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Mady Mooney

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ART THERAPY FOR RELIEF OF PHYSICAL AND EXISTENTIAL PAIN IN WOMEN DIAGNOSED WITH RHEUMATOID ARTHRITIS

A THESIS

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by

Mady Mooney

Edmonton, Alberta

Dedication

This thesis is dedicated to the memory of my father

Albertus Johannes Leewens (1921–2006)

Abstract

Rheumatoid arthritis (RA) is a chronic autoimmune disease with debilitating symptoms often including stiffness, joint inflammation, fatigue, and mood changes. It affects more than 20 million people worldwide. The purpose of this study was to examine whether group art therapy could help decrease existential and physical pain in women diagnosed with RA. Five women with daily RA pain were recruited to participate in a four-hour workshop, during which they created two intuitive mandalas bridged by a short journalling session. For their initial mandala, the participants were invited to represent their experience of pain. Following this, they journalled about resources they used to cope with their illness. In their second mandala, the participants imaginally represented about what they had journalled. Data collection included photographs of the women's artwork and journal entries completed during the workshop, along with transcribed audio-recordings of the women's discussions, and post-workshop interviews. Pain rating scales were utilized to record pain levels. In addition, I created two mandalas post workshop to gain a deeper understanding of the participants' experience. Analysis of the data yielded four major themes, along with a number of related sub-themes, including: (a) experiencing physical and existential pain, (b) holding pain in, (c) tapping into resources, and (d) how art therapy helped. The women's mandalas, workshop, and interview conversations indicated that pain was significantly reduced at the end of the workshop. Thus, the study demonstrated the potential benefit of group art therapy with a meaning-making focus to help relieve physical and existential pain for women diagnosed with RA.

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Chapter 1: Introduction

Our True Heritage

The cosmos is filled with precious gems.

I want to offer a handful of them to you this morning.

Each moment you are alive is a gem,

shining through and containing earth and sky,

water and clouds.

It needs you to breeze gently

for the miracles to be displayed.

Suddenly you hear the birds singing,

the pines chanting,

see the flowers blooming,

the blue sky,

the white clouds,

this smile and a marvellous look

of your beloved.

You, the richest person on Earth,

who has been going around begging for a living,

stop being the destitute child.

Come back and claim your heritage.

We should enjoy our happiness

and offer it to everyone.

Cherish this very moment.

Let go of the stream of distress

and embrace life fully in your arms.

(Hanh, http://peacefulrivers.homestead.com/thichnhathanh.html #anchor_14816.)

A little over two years ago I lost the ability to straighten out one of my fingers. It was locked into an awkward position, and I underwent physiotherapy without success. A referral to a specialist led to a diagnosis of RA, a systemic autoimmune disease. I was fortunate to have been diagnosed at the onset of the disease, which translated in little joint or organ damage. I was informed that the prescribed medication would take six months to take full effect. During this half-year period I was unable to work in my profession as a massage therapist, had difficulty getting dressed, was incapable of performing a number of simple household duties, felt extremely fatigued, and the pain made it almost impossible to go up or down the stairs of our three level home. At this point my physical pain matched my existential pain, the latter being all the nonphysical pain that was caused by life with RA. This included worries about my ability to return to the work that I enjoyed, financial ramifications, my perceived need to have to keep my illness a secret from my clients, as I could not imagine discussing a possible loss of strength, the type of medication and if its benefits would outweigh its side effects. I tried to continue my routine at home whenever possible, ignoring extreme fatigue, as if the disease was not part of me. In hindsight I realize I was in denial.

A couple of months before my diagnosis I had completed my art therapy practicum with patients who had been diagnosed with a major illness, cancer, and I

realized that some of them had been able to get in touch with their inner resources, managed to improve their quality of life, found strength, discovered a new meaning, and/or enhanced their coping skills. For some, the resources were a spiritual connection, engaging with their faith community, spending time in nature, or becoming more authentic and finally doing the things that nourished them. This awareness sparked my personal research journey. I learned the best way to support the new me was to read as much as possible about RA–the disease and its treatment–and engage in art making and reconnect to Spirit. What I read supported what I had seen in cancer patients and was now experiencing myself: the disease affects people physically, emotionally, sometimes spiritually, and therefore medication alone is insufficient. As an art therapist the modality I chose to gain new meaning and purpose was to create mandalas. I understand these circular forms as a conduit to Spirit, envisioning that their centre holds the space for the Sacred, thus inviting in the Sacred. The spiritual underpinnings during the creative process came from a number of sources, one of them being what I had learned from reading the wonderful book *Theological worlds* by Christian theologian Paul W. Jones (1989). I understood from Jones' writings that I live my life between two poles, my obsessio (dilemma) and my epiphania (resolution). These two poles function as lenses through which I see my world, and together these poles constitute the rhythm of my life. Obsessio is the wake-up call that can, in part, lead me back to epiphania, thus allowing me to see value in both as opposed to "good and bad." My particular worldview is one of separation and reunion according to Jones, as my existential pain and the worrying over different aspects of my new life would envelop me in that sense of separation, aloneness, and alienation. Creating mandalas

helped me become truly present to the pain I was experiencing, and as my feelings were placed on paper a sense of space was created. In this space I was offered a glimpse of Spirit; there was always a bridge leading back to a feeling of coming home, filling me with hope. The creative process taught me that I could tap into something larger than myself. With it came the discovery that what is inside myself is also outside myself, the oneness of all things. Obsessio and epiphania are but two views of how I see my world. I noticed that when my perspective changed, my existential pain was positively affected, which was often followed by improved physical pain; I will address the different kinds of physical pain that people with RA experience in Chapter 2 as research has shown that physical pain experienced at different times of the day can or cannot be improved, which was also my experience.

These, then, are some of the building blocks for my research journey: a realization that RA affects individuals on many levels, and to return to a rich and meaningful life one needs to implement approaches that nourish body, mind, and spirit. The use of mandalas offers a vehicle that can relieve existential pain, which might result in reduction of physical pain.

Jones' (1989) following quote succinctly captures my perceived initial "death sentence of my old life, before diagnosis" and its subsequent "homecoming."

> The shock to a person diagnosed as having terminal cancer is heavy. It is all over– so much so that the temptation is to capitulate. Yet the experience can become such an awakening that life lived in the face of death becomes new and refusing to take anything for granted. Each day lived as perhaps one's last, becomes the miracle of gift. Each sunrise, each bird call, each moment becomes precious, as

> sacramental. Thus to be stripped to nothing is to be prepared to receive back everything; the Now is "graced." (p. 123)

Problem Statement

RA is a systemic autoimmune disease, which causes chronic inflammation of the joints, the tissue around the joints, and other organs in the body. The disease affects more than 20 million people worldwide. By 2026, at least 6 million Canadians older than 15 will have arthritis (The Arthritis Society, 2004). More than twice as many women as men have RA (Arthritis Foundation, 1998) and women diagnosed with RA suffer more pain than men with the same diagnosis and treatment (Karolinska Institute, 2008).

RA can lead to existential pain in the form of extreme distress due to major changes in a person's life, it can affect one's work, one's relationships, and cause worries about the future and disruptions to one's sense of meaning in life. Depression is comorbid in patients with chronic pain and may worsen the pain experience. Increased depression is linked to deteriorating social and occupational functioning, reduced activity, and increased use of medical services (Gatchel & Turk, 1999). A strong association exists between catastrophizing and pain in arthritis and other rheumatic diseases. Catastrophizing occurs when one magnifies pain-related symptoms, ruminates about pain, feels helpless, and is pessimistic about pain-related outcomes; it is a tendency to believe that the most pessimistic outcome is the most likely to take place.

Medication for RA can slow down the disease and reduce damage to joints, offer pain relief, and allow better daily function. However, of course there are serious issues with side effects from drug treatment (Venkatesha, Berman, & Moudgil, 2011).

Alternative and complementary treatments are being explored, especially treatments that focus on psychological, emotional, and spiritual dimensions of pain.

The psychology of pain is central to this study. Turk and Monarch, in *Psychological approaches to pain management*, (2002) write that despite ever increasing knowledge of how the body works and development of innovative treatments, no treatment is available that permanently alleviates pain. Pain is not merely a function of tissue or organ damage, it is also a subjective experience, with the amount of the pain defined by the individual. At the very least, active coping can reduce the risk of psychological comorbidity (Treharne, Lyons, Booth, & Kitas, 2007). Chronic pain is increasingly managed by multidisciplinary means, psychological intervention being one of them. Previous studies of cognitive and behavioural interventions for pain suggest that methods such as self-management skills, regulating one's thoughts, emotions, and behaviours are effective in decreasing pain related to catastrophizing (Jensen, Turner, & Romano, 2001). A general interest in psychological interventions to lessen pain is evident when one considers the number of available research articles and the many self-help books in bookstores. Topics that include psychotherapy, mood management, relaxation, stress management, meditation, and education about chronic pain are suggested as approaches to pain reduction that people can use as spiritual and psychological self-care.

Art therapy is a holistic approach that translates well into self-care and that has been used extensively with individuals with a variety of medical diagnoses and/or conditions (Klagsbrun et al., 2005; Visser, 2008; Stuckey, 2010) and with physical pain (e.g., Long, 1998; Nainis et al., 2006). This study looks at the potential of a spiritually-

focused form of art therapy, mandala making, to promote meaning making and to reduce physical and existential pain in women diagnosed with RA.

Art Therapy

Art therapy combines the creative process with psychotherapy and makes use of imagery, colour, and shape to facilitate self-exploration, insight, self-understanding, and the expression of thoughts and feelings that would otherwise be difficult to articulate. Inner conflicts can be expressed imaginally, becoming visible and available for processing.

> Finding personal meaning in one's images is often part of the art therapy process. For some people, it is one of the most potent therapeutic qualities of art expression. It is a powerful way of knowing yourself and a powerful form of healing. (Malchiodi, 2007, p. 22)

Art therapy uses the arts to communicate feelings rather than to create aesthetically pleasing end-products, making creative expression available to all people, not just those who have artistic ability (Liebmann, 1986). Art therapists and others have described multiple therapeutic processes of art therapy. Furth (1988), a Jungian scholar who used drawing in a therapeutic context, wrote "important unconscious psychic contents are conveyed in drawings not only by the seriously ill, but also by the healthy, those whom we call 'normal' individuals, both psychologically and physically" (p. xiii). He proposes that symbols or images from the unconscious act in a compensatory or a complementary manner; they give voice to something which has been avoided but now demands notice.

An individual encountering stress or anxiety can bring the unknown into the

known through art making and thus be able to better deal with and transcend the challenges at hand. The idea of compensation is echoed by Malchiodi (2002), who suggests “despite one’s illness or debilitating medical treatment, the creative source within flourishes and people naturally reach for something within themselves that makes them feel whole even if pain and symptoms are not completely alleviated” (p. 12).

Schaverien (1999) introduces us to the idea that an art image “becomes embodied, empowered, and is subsequently disposed of and that this may result in a resolution of some inner conflict … and [in the patient] enables the new state, or an altered sense of self to emerge” (p. 63). The image then becomes the scapegoat in the therapeutic context; it carries the evil or illness, much as in the old rituals.

Clinicians have proposed a variety of ways art therapy can help with pain reduction: by positively altering pain signals to transform them and provide emotional distance (Long, 1998); through distraction and stress reduction (Hiltebrand, 1999); by bringing a clearer sense of the interrelation of body and mind and empowering people to manage their pain (Wood, 1998); by addressing complex psychological, emotional, or spiritual issues that prevent effective pain treatment (Trauger-Querry & Haghighi, 1999); by re-establishing hope and the ability to set goals (Palmer & Shepard, 2008).

Mandalas

For many centuries people of various religions have created and made use of mandalas as graphic symbols of the universe to aid in meditation. In Buddhism, contemplation of sacred images portrayed in mandalas is central to religious ritual, American Indians have created mandalas called medicine wheels to engage with the Creator, and Hildegard von Bingen, a mystic and Catholic spiritual leader in the 12th

century, created many mandalas. Her art was described as:

> Visionary symbolic paintings in unmistakable mandala-forms. The pictures were thought to be as strong or stronger than the words themselves… There is a gestalt immediacy, what Hindu's refer to as darshan, meaning the simultaneous act of seeing and being seen by a deity. (Sizemore, http://sfmosaic.wordpress.com/2010/11/20/hildegard-von-bingen/)

The West was re-introduced to mandalas by Carl Jung, who suggested that mandalas can have a calming, meditative effect on their creators, and can bring psychic integration (Jung, 1959). Malchiodi (2007) sees the circle as the natural form to work with in art therapy; it is one of the first shapes children use when they start drawing. Malchiodi's examples of mandalas used in healing ceremonies include an account of the Navajo people in the southwest U.S. who would create sand mandalas to treat illnesses. These circles were large enough to contain individuals and were constructed in conjunction with purification rituals.

