically" (p. 175). It is important to remember, now more than ever, that "creative expression is especially important in times of uncertainty and grief that often accompany illness" (Hanna et al., 2011, p. 17).

Advocacy and support are essential, and this includes medical and health humanists and their training. Medical and health humanities, a growing field, can be on the forefront of this cultural transformation. It has implications for medical and health

humanities curricula, as well. The medical and health humanities curriculum at its core emphasizes and trains students in medical history and other resources included in the humanistic toolbox, but it needs to take the next step. It needs to embrace in its training best practices in how to implement such programs in medical and other centers. Its research needs to emphasize cost-effective, socially relevant programming focusing on mental and behavioral health issues that will ultimately inform policy on an institutional level. Training to further that agenda should include general health-care administration courses. Regarding the field of medical and health humanities, the future goal for the field, I believe, is to reach beyond the field and past its true believers. The arts and health field needs a homebase, an advocate to represent the field. Arts and heath, the healing arts, especially now that the health-care system is in crisis, needs trailblazers to come forward. The medical and health humanist is positioned nicely to reach policy makers, health-care CEOs, and funders (corporate and private) to prove through research methods the effectiveness of the arts in a health-care system. In turn, the medical and health humanist is poised to be possibly the best advocate for positive, creative, sustainable, and consistent change within our current medical system.

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APPENDIX A

IRB Approval and Consent Form

DREW

Institutional Review Board
Drew University
36 Madison Avenue
Madison, New Jersey 07940

G. Scott Morgan
Chair, IRB
Associate Professor

February 21, 2019,

Ms. Lupo and Dr. Ott,

The Institutional Review Board has conducted a review for your research project titled "Work Life Balance through the Arts and Creativity: An Intimate Portrait of Health Professionals" Your project has been approved. Please note that, if you make any changes to your research plans, the IRB will need to review and approve those changes.

Best of luck as you complete your research!

Sincerely,

G. Scott Morgan
IRB Chair

Consent Form

"Work Life Balance through the Arts and Creativity: An Intimate Portrait of Health Professionals "

You are invited to be a participant in a research study about direct care health professionals who are engaging in activities such as the creative arts to preserve their equilibrium and reduce stress. You were selected as a possible participant because of your role as clinician and your engagement in the arts. You were identified due to my personal knowledge of your work as a clinician and an artist or thru referral from a colleague. We ask that you read this document and ask any questions you may have before agreeing to be in the study.

1.Your participation is voluntary.

The purpose of this study is to explore on a personal, intimate level the correlation between engaging the arts and the management of stress within the health professions. The research will last approximately one year. As part of the study, you will be asked to participate in an interview (phone or in person) lasting approximately one hour. As part of the study, you may experience the minimal risk of sharing reflections about your art and profession. The benefits of participation are that through the interviewing process you may have a better understanding of your creative process. The study is being conducted by a Drew University, Medical Humanities Doctoral Student from the Department of Medical Humanites.

We ask that you read this document and ask any questions you may have before agreeing to be in the study.

2. BACKGROUND

The purpose of this study is to explore on a personal, intimate level the correlation between engaging in the creative arts and the management of stress within the health professions. In the health professions, it is acknowledged that burn-out rates are high among staff delivering frontline care. Many direct care health professionals are engaging in activities such as the creative arts to preserve their equilibrium and reduce stress.
Institutions such as hospitals and medical schools are taking steps to alleviate stress and fatigue through programming especially in the arts. Artists in residency programs and narrative medicine writing initiatives have been incorporated into the institutional healthcare landscape including medical school curricula. National
and regional programs have also been established operating as a resource in the field including: The National Arts Program, NJ Council on Humanities, The National Organization for Arts and Health.

3. DURATION
The length of time you will be involved with this study is approximately one hour.

4. PROCEDURES
If you agree to be in this study, we will ask you to do the following things: participate in an interview of approximately one-hour in length or less (in person or via phone). Participants are not required to answer all questions. Participants may end their participation at any time without consequence or penalty.

5. RISKS/BENEFITS
This study has the following risks: The Minimal risk is that participants will be sharing their reflections about
their art , their profession and personal information.

The benefits of participation are: For the participant it may give a better understanding of their own creative process as they reflect during the interview process. Participants will receive no payment or inducement for their participation in this study.

6. CONFIDENTIALITY
The records of the study are confidential and will only be available to the researcher. Records will be stored on
a personal, password protected computer. When Data is published or presented it will not include participants names or identifiers. Participants many choose to opt out of confidentiality
.
Optional: I grant permission to have photographs of selected pieces of my artwork included
in the published work or in presentations (TBD and mutually agreed upon).
Artwork included:
Title Date Media

7. VOLUNTARY NATURE OF THE STUDY
Your decision whether or not to participate in this research will not affect your current or future relations with
Drew University. If you decide to participate in this study, you are free to withdraw from the study at any time without affecting those relationships and without penalty.

8. CONTACTS AND QUESTIONS

The researcher conducting this study is Maria Lupo, MFA, MA-ATR. You may ask any questions you have right now. If you have questions later, you may contact the researcher at [redacted] or [redacted] or [redacted].
If you have questions or concerns regarding this study and would like to speak with someone other than the researcher(s), you may contact Dr. Scott Morgan, [redacted]

9. STATEMENT OF CONSENT

Please verify the following: The procedures of this study have been explained to me and my questions have been addressed. I understand that my participation is voluntary and that I may withdraw at any time without penalty. If I have any concerns about my experience in this study (e.g., that I was treated unfairly or felt unnecessarily threatened), I may contact the Chair of the Drew Institutional Review Board regarding my concerns.
Participant signature_______________________________________ Date___________

VITA

Full name: Maria Domenica Regina Lupo

Place and date of birth: United States of America – December 8, 1958

Parents' names: Alexander C. Lupo and Frances C. Lupo

Educational Institutions:

School	Degree	Date
Secondary:		
Our Lady of Good Counsel High School Newark, New Jersey	High School Diploma	1976
Collegiate:		
Rutgers: The State University Newark, New Jersey	Bachelor of Arts	1980
Graduate:		
Hunter College—CUNY New York, New York	Master of Fine Arts	1984
Caldwell University Caldwell, New Jersey	Master of Arts in Counseling and Clinical Psychology (Specialization: Art Therapy)	2008
Drew University Madison, New Jersey	Doctor of Medical Humanities	May 2022