Malchiodi goes on to say that the creation of mandalas provides a way of slowing down and refocusing often uncontrollable states of being. Malchiodi suggests that mandala drawing is an art process and can be valuable when extended over a longer period of time. "What's important is to experience the focus and centering derived from creating circle drawings" (p. 132).

The process of creating mandalas can offer a means of meditation and insight. McLean (1989) states "to meditate on a mandala one must know it completely and have a sense of its structure, polarities, and symbolic content" (p. 16). Contemplating a mandala is meant to stimulate a sense of inner peace, the feeling that life has again found its

meaning and order (Jung, 1964).

Fincher (2009), a Jungian-oriented psychotherapist and expert on mandalas, writes that artists frequently describe their creation of circles as a relaxing, meditative, or soothing activity as they offer us a safe space in which we can recapture our sense of balance. She writes, “Through the work of these artists we can see that the circle holds us, creates a place for us to know ourselves, and helps us grasp our place in all that is” (p. 21). She further suggests that mandalas both express and move us along our growth process towards wholeness. She states “mandalas can facilitate communication between our conscious and unconscious and support our ego as we discover our connection to the Self, our true center” (p. 31). Fincher describes how mandalas were often used to create a sacred place; evidence of the circular structures is found worldwide from South Africa to Scandinavia and from the southwestern U.S. to Australia. She explains that a mandala is not just a physical structure. For example, in some places its shape is constructed by the way pilgrims might circumambulate a temple or shrine, as seen in Bodh Gaya for the Buddha, or in Indonesia at the site of the Borobudur Temple, where a huge dome is surrounded by steps and pathways, thus creating a sacred mandala for the pilgrims in space. Fincher (2009) has also suggested “Ceremonial mandalas are believed to attract and hold the attention of the gods and goddesses during rituals” (p. 4). These days a mandalic road formed by a labyrinth is used to symbolize a spiritual journey to God as worshippers walk the pathways to the center and back out. Here the mandala can be used for longing to know God, oneself, or to experience harmony. Fincher wonders: “This widespread reliance on circles, circular movement, and mandalas when addressing deep human concerns demonstrates that the circle has remarkably universal

appeal. Could it be that the circle is especially useful for organizing human experience?" (p. 16).

Farrelly-Hansen (2001), in her book *Spirituality and art therapy*, introduces us to Kellog's (1978) theory of the Great Round. Kellog collected thousands of mandala drawings, which she sorted into categories looking for a unifying principle among them. Twelve stages of consciousness were discovered, and at "the centre of this wheel of creativity was Stage Zero, an exceptionally luminous space that transcended the personal … a place from which you witness your own life" (p. 151).

By creating mandalas we can tap into sources that can help us transform. Whether we see these sources as being inside ourselves, or coming from Spirit, their gift to us can be one of transcendence. Within art therapy, mandalas can be used to focus on meaning making and existential issues (Malchiodi, 2010).

Theological Thread

This study is informed by my own spiritual beliefs in addition to research about spirituality and pain reduction. I believe that spirituality and meaning making are important components of becoming whole; and attending to spirituality can help us to cope and construct meaning in times of adversity. Meaning making, whether personal/existential or spiritual, will be explained in this research in relation to the participants' contemplative and meditative work with mandalas. Mandalas, circular containers, can help organize inner chaos, offer a calming effect, cultivate attention in the present moment, and establish a connection to Spirit. The creative process can bring about transcendence if artists are willing to let the unknown arise, like the Divine who creates from nothing. Frankl (1959) writes: "Emotion which is suffering, ceases to be

suffering as soon as we form a clear and precise picture of it" (p. 82). Art therapy that is open to spirituality gives the artist/creator permission to be her authentic self and attract hope, strength, and insights from the depth of her being.

A research survey about pain and spirituality suggests that spirituality/religiosity can support the active coping process (Büssing et. al., 2009) and that although spirituality may not alter the level of pain (Keefe et al., 2001) as shown in a preliminary study, it may alter how well pain can be endured (Wachholtz & Pargament, 2005). Meaning making, whether personal/existential or spiritual, will be introduced in my research study through the participants' contemplative and meditative work with mandalas. Koenig (2000) found in his review of empirical studies focused on religion and health that the majority revealed "religious people are physically healthier, lead healthier lifestyles, and require fewer health services" (p. 1708).

Keefe et al. (2001) found that persons who used positive spiritual coping skills were more likely to describe their pain as bearable on the days they implemented those techniques.

Frankl (1963) described the search for meaning during illness as a spiritual process and this is my point of view as well. In my experience the support of a community, which may have either a spiritual or a psychological focus or both, can be instrumental in helping one learn from one's pain. I also expect that group art therapy might offer this as well.

Research Question

As little is known about the outcomes of using art therapy with mandalas as an intervention for reduction of pain in individuals with RA, this led me to the question

"Can group art therapy with a meaning making focus help relieve physical and existential pain for women diagnosed with RA?"

Why I am Interested in This Study

Since young adulthood I have had an interest in psychology, meaning and purpose, spirituality, and the healing arts. I have been self-employed for the last 20 years offering services to enhance an individual's well-being such as body-centred therapies, coaching, and facilitating meditation groups. I chose to do my thesis about art therapy and mandalas because I plan to work as an art therapist. My interest lies in assisting people to connect to their inner resources such as meaning, purpose, and spirituality, hopefully leading them to a sense of self-empowerment and authenticity. I see art therapy as the piece that completes the totality of a wholistic approach for me; I can now serve others in matters of body, mind, and spirit.

As I have been diagnosed with RA myself I have first-hand experience with the physical and existential pain that can come with the disease. Although I consider myself fortunate as my pain has almost vanished while on the lowest possible dosage of medication, the existential pain in the form of worrying about the effects and lasting potency of medication, whether the disease has truly been halted, and what the future might look like definitely makes me an insider with knowledge of this disease.

I am a believer in the dynamics and support of groups and group counselling. While attending a week-long series of informative RA sessions at the hospital with other women, I felt understood and supported by the group. Being able to listen to and discuss the lived experience of RA with others was helpful and informative. This event became

one of the catalysts for my research project.

I became intrigued with the effects of art therapy on pain perception when working at the Cross Cancer Institute as a workshop facilitator and art therapist. Patients would say they had not experienced the sense of calm that followed art making for a long time, and some would add that they had completely forgotten about their pain. I noticed that during the creation of mandalas, adults as well as children often drew spiritual imagery such as crosses, fish, halos, and bright lights and would comment on how surprised they were to "find" these symbols in their art as they had not consciously set out to create them. The images would lead to conversations around their spirituality or meaning and purpose in life, offering an avenue to talk about their sense of connection with a faith community.

Significance of This Study

Even though the significance of this study is implicit throughout the body of this thesis I would like to reiterate that this undertaking hopes to describe how art therapy might assist women in improving the chronic pain experience that can accompany RA. Receiving a diagnosis of a serious disease such as RA can be life-changing and learning what can move an individual towards a better quality of life is vital. It is becoming clear that chronic pain is multi-layered and that none of the most commonly prescribed treatment regimes, alone, is adequate to eradicate pain or have a significant impact on physical and emotional functioning. This is of importance to health professionals. Emotional distress is often associated with chronic pain. Interventions offered through art therapy can positively impact physical pain; we know that cognitive activity can influence physiological activity. These interventions can be a great adjunct to traditional

medical interventions.

This study further hopes to provide the reader, those who suffer from RA, the field of art therapy, and the researcher with qualitative evidence that the creation of mandalas as part of an art therapy setting can connect one to one's inner resources and to what is meaningful, resulting in reduction of pain perception.

Choice of Methodology

I have chosen arts-based methodology for my research (Knowles & Cole, 2008). According to Knowles and Cole, arts-based research has several defining elements: there is a commitment to a particular art form; the researcher uses a natural flow of events, imagination, intuition rather than a set of rigid guidelines, and the researcher is not only an instrument, but also an artist. Arts-based methodology requires attention to the ways the creation and processing of mandalas inform this study. This image-based art form is the defining element of this research as it unifies and explains representation with the inquiry process. An arts-based approach fits the topic, my beliefs, and my interest in ways of knowing that are emotional and spiritual. I am drawn to engaging the imagination and the subconscious, stepping into the unknown, and opening up to images. I believe images and the metaphors in them can be messengers of understanding that can capture more of the emotion and meaning of participants' experience than would be possible with words alone.

This study is arts-based in three ways. During the workshop, the women used art making to better understand and describe their own pain, their art was used during the post-workshop interviews, and I will use my own art making to help understand the women's experience and help interpret the results of the study.

Summary

Living with a chronic autoimmune disease characterized by pain, inflammation, swelling, and possible loss of function in the joints can be debilitating. The physical pain and subsequent existential pain can be life-changing. Through this research I explored whether the creation of two mandalas enabled the participants to connect to their feelings of pain as well as to their inner resources and if pain reduction resulted. It is my hope to contribute to those who suffer from this disease and to the field of art therapy.

Chapter 2: Literature Review

The literature reviewed herein is organized into five major sections. I first introduce the reader to the field of art therapy, in particular the mandalas in art therapy. This is followed by a section on the psychology of pain and research about treatments. The review continues with a segment on rheumatoid arthritis, focusing on the relationship between pain and affect as well as treatments. Theological considerations focusing on the value of meaning making and individuals diagnosed with RA experiencing pain are presented next. A review of arts-based research completes the arts-based methodology section.

Art Therapy

Research has shed light on outcomes of art therapy for people with medical illnesses, including pain reduction. In a non-randomized clinical trial conducted about art therapy and depression (Bar-Sela, Atid, Danos, Gabay, & Epelbaum, 2007), 60 cancer patients were invited to participate in weekly art therapy sessions where they were asked to express their feelings on paper. Only those who had participated in four sessions or more over a period of one year were evaluated as the intervention group, while the information from other participants (one to three sessions) was used to compare with the intervention group. The Hospital Anxiety and Depression Scale was completed before each session, relating to the previous week. The level of depression was high in both groups at the start. The study showed a statistically significant improvement in depression for those who participated in four or more art therapy sessions.

Greenwood, Leach, Lucock, and Noble (2007) describe outcome data for a client who received weekly sessions of art therapy for six years, an uncommonly long-term art

therapy. The research participant presented with severe anxiety, phobias, and depression. It is significant to note that the client had experienced mental health problems for many years and had not benefited from previous treatments, which included other forms of psychological therapy and antidepressant medication prescribed by a psychiatrist. Even though the client received unusually long therapy and might have improved over time, there was strong evidence from evaluation data that progress was substantial at the end of six years of art therapy. This improvement was maintained three years after therapy and the client was not on antidepressant medication. The Greenwood, Leach, Lucock, and Noble (2007) study was influenced by the work of Schaverien (1991), who demonstrated that clients' pictures and therapists' post-session notes can be used as data for art therapy research and Zammit (2001), who examined the benefits of art therapy on the healing process of a patient suffering from a life threatening disease using interviews along with the client's journals and artwork for finding patterns and themes. In Zammit's study, the client's subjective evaluation was that art therapy "still helped a great deal" after the conclusion of therapy and at the one-, two-, and three-year follow-ups.

Rao et al. (2009) conducted a randomized trial to assess the efficacy of art therapy with the primary aim of evaluating the change in physical and psychological symptoms experienced by people diagnosed with HIV/AIDS. These symptoms included pain, tiredness, and depression, among others. Seventy-nine people diagnosed with HIV were assigned either to participate in a one-hour art therapy session or to view a tape about art therapy. The study showed that physical symptoms improved significantly more for those who participated in a one-time art therapy session than for participants who watched the video ($p > .05$).

Nainis et al. (2006) conducted a study with one-hour bedside art therapy sessions for cancer patients, with before and after measurements of physical and psychological symptoms. Fifty patients were offered art therapy to determine the effect of the one-hour session on pain and other symptoms that cancer patients generally experience. There were significant reductions in eight of the nine symptoms measured. The study showed a link between expressing emotions through art therapy and reductions in anxiety and tiredness, evaluating the immediate symptoms after one session, rather than long term benefits. This study was the first to assess the benefits of art therapy on pain and other symptoms generally experienced by cancer patients in an empirical way. Of particular surprise was the reduction of tiredness experienced at the end of the intervention and participants' anecdotal reports of feeling energized.

Monti et al. (2006) conducted a randomized controlled pilot study to assess the efficacy of mindfulness-based art therapy (MBAT), a psychological group intervention that combines mindfulness meditation skills and aspects of art therapy, with the goal of decreasing distress and increasing quality of life for cancer patients. Jon Kabat-Zinn (1990) defines mindfulness as purposeful moment-to-moment awareness for deep spiritual self-inquiry and self-understanding. MBAT provides patients with skills for cultivating self-regulation (i.e. how people manage and adapt to stress, such as encountered in health crises) in a format that is not confined to verbal processing alone; rather it integrates verbal and non-verbal modes of processing, as does art therapy. The intervention in this study consisted of eight consecutive weekly meetings of two-and-a-half hours each, during which participants received mindfulness meditation training and art therapy tasks that were directed at exploring present moment experience; patients

focused on becoming (more) present to actual experiences and their emotional responses to them. The intervention group showed significantly overall greater decreases ($p < .001$) in symptoms of distress (including anxiety and depression): ms = .81 versus .73, providing preliminary support for the hypotheses that MBAT can benefit cancer patients.

Although these clinical perspectives and research studies provide evidence that art therapy may be helpful to people experiencing pain due to physical illness, there has been no research assessing the potential of art therapy, in particular through use of mandalas, to reduce physical pain and associated existential pain for people diagnosed with RA.

Mandalas

Carl Jung first encountered mandalas (Flanagin, 1994) when tried to relieve suffering, his own as well as that of his patients. Jung discovered that sacred symbols including mandalas rose spontaneously in dreams and artwork, with stabilizing emotional effects. He proposed that it is not actually we who are creating the mandala, but rather the mandala revealing itself. Believing the mandalas represented his own process of self-renewal, Jung encouraged his patients to become conscious of these symbols in order to promote their healing. He wrote:

> I sketched every morning in a notebook a small circular drawing, a mandala, which seemed to correspond to my inner situation at the time. With the help of these drawings I could observe my psychic transformations from day to day … I knew that in finding the mandala as an expression of the self I had attained what was for me the ultimate. (as cited in Flanagin, 1994, p. 142)

Jung credits mandalas with two purposes: to restore a previously existing order and to give a voice through expression and form to something that does not yet exist, something

new and unique. Jung (1964) proposes that in this new order the older pattern returns in a higher form.

Henderson, Rosen, and Mascaro (2007) explored the benefits of mandala making for people diagnosed with post-traumatic stress disorder (PTSD) in a randomized controlled study. The research was based on the work of James Pennebaker, whose innovative research regarding written disclosure has shown that writing about an emotionally laden issue for as little as 15 minutes per day over three to four consecutive days can bring improvements in physical and mental health (Pennebaker & Seagal, 1999). The Henderson et al. (2007) study facilitated drawing of mandalas for three consecutive days in sessions of 20 minutes. At one month post-intervention the mandala group showed more of a reduction of trauma symptoms in the study (these included depressive symptoms, anxiety, spiritual meaning, and the frequency of physical symptoms and illness) compared to control group participants who were instructed to draw 3 simple objects over 3 days.

Curry and Kasser (2005) sought to determine whether colouring mandalas was effective in the reduction of anxiety. Participants in their study were divided into three groups. One group coloured a pre-drawn geometric mandala, the next group coloured a specially designed irregular plaid design, and the last group coloured freeform. Anxiety levels were measured three times. Before the drawing activities all groups were asked to think about what makes them most fearful, followed by four minutes of writing about the experience. Results clearly showed that colouring mandalas for twenty minutes reduced anxiety more than free form colouring. The findings of the studies seem to point to the power of the mandala to reduce anxiety to levels lower than before the anxiety induction.

Hieb (2005), the author who has used mandala creation as a form of meditation to assist clients to connect the deeper presence of the Holy within, states “It is very helpful for some people to use the shape of a circle in their art journaling-prayer. The circle may both enhance and limit your freedom of expression, or may otherwise intensify some aspect of this particular theme” (p. 164).

The findings of these short and long term interventions seem to point to the power of the mandala to increase relaxation, reduce anxiety, and evoke meditative states.

Psychology of Pain

This section explores information available about the psychology of pain and studies about the psychological treatments for pain. A common method of assessing pain is having individuals complete a quantitative pain scale where one side represents no pain and the other extreme pain. However, this does not represent the complete experience of pain as the psychosocial factor has not been taken into account. Pain is a multidimensional experience; it is not only due to physical pathology, but cognitive factors are an integrated component of the pain experience. We develop patterns around pain that can be influenced by culture, environment, family, gender, attitudes, moods, expectations, or coping skills. These psychological aspects can translate into physiological changes; they cannot be separated from it. A growing base of research suggests that self-efficacy beliefs notably contribute to the extent that a person is disabled by their chronic pain (Peacock and Watson, 2003; Keefe, Abernethy, & Campbell). Effective pain management must therefore engage in a multifaceted approach.

While examining psychological influences on chronic pain, Turk (2002) points to the impact of affective behavioural and cognitive factors on pain. Turk brings to

our attention that living with persistent pain requires emotional strength and can easily exhaust people's mental and emotional reserves, and treatment of physical problems must be supplemented by methods that can improve quality of life. Cognitive factors such as beliefs about their pain, social support, or the health care system can help or hinder physiological activity, as can patients' commitment to treatment or their communication to health providers and those close to them.

Gallager and Verma (2004) write that chronic pain has an emotional component and many studies reveal a high degree of comorbidity of depression and chronic pain, higher than for any other chronic medical illness, with evidence showing that depression often follows chronic pain. In a review of psychological approaches and treatments Turk, Swanson, and Tunks (2008) concluded that the individual's thoughts, behaviors, and psychosocial aspects are of significant importance in the experience of pain, maintenance, and exacerbation of pain. Self-management strategies directed to replacing feelings of passivity, dependence, and hopelessness with activity, independence, and resourcefulness were found to produce the best results. Review of another study addressed the value of meditation. Turk et al. suggest that in mindfulness meditation suffering becomes the object of meditation and rather than avoiding one needs to explore it. Research shows that this kind of intervention has help decrease pain, stress, and enhanced well-being. Vlaeyen, Crombez, and Goubert (2007) discuss the importance of cognitive and behavioural processes of chronic pain and pain-related disability. They suggest that it is difficult for individuals to separate themselves from cognitive processes, such as paying attention to pain, or signals for pain, as well as the fear that accompanies catastrophizing, or trying to make sense of pain, which in turn will influence pain

behaviours and levels of disability. They propose that cognitive behavioural treatment interventions are effective in reducing the immense suffering which individuals with chronic pain experience as these strategies lessen the feeling of being trapped into a vicious circle of physical, emotional, cognitive, and behavioural problems. Treatments may include stress-oriented cognitive therapy, problem solving skills training, and cognitive behavioural therapy.

> Schapiro, Schwartz, and Bonner (1998) propose that
>
> Mindfulness meditation may not only connect one with him/herself, it may also foster a sense of connectedness with others and with a greater whole … and that these positive psychological changes associated with the cultivation of mindfulness have been linked to greater psychological/and or physiological well-being. (p. 584)

Even though the origin of meditation was religious or spiritual and used for personal transformation or bringing an end to suffering, as a healthcare intervention it is offered to patients regardless of religious backgrounds with a secular application. As pain and suffering become the object of meditation, a reduction in pain, improved mood, decreased stress, and increased healing speed are often the outcome. Grossman, Niemann, Schmidt, and Wallach (2004) performed a comprehensive review on mindfulness-based stress reduction (MBSR). MBSR is a program that uses mindfulness meditation to decrease pain and suffering related to psychosomatic disorders. Its aim is to become aware of one's conscious mental processes with the hope of getting a more truthful perspective, which reduces negative mood and improves one's coping skills. The findings suggest that MBSR may help a broad range of individuals to cope with their

clinical and nonclinical problems.

Fernandez and Turk (1989) also describe guided imagery as a beneficial tool for relaxation, distraction from discomfort and pain. Guided imagery is a modality that encourages the patient to create a variety of mental images, in this case the images selected are enjoyable, pleasing, and can thus be used as a new focus, away from pain or discomfort. Images created through art therapy can be used for meditation and relaxation.

Smith (2007) researched more than 40 relaxation techniques, relaxation and relaxation states (R-states), and found that they point to 12 basic R-states which he organized in four groups that include: R-1: basic relaxation, R-2: core mindfulness, R-3: positive energy, and R-4: transcendence. Each study yielded many findings, some of which reveal people who suffer from any form of mental distress may evoke R-states, more women report positive energy when using relaxation techniques, and health is positively affected with the R-states of being mentally relaxed (R-1) and being optimistic (R-3). Of particular interest to this study is the R-4 state with its interest in that which is larger than the self and includes mystery quiet, prayerful, and [being] “at one.” The R-4 states prayerful, “deep mystery,” and “at one” are spiritual states in which the individual experiences something larger than oneself; this can be God, or simply the feeling of awe and wonder at the universe; one is said to experience a state of transcendence.

In a synopsis of empirical evidence for the most used interventions for chronic pain in people other than cancer patients, Turk, Wilson, and Cahana (2011) concluded that none of the most commonly used treatments, pharmacological, interventional, physical, psychological, rehabilitative, or alternative are by themselves able to eliminate pain and/or increase a person’s physical and emotional functioning. These conclusions

are not so surprising in view of the fact that chronic pain is complex and affects people on many levels.

In summary, chronic pain is complex and research suggests that chronic pain outcomes appear to be dynamic and ever-changing states; they are determined by who we are and how we cope and the circumstances we find ourselves in while coping with chronic pain. People who have recurrent pain often become frustrated, lose hope, and at times the support of those close to them, their employers, and/or the healthcare system which financially supports for short term rather than for long term periods, all of which contributes to emotional stress. In the absence of one particular cure for those afflicted by chronic pain, it becomes imperative to find what helps people function best and improves quality of life. The therapeutic benefits of psychological interventions on one's experience of pain have been well researched (Baird & Sands, 2004; Danoff-Burg, Agee, Romanoff, Kremer, & Strosberg (2006), Danoff-Burg & Revenson, 2005; Dixon et al., 2007). Art therapy is a modality that has potential as psychological treatment and as such is well-suited to be part of a more comprehensive approach; it is a mind-body intervention that may well mobilize powerful healing and alter a person's physiology and affect from one of stress to one of relaxation, positively affecting one's pain perception and management.

Rheumatoid Arthritis

This section looks at the relationship between pain, attitude, and affect of those diagnosed with RA, as well as the need for a holistic approach and coping skills. RA is a chronic autoimmune disease that causes inflammation and/or destruction of joints and surrounding tissues, causing people to experience swelling, stiffness, and making chronic,

debilitating pain its primary symptom. Chronic pain is typically associated with secondary stressors that may include sleep disruption, fatigue, depression, difficulties with basic tasks of daily living, and existential burdens such as interpersonal tensions, loss of one's career and hobbies. These problems increase the need for improved coping resources.

Great progress has been made recently with disease-modifying anti-rheumatic drugs (DMARDs) affecting the way RA is treated (Lorig & Fries, 2006). Evidence shows that these drugs slow down the destruction of joints and are now used as soon as treatment starts rather than reserved for later use, positively affecting patients' level of chronic pain. Of course despite these advances there is still a significant number of people with RA who suffer from chronic pain. Of importance as well is the consideration of the characteristics of many people who have been diagnosed with RA. Maté (2004) writes that RA patients carry stoicism to an extreme degree, which results often in putting up with great discomfort, not complaining, keeping their pain hidden, not seeking medical help and/or resisting taking medication. He adds that a medical-psychiatric study conducted for the Maryland Chapter of the Arthritis and Rheumatism Foundation (1969) found a common psychological profile for RA patients. In particular they observed a quality of pseudo-independence as characterizing this patient group, which included a belief that they could get through everything by themselves, without help. When comparing pain intensity in patients with RA and fibromyalgia (FM), Viitanene, Kautiainen, and Isomki (1993) found that the pain intensity of patients diagnosed with FM was constantly twice as high as in RA patients.

In a review of articles on catastrophizing and pain, Edwards, Bingham III,

Bathon, and Haythornwaite (2006) demonstrated that catastrophizing results in higher pain severity among patients diagnosed with RA and may also influence the success of pain related treatments in patients with musculoskeletal disease. Catastrophizing is also strongly associated with measures of negative affect and may contribute to depressed mood on the short and long-term basis. In addition it relates to lower coping efficacy in patients with RA (Bergbom, Boersma, Overmeer, & Linton, 2011; Keefe, Brown, Wallstone, & Caldwell, 1989).

A non-randomized study with 82 RA patients was conducted to predict whether pain, physical dysfunction, and affective disturbance were directly affected by the manner in which patients processed their stressful life events rather than by the events themselves (Lumley, Kelly, & Leisen, 1997). The authors concluded that stronger pain and poorer adjustments occurred amongst those who recognized their emotions, but were reluctant or unable to disclose their feelings. This ambivalence impacted their negative moods and increased health-related problems. The study also showed that failure to share stressors caused participants to have a tendency to excessively ponder about events, which resulted in increased pain. Life stress was dependent on thinking about what was stressful rather than on actual pain and physical dysfunction, and it increased pain and dysfunction.

In a non-randomized study, Shariff et al. (2009) found that patients who suffered from chronic pain used three strategies to live with their pain. Some embraced a body-management approach; others chose mind-management; the third group chose to integrate body and mind by using mind-body management. In the first group, body management, participants tried to control pain through drugs, surgery, and body therapies

such as physiotherapy and complementary therapies. People in the second group, mind-management, saw the body as weak and the mind as strong, and would try to “spare” the body, finding ways to compensate by using protective strategies. In mind-body management the focus was on integration of mind and body to achieve meaningful everyday life. Interviews with 46 people experiencing chronic pain and 46 interviews with RA patients were conducted. Results showed that quality of life was not improved by pain control alone, but improved with a variety of mind-body techniques for managing pain. Being mindful was one of them, this included purposefully concentrating on things that are in the present moment (breath) and another was distraction from pain. Accepting a new normal and adjusting the way people related to themselves also played an important role. Results also revealed that people valued well-being and having a meaningful life distinct from pain, and that specific kinds of mind-body management may be of importance to those experiencing chronic pain and RA.

Pradhan et al. (2007) further support the benefits of meditation through their research in which they studied the effects of mindfulness-based stress reduction (MBSR) in RA patients. This controlled pilot study measured the effects of MBSR on patients' psychological status and disease activity. The control group participated in an eight-week meditation program, during which they practiced mindfulness, defined here as moment-to-moment nonjudgmental attention, which was followed by three refresher classes over the next four months. The participants in the control group were offered MBSR at the end of the study only. Both groups returned after two months and even though the results supported a trend that was promising; it was found that at this observation point, there were no differences between the control group and the intervention group, both had

improved somewhat. However, major changes were observed at 6 months, after a four-month maintenance program, in regard to well-being and psychological distress; the control group which was active only until the end of the study, had lost its benefits, and patients in the MBSR intervention group maintained their improvements. Of interest was that there was no impact on the RA disease itself, as no improvement was seen in the active joints.

Hwang, Kim, and Jun (2004) conducted a small phenomenological study on Korean women suffering from RA. The participants of this study were interviewed about their experience of RA in the hopes to bring to the fore the philosophical and existential basis of women suffering from this disease. The results of this study identified eight needs through major theme clusters which were: severe pain, self-esteem, negative feelings, reflect the past life, concentrate on recovery from disease, a comfortable mind in pain, support of family and others, and new life. The clusters described various aspects of the lived experience of women with RA. These results are of importance in order to provide effective interventions for women with RA.

Quality of life for women with RA is dependent on support of the family. In a male-oriented society like Korea, female patients are considered socially inferior and are typically suppressed. These women were reluctant to disclose suffering due to the disease to their families and others and did not receive benefits such as rest time periods. Support of one's family and others is an important factor of well-being, resulting in reduced anxiety and episodes of depression, all of which are directly related to one's experience of pain (Hwang, Kim, & Jun, 2004).

In a study that used questionnaires, self-report measures, and daily record

keeping, Newth and Delongis (2004) examined the role of one's personality on mood, coping processes, and chronic pain as they unfold within the time-frame of a single day in individuals diagnosed with RA. Chronic pain was associated with stressors such as tension, difficulty performing daily tasks, disruption of sleep, all of which compound stress and require more coping skills.

Seventy-one individuals with RA reported their pain, coping efforts, and negative mood via structured daily records. Results showed that negative moods and coping strategies were directly related to pain. Participants with RA who experienced high levels of pain in the morning are likely to remain in higher pain throughout the day regardless of their mood, but for patients with little pain in the morning the ability to affect their mood played a significant role.[1] Shifts in affect within days were indicative of changes in pain within days; a higher negative mood brought about an increase in pain later in the day, often within a matter of hours.

Cognitive reframing, explained by the researchers as occurring when one "represents efforts to perceive one's current situation positively via positive reappraisal and downward social comparison" (meaning comparing oneself with someone whose troubles are more serious than one's own) was essential, as was rediscovering what is important in life, or whether one changed or grew as a person. The more cognitive reframing was applied the less severe the pain became; it appears to be an adaptive way of coping with chronic pain due to RA.

Treatment for RA conventionally focused on medication, however from these studies we learn that it is important to encompass a holistic, multidisciplinary approach.

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1 It is important to note that immune-based RA pain is typically worse in the morning versus damage-related pain that is typically worse later in the day.

Awareness of one's thoughts and attitude, self management, coping skills, and support from loved ones are imperative; a lack of these might lead to increased tension in the body, leading to impaired functioning, pain, and additional symptoms of RA. Art therapy can bring to focus a deeper awareness to one's present state, give voice to the experience of pain, sadness, or anger, an acknowledgment which, as seen in the forgoing, can aid to a decrease in pain.

Spirituality, Meaning Making, and Pain

People with chronic pain and/or disabilities often turn to spirituality. Research studies show that meaning or purpose in life and/or spirituality can be valuable coping resources. Better mental health and optimistic coping style are significantly associated with higher purpose in life scores and better well-being scores (Verduin et al., 2008). "How well people can face the challenge of such a life-threatening illness will in part depend on their ability to find meaning in the adverse event" (Ardelt, Ai, & Eichenberger, 2008, p. 290). In a non-randomized study, Glover-Graf, Marini, Baker, and Buck (2007) assessed the role of spirituality in persons who suffer chronic pain from a variety of conditions. Participants indicated, by way of a spirituality and chronic pain survey, that being spiritual and/or prayer played a positive role in dealing with pain. Spirituality and/or prayer also provided a source of happiness, social support, and a sense of meaning and purpose in life. The study further revealed that by embracing a life that includes spirituality, people felt helped with their sense of guilt or worry over their predicament. Some expressed feeling closer to God or Spirit. Some felt spirituality was preventive; others viewed it as curative. It was discovered that prayer was second only to taking medication and that the combination of both was the most frequent treatment for pain.

Skaggs and Barron (2005) published an article to advance nurses' understanding of patients in regard to meaning making, life change events, stress, and coping in negative health events. They considered the term meaning in relationship to two broad categories: (a) global meaning–significant perceptions of one's life or place in the world and (b) situational meaning–significant perceptions that are attributed to a specific situation. Global meaning is understood to be the person's general meaning in life in regard to their goals, purpose, values, and beliefs about what is essential, along with awareness that life is generally predictable and comprehensible. A person's worldview will influence the way she thinks, feels, and behaves. Situational meaning is defined in this study as: "a person's interpretation of an event or situation perceived as important or significant and having an impact on their values, beliefs, commitments and sense of order in life" (p. 563). Situational meaning is further considered to have three major components: appraisal of the situation, search for meaning, and meaning as outcome. When a person sees an expected event as negative while also lacking coping skills, then searching for new meaning follows, suggested Skaggs and Barron. When global meaning and situational meaning are not aligned, i.e. incongruent, people suffer. Challenges experienced due to illness, for example, may be the cause of psychological distress, expressing itself as anxiety, fear, anger, sense of loss, or hopelessness. Reassessment of the event will be called for. "People may emerge from the life-changing event with a sense of personal growth characterized by a new outlook on life, new priorities, realistic goals, new coping skills and a deeper appreciation of life" (p. 567).

Reynolds and Prior (2003) sought to investigate the meaning and function of art for women who lived with chronic illness. Participants in this study were asked to use

textile arts only, such as embroidery, tapestry or quilting, and mixed media; it was thought that excluding other art media would help discover common shared themes more readily. Findings suggested that art making provided a means of positively enhancing quality of life, and showed the participants the importance of having goals, and the benefits of having a social network. The researchers hold that chronic disabling diseases interrupt the status quo of our roles and daily occupations, causing loss of identity, quality of life, and often bring about adverse effects on the person because of pain which can affect the self, family roles, careers, and lifestyles. This idea is further supported by Wikstrom, Isacsson, and Jacobsson (2001), who found that those diagnosed with RA report a loss of about two thirds of their leisure activities. People who are able to maintain leisure pursuits and self-care during illness tend to fare much better. Art making may bring a sense of an able identity, improved quality of life, and a remedy to the stresses of illness. Research findings in the Reynolds and Prior (2003) study showed that art making brought new meaning to life by filling an occupational void with a satisfying creative activity. Creativity offers a plethora of benefits, including an opportunity to re-assess one's lifestyle and self image; a sense of control that patients could exercise over the creation of products, as many lost that sense of power over their health; a new appreciation of one's aesthetic surroundings, colour and design of every day objects, resulting in less focus on the illness; a sense of adventure and completion of a goal; the ability to revise priorities as some found they did not have to pay so much attention to goals that had been threatened by the illness; building new relationships; making an artful contribution to others and making future plans as further art products and ongoing projects seemed to some to guarantee their survival.

The studies in this literature review confirm meaning making, purpose and/or spirituality as essential to the well being of an individual. It might be beneficial to further study mandalas to advance research that defines the relationship between meaning making and stress reduction in women diagnosed with RA.

Arts-based Methodology

In the visual arts, collage is gaining importance as an arts-based research practice (Butler-Kisber, 2008). Collage is a French word, meaning a glued work. Observing her students use artful ways to encourage new means of communication and learning shaped Butler-Kisber's own research. In employing collage as inquiry, the author asserts that a more embodied and alternative representational form is created. The perception of the relationship between the creator and the visual text expresses meaning in concrete ways to the viewer. Butler-Kisber states that researchers usually define ideas followed by words and ways of expressing the ideas when engaged in writing up research; she suggests that this is not the case when using collage in arts-based research. Here the development travels from intuition and feelings to thoughts and ideas. The analytical process embraces establishing evolving clarity about meaning and interpretation, whereas in working with collage, a metaphorical product is created that may offer different responses. The author further addresses memoing in qualitative research, which is a linear process that examines data in new ways and grapples with ideas in order to gain insights that affect the analytical process. Using collage as memoing lets the researcher work in an intuitive and non-linear way as she cuts and pastes found images to portray an aspect of the research process upon which there is a focus.

Butler-Kisber further employed collage to conceptualize a response to a research

question. Once the question was verbalized, a series of collages were produced to answer the question. The collages were interacted with to determine the various themes, which were then named to reflect their essence. By examining the clusters it became clear to the researcher that additional possibilities for interpretation existed, such as colours, shapes, composition, and content. Viewing, discussing, and writing repeatedly can be used to analyze the results in order to distil distinctions and common attributes of the collages. Weber (2008), in "Visual images in research," in J. G. Knowles and A. L. Cole (Eds.) *Handbook of the arts in qualitative research* (pp. 41-53) acknowledges the importance of the use of images in research. She suggests that the researcher may invite people to draw or paint an image that relates to the research question. The image can ignite thoughts, feelings and reactions, which can become a basis for discussion, interview and/or analysis. Weber posits that we can expect to find an increase in image-based reporting of research findings to convey theoretical and empirical meaning.

Leavy (2009) suggests that knowledge-building tools shape our research question and design. Methodological innovation such as arts-based research does not merely add to existing methods, but rather opens up new ways of thinking about knowledge building and new ways of seeing. Arts-based practice is an extension of conventional qualitative research; it requires different skills on the part of the researchers. "Although the arts are most typically associated in social research with the representation stage of research … the arts [in arts-based research] are being used during all phases of the research endeavor from data collection to analysis and representation" (p. 4).

Visual art is just one of many different method-practices offering valuable approaches for accessing what needs to have a voice, evoking emotional responses,

eliciting discussions, and facilitating possible transcendence. McNiff (1998) asserts that art therapy research is often conducted through the practitioner-research model, whereby art therapists use their skills as a basis for investigation of the art therapy experience. An example of this is found in *Art is a way of knowing* (Allen, 1995), for instance, through the artist's spontaneous images, which were expressions of her felt emotions. McNiff (1998) proposes, "The visceral and animated qualities of the images themselves can be viewed as evoking a new type of complete examination and showing in art therapy research" (p. 123). He suggests that we be extremely cognizant of overly technical methods of research as they may come between us and the language of the image and may well interrupt the innate wisdom of the creative process.

Summary

In view of the complexity of pain, the above literature review makes it abundantly clear that not one treatment by itself has the ability to eliminate pain, restore function to a high level, or reinstate previously enjoyed quality of life for those who suffer from chronic pain. It therefore befits patients diagnosed with RA to integrate treatment modalities that maximize symptom relief related to body, mind, and meaning making. Art therapy research offers patients a creative means of expressing their internal experience, evokes relaxation, and facilitates moment to moment awareness for deep spiritual self inquiry. I choose to work with the mandala in particular as it is my hope that this circular shape might connect its creator to her core, her most inner, essential Self, and ultimately to Spirit. The Sanskrit word mandala, typically translated as circle, offers us a secondary translation where the word "manda" means essence and "la" stands for container (Grey, 2001, http://www.international-relations.com/CM4-2/Encounterwb.htm).

The need for meaning making is ontological. Search for meaning often happens as people try to make sense of life after a diagnosis of a serious illness or when living with constant pain. Some might define this as spirituality, although this search may or may not include a belief in a higher power. The literature review here suggests that people who embrace a spiritual practice may improve their ability to cope with pain, as a (renewed) sense of meaning is associated with positive emotional and physical health outcomes.

it doesn't matter

how the branch moves

as long as it moves

it means there's a breeze

o branch

don't think you have to move

this way or that way

and don't try to run away either

don't you know that the only guidance you'll ever need

comes from the wind?

(Rumi, as cited in Johnson, 2010, p. 106)

Chapter 3: Method

I chose an arts-based approach for this study about art therapy. Arts-based methods allow a different kind of knowing, an artistic knowing that is so eloquently described in *Art is a way of knowing* (Allen, 1995). When art is used, the researcher works in an intuitive, non-linear way and images can give rise to information that might otherwise not become conscious (Knowles & Cole, 2008). I based the study on an art therapy workshop; I used the participants' art and art making as sources of data and as prompts during post-workshop interviews, and I used my own art to deepen my understanding of my findings.

I offered a mandala making workshop for women with RA during which they made two mandalas that they wrote about and discussed as a group. Drawing or painting two mandalas offered the women two "containers," the first one to hold feelings about their experience of physical and/or existential pain, and the second for exploration and expression of resources which had supported them through their pain and what they enjoy in life. I based the study on an art therapy workshop because art-induced processes can offer a different perspective and/or new insights as they are fuelled by feelings or intuition, rather than by thought processes. A new perception can invite new behaviour, which might support pain relief.

Recruitment

My goal was to have a workshop with seven women. I recruited eleven women to participate in the study, allowing for dropouts. The women were over the age of 18, diagnosed with RA, and experiencing arthritis pain on a daily basis. I inquired into whether each potential participant was currently receiving psychiatric support for

experienced emotional distress. If she was, I planned to suggest that the group session might not be suitable for her at this point, but no one was. The women had to be willing and able to engage in the art making process and in a post-workshop interview in English.

Several people agreed to help me with recruitment; an acquaintance who is a respirologist at the University of Alberta Hospital forwarded my poster to her colleagues who specialize in auto-immune diseases, my own physician supported me by making the poster available to his patients, and the poster was placed on the University of Alberta Arts and Humanities in Health and Medicine (AHHM) listserve.

I sent letters requesting referrals of research participants to 17 rheumatologists in Edmonton, the Director of Education at the Edmonton Arthritis Society (see Appendices C and D), physiotherapists, yoga studios, and chiropractic clinics. These letters were accompanied by a poster that had pertinent information about the research study on it, mention of ethics approval, and my contact information as well as that of my thesis advisor (Appendix E). The recruitment notice was also posted on RA and related research websites.

Eleven women contacted me to express their interest and get additional information. Appendix F lists the requirements I was looking for in my participants. The women who were interested in participating were then screened by telephone to make sure the study was a good fit for them (see Appendix G). If this was the case, I sent the woman a consent form to read, sign, and return to me (see Appendix H), as well as a brief demographic questionnaire (see Appendix I).

The consent form was clearly explained during our telephone conversation, as were some of the details of the workshop and post-workshop interview. Questions were

invited and answered during our telephone conversation. Once a signed consent form was received, I officially enrolled the woman in the study, assigned her an identification number to protect her confidentiality while analyzing the data and reporting the findings, and I sent her the information about the workshop time and location. The date of the workshop was emailed to the women when the largest number of participants able to attend on the same day was agreed upon. Of the eleven women, four dropped out and one did not meet all of the criteria; of the remaining six who attended the workshop, one participant decided to discontinue early in the session.

The Workshop

The four-hour workshop (Appendix A) took place in a private art studio, which provided space for art making and a quiet area for anyone needing a "time out" from art making or processing. I have been leading mandala workshops for four years and therefore facilitated this workshop myself, with the help of a co-facilitator who is a professional art therapist (Appendix B). The co-facilitator assisted with the following: greeting the participants, issuing nametags (first names only), helping the women get comfortable, and offering refreshments. During the workshop she was observant of participants regarding level of participation, body language, and emotional states, and she ensured that participants felt free to ask for assistance when needed and responded when they did. She aided with audio equipment, art supplies, camera, and wrote up a summary at the end of the workshop, which included her observations of what took place during the art making and discussions.

The workshop started with an opening circle that included a welcome, an overview of the event and introductions; the women were instructed to use first names

only to respect confidentiality. There were six women and after an official welcome I invited each to share briefly around their experience with RA, including when the disease started, how it affected their lives, and ending with the current state of the disease and their perception of pain.

The co-facilitator introduced herself next, explained her position and role, and that she would take some notes as part of the data collection. In addition to my own introduction I briefly explained my reason for the research, which was to explore the possibility that a mandala-making art therapy workshop could help reduce physical and/or existential pain associated with RA. I decided to not tell the women that I too had RA, however when one of the participants asked me the question later during the session, I disclosed my diagnosis.

This introduction was followed by group guidelines which included a short discussion about the content of the consent form, reminding the women that their participation was strictly voluntary and that they were free to leave at any time should they feel the need to do so. I explained that expressing oneself through the arts can, at times, result in unexpected surfacing of emotions, and it is helpful if participants feel safe to experience these, making confidentiality important. I asked the participants to ensure that everything they heard and shared during the workshop would "stay in the room" in order to provide that safe place for all, where everyone could express whatever they deemed necessary. Of course I have to trust that none of the members discussed what had taken place once they left the group, as I cannot protect confidentiality for a group outside the workshop environment. Participants were also made aware that, for some, letting go of emotions might be a first or awkward and to respect it by letting the person

experience it without immediately running to her aid.

I then briefly introduced the women to the mandala: its meaning, sacred circle; its history and its use as a healing form by many different peoples for self-transformation; its potential to connect to Spirit. I passed around images of intuitive mandalas to provide the women with visual examples, at the same time hoping that the images would make them feel comfortable when drawing their own, as the examples clearly showed that artistic skills were not required. I used illustrations from *The Mandala Workbook* by Fincher (2009) and the *Groot Mandala Basisboek* by Husken (2000).

I explained to the women that they would be creating two intuitive mandalas and engaging in a short journalling session between drawing the mandalas. These three creative invitations would be followed by a voluntary discussion. The first mandala would contain colours, shapes or symbols that would be influenced by their feelings around physical and existential pain related to RA. I told the participants that they could draw or paint anything within the circular form that came to mind or that they were attracted to intuitively, no particular structure was required.

The second creative invitation was a short journalling session about what they liked in their lives as well as resources that had enabled them to cope better with the disease. The purpose of journalling was to form a bridge between painting the two mandalas, thus easing into a focus on previously used resources.

The invitation for second mandala (the third creative invitation) was to paint what they had just journalled about, thus offering an intermodal approach to the question of personal resources. The choice for the order of the mandalas, “pain” followed by “resources,” was influenced by wanting the women to feel joyful, empowered, and

hopefully in touch with their sense of meaning and purpose at the end of the workshop.

My instructions about the art making were brief as I did not want the women to over-analyze. I introduced them to the art supplies, which included colouring pencils and paints. Acrylic paints were used because they are easy to work with in that they can be painted over at any time while easily holding the new colour, and coloured pencils because of their familiarity and to add a slightly different texture to the image.

As the directive for the first intuitive mandala was for the participants to express their experience of physical and existential pain in a form or symbol and colour of their choosing, I asked the women to take a few moments to bring their focus inward and to connect to remembered feelings of pain from RA. This visualization was followed by focusing on colours of the paints and pencils, which had been placed in front of the women, intuitively letting colours match their feelings. The instructions were similar for their choice of brushes, in that they were selected intuitively, size matching feelings. They were then told to let their feelings move their brushes.

Once their mandalas were completed, each woman was asked to comment on her experience. They were told that others' feedback represented the owner's reaction to the artwork and that the artist might or might not necessarily agree with what was offered. The directive for the second mandala was to express artistically what they had written in their journals, which offered the women an opportunity to reflect on inner resources they might have used to deal with their physical and existential pain. After the creation of each mandala there was again a voluntary group discussion, only if people felt comfortable doing so. All voluntarily shared their journaling page. The workshop ended right on time after checking for questions, comments and/or concerns. A formal thank you was given

to all participants for their time and courage; photographs of each mandala were taken; I was given everyone's journalling sheets, after the women had made a copy for themselves. Post workshop appointments were set up for within a two-week time-span.

Data Collection

Data was collected through a variety of methods. Photographs I had taken of each woman's mandalas (2 each) and their journaling sheets were collected to aid in understanding of the participants' experience. Audio-recordings of the women's reflections, discussions, and post-workshop interviews were used. Pain rating scales were used to record pain. Notes written up by the co-facilitator added to my understanding of the women's experience. I used my own art, created while listening to each woman's reflection and discussion of her mandalas, to gain a deeper understanding.

I also measured physical and existential pain before, during, and after the workshop using a brief pain rating scale. I asked the women to give numbers to both their physical and existential pain – after explaining what I mean by existential pain (see Appendix J). The numbers on the scales were between 1 and 10, with 1 indicating the least amount of pain and 10 the highest. I asked them to fill out the pain questionnaire at the beginning of the workshop, just before art making, after their reflection and discussion regarding their first art piece, after completing their second work of art, and again at the beginning of their post-workshop interview. This meant that I measured both physical and existential pain at four time points for each of the five participants.

I made audio recordings of each woman's discussion about her experience of creating two mandalas during the workshop, using two digital voice recorders, ensuring all dialogues were properly recorded for analysis. I photographed each mandala and

received the women's journalling pages at the end of the workshop, which afforded the opportunity for me to think about the images and writing before the post-workshop interviews.

Within two weeks after the workshop, I conducted 20- to 45-minute interviews with each woman (see Appendix K) either in my office (4) or in the woman's home (1). The aim of an unstructured interview was to give the women another opportunity to engage with their mandalas and possibly re-enter into their process. The interviews were organized around the women's mandalas and their pain rating scales, which were used as interview prompts to help the women embody their stories and to help us discuss any shifts in pain perception. The interviews were audio-taped, with consent. I made sure that each woman addressed changes in pain perception as well as meaning making and the spiritual aspects of their resources to ensure ample reporting on these main topics of interest.

Summary of Data Collected

Altogether I collected data using eight different means. Before the workshop I collected demographic data about each participant. At the beginning of the workshop each woman completed the first of four measurements of self-reported physical and existential pain. The second pain measurement was collected after the creation and discussion of the first mandala and the third measurement after the second mandala. The data collected during the workshop included audio-recorded discussions and reflections for which I used two recorders to secure the data. After the workshop I collected photographs of the art that was made during the workshop in order for me to think about it before the post-workshop interviews and I collected the journalling sheets and the co-facilitator's notes. I audio-recorded the interviews. At the beginning of each interview I

measured self-reported pain for the fourth and final time. Finally, I created an art piece after analyzing the verbal data to help me understand the findings of the study on an intuitive level (Jongward, 2009).

Data Analysis

The goals of the analyses were to find out if the women found the workshop helpful for relieving pain and to capture their ideas about aspects of the workshop that either helped or hindered. I analyzed the written and transcribed data together. I considered the pain data and the art work separately.

Pain Scale Data

With only five women in my study, I could not undertake a statistical analysis of the pain rating scale data, I could only tabulate it (see Figure 1). During the interview I discussed the four recorded measurements with each woman to determine the impact of their art work. The first measurement established a baseline. I compared the second measurement, which was taken after creating the pain mandala to the baseline measurement and the third measurement taken after the second mandala to the second measurement to get an idea of how the women felt at the end of the workshop. The fourth and final measurement, which was taken at the beginning of the interview, was to inform me of how the women felt post-workshop and if they still experienced benefits. The art work was used to help analyze the written and transcribed data, as it added another dimension to what the women articulated. It expressed intensity of feelings through use of colours, placement, and size of the images.

Written and Transcribed Data

For content analysis I used the transcripts of workshop reflections and

discussions, transcripts of post workshop interviews, the women's journalling pages, and co-facilitator's notes. A transcriptionist and I transcribed the recordings of the workshop discussions and post-workshop interviews verbatim. The transcriptionist signed the Oath of Confidentiality form (Appendix M) and after completion of her work I asked her to delete all the data from her computer. I analyzed the transcribed interview data using content analysis (Hesse-Biber & Leavy, 2006).

First I read all of the written and transcribed data three times and made note of all the comments that stood out for me, including distinctive features in individual stories and comments specifically addressing the research question: Can group art therapy with a meaning making focus help relieve physical and existential pain for women diagnosed with rheumatoid arthritis? I colour-coded this material (using highlighting) for each woman in order that I would be able to trace each comment back to the particular participant at any time during the analysis. I transferred the coloured fragments to their own page for each woman. Next I sorted these comments by general topic and grouped the topics into categories. I then compiled the material in every category to include all participants to analyze the group rather than each individual. Once these categories had enough data, I reduced and combined them into themes and sub themes. Because the material pertaining to one of the themes addressed the research question very directly, I did an extra round of analysis on this material. I recoded the data based on the topics within this theme. This theme was analyzed further by distilling the essence of what was being said by each woman. The distilled material was once again placed on a new page keeping the colours of each woman intact, and then grouped into similar statements, much like a summary, which then indicated which groups were most important, by way

of the largest representation of colour coded statements. Once I had finalized the themes and subthemes I wrote descriptive paragraphs about them and looked for relationships between them (Morse, 1995), paying attention to commonalities and differences, which were reviewed with my thesis advisor.

Ethical Considerations

Informed consent.

In respect for human dignity and ethical concerns related to human subjects, a signed informed consent was obtained from all participants before the workshop. The consent form included:

- The purpose of this study.
- The framework of this study, i.e. a 4-hour workshop, opening and closing circles, creation of two mandalas, journalling, and a 30-minute to 1-hour post-workshop interview.
- A statement that the women's participation was voluntary; they can withdraw at any time with no penalty.
- Explanations of confidentiality and privacy.
- A notification that mild emotional distress is a risk.
- An art release form (Appendix L) and notice that the art belongs to the participant.

Confidentiality and privacy.

In respect for the participants' privacy and confidentiality, I promised to protect their identities by removing all identifying information from the data gathered during the study. All third party identities (e.g., physicians and family members) will also be

concealed. When we discussed confidentiality at the beginning of the workshop, I encouraged the women to protect each other's confidentiality and privacy by not telling other people who was in the workshop and not disclosing anything said by the other women.

Research data (i.e., audiotapes, paper copies of the transcription texts, and art pieces) were kept in a locked cabinet and/or on a password-protected computer in a locked room. Taped data was erased once transcribed.

Balancing harms and benefits.

Researchers must be conscious of minimizing potential harm. There is a risk of mild emotional distress during the workshop or interviews as difficult issues are explored. There is always a possibility that an emotional story will be told. To minimize this risk of emotional distress, I kept the group small, and with the assistance of another art therapist I intended to create an emotionally safe environment. The women could withdraw at any time from the study. Debriefing took place during our closing circle and referrals would be offered if needed.

From my experience with other art therapy groups, I am aware of the beneficence of the art process. The risk of mild distress is balanced by the benefits the women are likely to receive in the form of relaxation and new insights. There is also a possibility of future benefits for other women with RA.

Interviews.

Even though the consent form states that participants can withdraw from the study at any time, Hesse-Biber and Leavy (2006) remind me of the importance to restate this at the beginning of an interview. The authors also suggest that participants be made aware

that they can ask questions at any time.

Rigor

Guba and Lincoln (1980) frame the concept of rigor in qualitative research in terms of 'trustworthiness,' with four aspects: credibility, transferability, dependability, and confirmability. Credibility will be established in the following ways: prolonged engagement and observation, triangulation, member checks, negative case analysis, transferability, dependability, and confirmability.

Having RA myself helped with observation, as did spending time with other women diagnosed with rheumatoid arthritis by facilitating the workshop and conducting the interviews myself (prolonged engagement).

I collected a variety of types of data, including verbal, visual, numerical data, and observations of a co-facilitator (methods triangulation). I compared the data collected by my co-facilitator with my own and examined the data at different points in time (triangulation of sources).

I informally performed member checks with the women during my conversations with them that the collected data and interpretations are aligned with their truth, giving me an opportunity to discuss misunderstood perceptions with them.

During the analysis I looked for data that appeared to contradict emerging patterns and I reported these when writing up the results.

In order to help other people judge whether the findings of this study could apply to other situations, I provided a thick description of my research process as a way of attaining external validity (Lincoln & Guba, 1985). Describing the phenomenon in detail will help me and others discern if the conclusions drawn are transferable to other settings.

Dependability was achieved by external audits, which have been conducted by my supervisor to ensure the accuracy and validity of this study. This included assessment of adequacy of the data and initial findings, and feedback from my supervisor which led to further elaboration and improved expression of the findings.

Confirmability was established by external audit, audit trails, triangulation, and reflexivity. An audit trail is a clear description of all the steps taken from the beginning of this study to the end, including descriptions of data collection and management, data reduction (i.e., summaries), data reconstruction (e.g., themes), and my expectations.

Evidence of reflexivity was noted in comments, observations, and clarifications regarding my thought processes, experiences, values, and interests in this study and has been recorded on my discussion pages.

Chapter 4: Research Findings

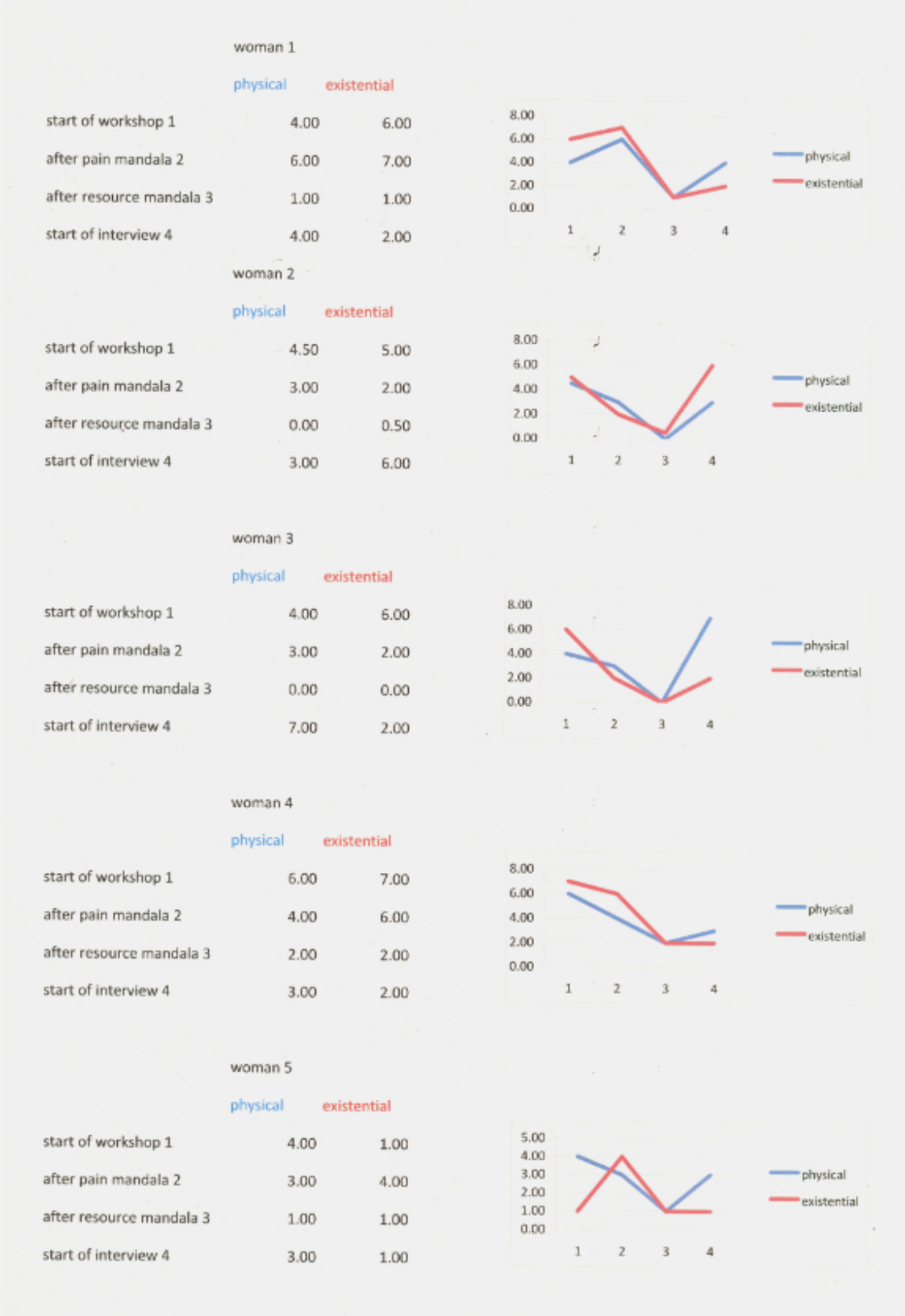
Who the Participants Were

All the women in the study had careers in healing or helping professions. Four of them were employed, and one was disabled from work. Four had graduate school degrees; all were white. Two of the women were married and three were single. Their ages ranged from 27 to 56 years of age (median 46). Four of the women had been diagnosed with RA within the last five years, while one woman received her diagnosis some 44 years ago. According to the Arthritis Foundation (1998) the onset of RA occurs in middle-age, but also often manifests in early adulthood, and the average age of people with RA is 66.8 years. All of the women shared that they suffered RA-related pain on a daily basis. They were all generous with their time and interested in art expression. Three out of the five said they sometimes engaged in painting or other forms of creativity.

Pain Rating Patterns

With only five women in the study, it was not possible to draw conclusions from the pain rating data. However there were changes in self-reported physical and existential pain over the four measurement times and my tabulation of the pain rating data showed interesting patterns of pain reduction (see Figure 1). The most notable was a decrease in self-reported physical and existential pain after the second mandala, which was about resources. During the post-workshop interviews, the participants explained the changes in physical and existential pain they said they experienced.

Figure 1


woman 1
physical existential
start of workshop 1 4.00 6.00
after pain mandala 2 6.00 7.00
after resource mandala 3 1.00 1.00
start of interview 4 4.00 2.00
8.00
6.00
4.00
2.00
0.00
1 2 3 4
physical
existential
woman 2
physical existential
start of workshop 1 4.50 5.00
after pain mandala 2 3.00 2.00
after resource mandala 3 0.00 0.50
start of interview 4 3.00 6.00
8.00
6.00
4.00
2.00
0.00
1 2 3 4
physical
existential
woman 3
physical existential
start of workshop 1 4.00 6.00
after pain mandala 2 3.00 2.00
after resource mandala 3 0.00 0.00
start of interview 4 7.00 2.00
8.00
6.00
4.00
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1 2 3 4
physical
existential
woman 4
physical existential
start of workshop 1 6.00 7.00
after pain mandala 2 4.00 6.00
after resource mandala 3 2.00 2.00
start of interview 4 3.00 2.00
8.00
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4.00
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0.00
1 2 3 4
physical
existential
woman 5
physical existential
start of workshop 1 4.00 1.00
after pain mandala 2 3.00 4.00
after resource mandala 3 1.00 1.00
start of interview 4 3.00 1.00
5.00
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0.00
1 2 3 4
physical
existential

Content Analysis

The content analysis of the written data (participants' journalling during the workshop) and the transcripts of the participants' experience of the mandala creation during the workshop and the post-workshop interviews yielded four major themes representing the combined views of the five participants. The four themes were: (a) experiencing physical and existential pain, (b) holding pain in, (c) tapping into resources, and (d) how art therapy helped.

Experiencing Physical and Existential Pain and Holding Pain in

The participants initially described their physical and existential pain in a wide variety of ways that touched on the intensity and many layers of pain and their reasons for hiding it, using labels such as: "uncontrolled," "intense," "you can't bear it," "dynamic," "layered," "it's in your face," "disruptive," "it stinks," "dark," "smelly," "gross," " hampers the truth and essence of me," "barrier," and "invisible."

The women shared there were feelings associated with the pain that included: "sad," "anger," "isolation," "denial," "guilt," "being incapable," "frustration," "fear," "feeling sorry for yourself," "worry," "depression," and "disconnected."

Theme 1: Experiencing physical and existential pain.

All the participants said they experienced RA-related pain. Some of them spoke about physical pain while all talked about the existential pain that they felt. They said the pain was unpredictable and sometimes bewildering. One woman stated: "Some days out of the blue you have so much pain and other days you don't have any pain, it's like, well, maybe I don't have this disease." She said she sometimes wondered if it was all in her head. During the workshop she folded her still wet painting in half, wet sides together,

and then pulled the two halves apart. When I asked her about this during her interview she shared that her art making represented her experience of RA–sometimes controlled and sometimes not: “I realized I wanted part of [the painting] to be controlled and part of it to be uncontrolled … where the paint would go” (see Figure 7: Participant 4 Pain).

The women talked about the effect of pain on their day-to-day lives. One said, “How can I do my job so I’m not standing for eight hours? If I stand for three hours I pay for it the next day. I am in excruciating pain standing on my feet.” They talked about pain being invisible and confusing to others: “[Pain] is not visible, ‘cause on my good days, I go a million miles an hour and do everything I can, and on the off days, it’s off.” Many talked about loneliness and isolation. One woman said, “Nobody else can really see it [RA], it’s not like you have a broken leg.” Another shared that her emotional stress immediately impacted her physical pain. She said, “There is more pain if I have relationship issues with my husband” (see Figure 4: Participant 1 Pain).

The most profound effects the women described were emotional, spiritual, and existential. One woman, whose physical pain was controlled at the time by a variety of five different medications, described existential fear:

> I find that the physical pain is probably less of a factor on my life than the existential pain and the stress related to the fear of can I be in that [pain] for the rest of my life. How will I financially support myself if I’m not married? I’m… on my own.

Existential pain was described as “not having that sense of power or control” and not being able to do the things they used to do:

> Since I've developed RA I spend part of my time kind of watching what everyone around me is doing and wishing that I could do the things I used to do and that I want to do … You feel like constantly there's this real struggle between trying not to push yourself to be something you can't be, trying not to spend all your time feeling sorry for yourself. (See Figure 6: Participant 3 Pain).

In her place of work one woman was confronted by intense fear, which was clearly depicted in her image by a black circular form within the mandala:

> The black [dot in the image] is my fear. I don't… really think about what could happen and what could happen to my joints and everything but, well, being a doctor … every once in a while I have a patient with RA, an older patient I see, and when I do I become afraid. It's like an intense fear. It's not just sort of like a reminder … [RA] is like, shoot, this is the worst thing in the world, so, that's why that fear dot is so intense but so, so specific (See Figure 8: Participant 5 Pain).

In one woman's painting, pain showed up as "shit" that cut her off from her spirituality. During her discussion she said: "The brown shit stains are pain, it's disruptive, it stinks, it's dark, it's smelly, gross, but mostly it hampers the truth and the essence of me, the light and life, the god-light within me." She continued while visibly emotional: "The border [in her image] represents how isolated I feel and disconnected from the oneness of enlightenment and the essence and god-energy through my pain" (see Figure 5: Participant 2 Pain).

To explain a painting with clearly demarcated partitions, another woman said: "Everything has to be very compartmentalized in my life…I don't feel like I have the

opportunity to be outwardly joyful, it's all very, set."

Theme 2: Holding pain in.

The women expressed a variety of reasons for not disclosing their pain to others and sometimes not even always acknowledging it themselves. One woman shared that the most difficult thing for her was that "some people don't want to hear about [pain] so you don't express to them." She said her experience was that her friends and people her age "don't want to hear that you're sick and they don't want to even talk about it–and you don't want to constantly talk about it either."

Some said that family members, friends, or co-workers would be burdened by their accounts of pain, with the possibility of eventually turning them away. Others worried about being labeled as whiners or complainers. One said that disclosing her pain to people who don't know her circumstances makes them feel awkward or makes them feel sorry for her.

One of the women who was working said that separation between workplace, family, and friends was imperative. Disclosure of any feelings around RA was impossible in her workplace. She didn't discuss her RA or pain with her friends or her partner very much either and she only disclosed her feelings around RA with family members when things became a problem. She added that she felt guilty about spending time thinking about RA.

Several participants described denial as a mode of coping. One said she denied her diagnosis for a year. She shared, "And then once they told me I had RA, I spent at least the next year being really angry … No, I don't have this. This isn't what it is. No one in my family has it. There's no way." For another woman denial translated into not

giving any attention at all to pain. She said that pain was "something that is so easy for me to just kind of gloss over and not to really talk about." Another said, "It's so horrible, I just gotta stay away from it."

They talked about the effects of holding it in and how "it's self-destructive to not acknowledge our pain and to share it with others." One woman described 'holding it in' this way:

> I tend not to tell people anything about the suffering part of illness, I just might mention it or people see me walking with a cane, but I don't really say much about it. I don't provide explanations. If people ask, I just say I have a bit of arthritis and move on. I don't really want to give it a whole lot of energy, and yet by denying it it's like a big huge dam, it gets really powerful.

All of the participants talked about holding in their feelings about RA and about hiding it from others, themselves or both. They had different ways of handling this problem. One said:

> My kids don't want to hear it, my friends don't want to hear it, I don't want to hear it, but … the thing that I've used mostly in the last years when people ask me how old I am I say that I'm actually 200.

Theme 3: Tapping into resources.

During the workshop the women began exploring what gave them strength and helped them cope through engaging in a brief journalling session. This area of focus became the foundation for the second mandala activity, about resources. When they reflected on these mandalas during their discussions they talked about both spiritual and personal resources that were important to them.

Spiritual resources.

All of the women expressed a form of meaning and purpose and in particular their spiritual connection. Each had a unique way of describing it and names included: "being spiritual," "spiritual pursuits," "connecting to the Pillar of Light," "belief in God," "going to church," "Sparkles," "what we call God, or the All Knowing." They shared that these connections were resources in coping with their RA pain. One woman pointed at her second image and stated:

> The white paint through the middle is my spirituality … Going to Church is a big piece of feeling better in life … My belief in God, my spirituality, ties together, which is what the blue [earlier identified as "inner calm"] and the white is, all intermingled" (see Figure 11: Participant 3 Resources).

Someone else shared her vision of and connection to the Pillar of Light as having sustained her. She pointed to a "yellow stream" coming into her painting and said, "I'm aware of this pillar. It always seems to be in my paintings. It's something that I really hold on to. You could call it the Pillar of Light." She went on to say, "When I thought I would die I had so much pain, that was the only thing that connected me back" (see Figure 9: Participant 1 Resources). Someone else added that her resources used to be external, but changed over time, and she shared: "At first I resourced medicine and external resources, believing that I needed outside intervention … When I have sought my own inner guidance … through spiritual pursuits this is my greatest resource" (see Figure 10: Participant 2 Resources).

Another woman said that she wanted to paint sparkles in her image, and later added more sparkles by gluing them on; she said that these sparkles were "that thing that

we call God, or the All-Knowing." She went on to say that she had wanted to add even more sparkles "all the way through" (See Figure 12: Participant 4 Resources). Pointing at the yellow portion of her resource mandala, which took up the entire top third part of the circle, another participant said: "The upper yellow part is just my faith in God and, you know, how He can just help me get through things" (see Figure 13: Participant 5 Resources).

Personal resources.

All participants mentioned themselves as one of their resources. At the end of her discussion about her image one woman recognized her resource as that which she found inside herself:

> Yes, it's all about what's inside of me and not inside of me 'cause I used to look externally, you know, to doctors or to medicine or to therapists, and those are great tools but only to get more deeply inside of me. It's an inner process not an external process.

Another echoed this during the journalling: "Just felt free. Always comes from the inside out. Feel it [pain] is bottomless when you need to let go you have to reach inside and it lets go of the pain." Another woman's belief in herself as a resource came from her ability to use her physical senses like touch, sight, and movement and she shared:

> In order to portray my resources I use all my resources doing it. For me resources are dance, movement, flow, so is dancing and moving over the page… touching the paper, touching the colour, weaving the colour in, sculpturing the colour, anything from painting to sculpting to listening to music.
>
> Another woman found her inner strength through her will and desire: "The thing

that I wrote in my journalling that's gotten me through everything is my desire to keep going. I just want to keep moving forward."

Theme 4: How art therapy helped.

The sub themes were: "Connection" and "A different perspective."

Connection.

All of the women said they experienced a sense of connection that was facilitated by participating in the group art therapy workshop; some explained connection as feeling closer to one another, while others expressed it as a better connection to themselves, to a partner, or to something larger than themselves, a Higher Power for which they had their own name as we saw in the theme called Spiritual Resources.

Connection to one another became clear shortly after the creation and discussion of the first image; it was something that the women agreed on in their discussions and one shared: "Making art in a group of people diagnosed with RA makes me feel understood and supported." Another stated: "I gain an energy from being with other people." She further explained how this sense of connection had impacted her: "What was super powerful for me is hearing them say what this experience [of their image] was, so the existential pain was really, really lessened quite a bit and the physical as well."

Someone else also found art making in a group setting especially beneficial, especially accessing her creative, spiritual side "and then sharing that with other people doing the same thing." Another woman said her anxiety and feelings decreased by being with people "who go through the same thing [RA]."

One of the women commented on how her art improved her connection to her boyfriend as she said that it helped her to put her pain "out there" so she could address it as "an objective thing" when she talked to him. She said her art was: "kind of like a good connection between two people that understand."

Art therapy helped all the women connect to themselves–in particular to their feelings. The act of painting their pain made it "become more of an emotional response." They liked having their feelings concretized and made visible: "When you draw, you kind of get the picture, a representation of what you're feeling." It helped one woman realize the extent of her pain: "Just doing the painting… it made you realize, maybe more of the breadth of pain that you tend to have." Another woman was surprised by the impact the visual representation of her pain had on her and the insight it gave her. She commented: "it never occurred to me that by doing a painting and then thinking about it, could make such a difference … It was a powerful piece of information."

When they connected to their emotional selves, they could express feelings they had been holding in. They found that "going into the pain" was more helpful "than running away from it." One woman said: "It was definitely a good experience, pulling out some of the feelings that you have and then discussing them." She continued: "I actually felt really, really good after I painted this and talked about it." Another woman was visibly touched after sharing her feelings about her pain image: "That makes me cry [pause] and I don't know why [pause] I think it's because I finally did it, I expressed it, I communicated it, and I told you."

Creativity led to spiritual meaning for one woman as she experienced a sense of

connection to God while she painted her pain image. She shared:

> The god-light within me, which is [depicted by] the yellow [lines], and the essence of me which is [portrayed] the blue and green [lines], is partly accessible and runs through it [her pain image] as a constant and consistent strong thread.

She added that "art helps you realize that part of you and how it is intertwined with everything … not really a separate piece of you." Another woman said her connection to "church and spiritual time" which was depicted in the centre of her image was what helps "when I am emotionally overwhelmed by my RA."

A different perspective.

1. Looking at pain with new kinds of looking. [Taking a new perspective.]: Exploring it with their feelings, not just their thoughts.

Looking at their pain through a new lens, in the form of symbols, images, and colours offered the women a vehicle of self exploration and reflection that helped them see their suffering under a new light. They could explore it with their feelings not just their thoughts. One woman said she found respite from thinking: "I was able not to get in my way, because this is not a thinking activity." She added creating art offered her distance from her pain: "It feels really healing to have done it. I almost felt like an observer [of her pain]." Another woman shared how she loved the experience of being rather than thinking; she said she felt "like a kid, I just kind of go into the colours." She added that she tends to think more when she is under pressure and "when I paint, I don't think." Someone else referred to her work being science-based and having to "spend most of my life just thinking logically."

Exploring it with visual expression in addition to verbal expression.

One woman saw the need to create art on a regular basis "whether it's painting, drawing, writing, whatever, that has nothing to do with my work and my being sick and my curling and all the things that I put a lot of time into." Someone else added: "Yes, if I'd known that before (art offers such powerful information), I would have done a lot more of these pictures or something like it; I've really had a strong desire to work with clay."

Looking in a way that feels like meditation.

Someone else shared that for her painting was "similar to meditation, you know, where you take a different perspective, you take a distance, you go more in your being."

During her interview she added: "Yes, painting brings me in touch with being, coming more from the lightness of the inner movement."

Looking in different ways at once: painting + writing + talking.

All women shared in this experience. One woman said: "Art therapy makes me feel connected and it's good to talk about my experience." Someone else shared: "I realized when I was journaling, the yellows circle is actually my grandmother; she had rheumatoid arthritis." Another participant wrote a poem, which she shared with the group; her painting later responded to what she had written.

2. And distracting themselves from their usual ways of looking. Disrupting the old perspective.

Some women found that art therapy gave them an opportunity to take "time out" from pain perception, finding that it brought a distraction, enabled them to shift from pain to a new perception as they painted. Another woman stated that tapping into the right side [of her brain] "does get your mind off your stresses."

3. And choosing a different focus.

Focusing on oneself for a change.

Art making was seen as a vehicle to do something for oneself that was nurturing. As one woman put it, "It's not very often that I take time in my life to just sit down and just do something for me, and that's what this felt like." Another woman also saw the benefit of spending time with herself for which she seldom had an opportunity as she shared that it was also good for her to have attended an arthritis art therapy study, "because sometimes it's good to sit down and just think about it and be okay with it."

Focusing on the positive.

Some of the women noticed that focusing on the positive impacted their feelings. One woman commented: "So I really had a lot of fun with this. This was all of everything for me … this is the all of everything, all the time. It feels so huge and is just so beautiful to me and so flowing and I just want to move with it." Another woman echoed this as she spoke to focusing on "what helps as opposed to what doesn't help" and she said: "It changes your perception of pain." When asked about her second image, another participant agreed to having found meaning in it "because it makes you really think about everything you find fulfilling and everything that sustains you."

4. And resulted in new perspectives on pain.

Emotional distance.

Making art made one woman realize that art offered her distance from her pain "It feels really healing to have done it. I almost felt like an observer [of her pain]."

A more positive perception.

All participants discovered that art therapy offered them a vehicle to shift from pain

to a new perception. As one woman noted: “I added in the purple and blue, which are my happy colours and I put those on because they’re my calming colours… and realized that it [pain] isn’t my whole life.” The artistic process helped her to find meaning in it as she mentioned: “because it makes you really think about everything you find fulfilling and everything that sustains you … painting all the positive things within you that pull you through that disease, that always makes you feel emotionally and physically better.” Another woman noticed how focusing on the positive had impacted her; she shared

> It never occurred to me that just what you focus on in such a concrete way, by doing a painting [the resource painting] and then thinking about it, could make such a difference. … It truly startled me… it was cathartic for all of us to do it.

It was relaxing, fun and made the women feel good, as one shared: “I just had fun just placing things and then seeing what effect it has on the whole picture.” Another added: “I feel that sense of flowing energy, and it’s just really open and gentle, just like you say, it feels good.” Another commented: “The bright colours are what makes you feel happy, and [the colours] show how you feel and that’s absolutely genuine.”

Summary

Significant findings emerged pertaining to the experience of women living with RA. The findings suggest that self reported changes indicated a reduction in pain (see Figure 1). After reflection on the participants’ images, journalling, and discussions during the workshop and interviews, four major themes and sub themes became apparent. These themes included: (a) experiencing physical and existential pain, (b) holding pain in, (c) tapping into resources, and (d) how art therapy helped. In experiencing physical and existential pain, we are given an insight into how the women experienced their pain.

Although all had recorded physical pain, most women spoke more about their existential pain as they reflected and discussed their experience of the pain mandala. The inability to openly talk about their experiences of physical and existential pain in day to day living, coupled with a feeling of not being understood by others who do not have RA, led to theme 2, a theme that the researcher had not expected, holding pain in.

Tapping into resources through creating the second mandala significantly impacted everyone's pain scores as evident by the decrease in the self reported pain scale measurements and supported by each woman's explanation during the subsequent interview. The sub themes personal resources and spiritual resources illuminated how the women found the strength to cope with their disease.

How art therapy helped offers us insights into the benefits that the women experienced from engaging in the artistic process, followed by reflection and discussion. Two sub themes emerged: 1) connection and 2) a different perspective in which the women commented on how group art therapy helped them feel better connected to themselves, the women in the group, and their understanding of a Higher Power. A different perspective revealed how art therapy had provided the women with (1) additional ways of looking at their pain, (2) distraction, (3) choosing a different focus, and (4) new perspectives on pain.

> There is the solitude of suffering, when you go through darkness that is lonely, intense, and terrible. Words become powerless to express your pain; what others hear from your words is so distant and different from what you are actually suffering. (O'Donohue, 1997, http://www.goodreads.com/author/quotes/6224. John_O_ Donohue?page=1)

Chapter 5: Researcher's Artistic Response

Figure 2: Obsessio

Figure 3: Epiphania

Chapter 6: Discussion

In this study, I investigated whether the creation and exploration of mandalas in a group art therapy setting helped reduce the pain of women who were diagnosed with RA. There were five women present who experienced RA-related pain on a day-to-day basis. All were white, the median age was 46. Four had graduate degrees and all but one had received an RA diagnosis within the last five years. The women revealed through image making, exploration, and discussions how RA pain affected them in body, mind, and spirit. My hope is that through this study women will come to find help to cope better with the symptoms of RA, resulting in decreased pain.

Analyzing the data led to the emergence of four major themes: (a) experiencing physical and existential pain, (b) holding pain in, (c) tapping into resources, and (d) how art therapy helped. In the following sections, I offer reflections on these four themes. I have grouped them into two segments; the first section covers: experiencing physical and existential pain and holding pain in and the second section contains: tapping into resources and how art therapy helped.

There was a relationship between how they perceive pain, what their beliefs are around pain, and their levels of pain. For instance anger increases muscle tension and can increase pain; worrying, and in particular catastrophizing can induce feelings of helplessness, which can exacerbate pain (Edwards, Bingham III, Bathon, & Haythornwaite, 2006; Eccleston, 2001; Dubouloz, Laporte, Hall, Ashe, & Smith, 2004). Newth and Delongis (2004) support that people diagnosed with RA suffer from typical symptoms such as stiffness, joint inflammation, and fatigue, and these debilitating symptoms are often associated with secondary stressors such as mood disorders as just

described, changes in relationships, work, and quality of life. A sense of frustration is therefore understandable as there is no one treatment that will take care of RA pain. The women shared that pain combined with a loss of quality of life led to isolation and emotional upheaval, which included the feelings described in the previous paragraph. These experiences and feelings served to exacerbate their pain. While coping strategies can be used to manage persistent pain, it is clear that management of RA pain is not a simple task.

Chapman and Okifuji (2004) write:

> Pain is not a primitive sensory message somehow recognized by the cortex but rather the end product of massive distributed and parallel processing within the brain. It has emotional and cognitive features because it is the end product of central processing in the brain areas that produce the interdependent processes of emotion and cognition. (p. 3)

As the women reflected and discussed their mandalas, they revealed that not being able to talk about their RA-related pain to others added to their stress as did the concern that others might not want to hear about their suffering and would eventually be driven away. For example, one woman's experience of this showed up in her artwork as compartmentalization of different areas of her life. The image showed demarcated spaces for friends, work, family, and anger; there were heavy borders around each area. Only one tiny area represented an area that indicated an opportunity for sharing how difficult life was for her; it too was shielded by a heavy outline. When she saw how she had kept all areas separate from one another and how small the actual size of the portion was that she dedicates to talking about her RA, she became quite

emotional. In this example we can see that art therapy offers us a vehicle to get in touch with our wounds, our suffering, and making what is deep in our unconscious more visible. Art does not necessarily "get rid" of our problem, but when our suffering is visible through the image we have an opportunity to see it more clearly and take action; we can then transcend it. The art image truly carries the transformative components of our emotional experience; it shows us the pearl.

Holding pain in points to the women's perception that they have few occasions to openly express their pain. The creation of their pain images gave rise to exploration and discussion of a variety of reasons why the women did not express their pain. These included: pain was isolating; some avoided thinking about it; for others pain indicated a loss of strength and ability, which they were uncomfortable sharing with others; not wanting to be different from others; feeling guilty; the perception of not having the opportunity to share their experience with others; and, not wanting to draw attention to being incapable of what they could do before. What this suggests is that the women suffered from existential pain by stifling the impulse to integrate negative events into their life experiences and/or not disclosing their stories to others. Keefe, Abernethy, and Campbell (2005) have shared that "Reluctance or inability to process events that are emotionally stressful may lead to increase in symptom complaints and poor immune functioning" (p. 614). In their study, strong evidence suggested that people with RA will benefit from using active coping skills such as cognitive and behavioural strategies rather than a passive approach like withdrawing, as the latter leads to increased pain and dysfunction.

When taking a look at the participants' pain ratings (see Figure 1) and combining

these with information that the women shared during their post-workshop interview we can begin to appreciate how group art therapy helped the participants with their pain. Lower physical pain ratings were observed for four of the women after they created their pain mandala. During the post-workshop interviews, one woman explained the shift due to "having to think about pain, feel it, and talk about it helped resolve it by itself." Another woman associated the decrease in her pain to "sharing with others" and "hearing them speak about their experiences." She shared that "going into the image, makes the pain a bit less frightening." Another woman also attributed the decrease she experienced to "talking about her pain." Another woman shared that art making helped her "let herself go and enjoy the process." Additional perceptions regarding how they experienced art as helping to relieve their experience of pain are considered with respect to the How art therapy helped theme, presented later in this section.

Contrasting cases are provided by two of the participants who recorded increased pain. These two women were shocked by the pain they experienced after they had spent time painting and reflecting. Both shared that their anxiety had increased when they created their pain image. One woman shared that it was the first time she had taken a good look at her pain and understood its extent. The other participant shared that she was not relaxed "portraying the negative part of her disease." Keefe, Abernethy, and Campbell (2005) make a similar point in relation to initially increased anxiety. They state that, "studies using emotional disclosure paradigms have documented initial increases in negative mood immediately following the emotional disclosure task" (p. 614). Both women in the mandala study experienced a significant drop in pain perception when they next measured their pain.

Overall, these findings suggest that silent suffering involves significant costs to individual patients in relation to pain. In their research, Hwang, Kim, and Jun (2004) identified that many of the RA sufferers in their study did not disclose their pain. They even hid their distorted bodies from their husbands and pretended that all was well. This study considered the importance of social support and its effect on healing and found that spousal and family support was associated with reduced depression and anxiety, and suggested that social support for women with RA "may be significant to overcome the disease" (p. 244). Talking to others helps a person make meaning of their situation, whereas non-disclosure can lead to chronic worrying about pain and more distress. What is suggested from the foregoing, then, is that to improve quality of life, coping strategies must be included that enhance emotional processing and expression. Nainis et al. (2006) describe how art therapy is used to help cancer patients and their families adapt to stressful events. They suggest that "the objectives of art therapy are to use the creative process to allow awareness and expression of an individual's emotions" (p. 163). I think creating the pain mandala helped the women get to know themselves better, in particular in regard to understanding their feelings and emotions around pain. In addition, it connected them to their unconscious and illuminated what was pertinent to move toward becoming whole. All of the participants stated that they gained insight into themselves by talking about their images with others who could identify with their pain. By doing so, they felt supported which helped them to feel better. They shared that it helped to know they could discuss their pain without feeling like they were complaining. Creating the mandala image allowed them to accurately portray their pain in relation to its intensity, size, and placement. The image also served as a prompt that helped the women to talk

about the meaning of their pain. Some felt that creating an image of their pain on paper made it easier to talk about. In this way art therapy may be appreciated as creating an emotional distance that allows a person experiencing persistent pain to observe their pain, which may help with describing it. This last benefit is one that two women recognized and mentioned during the post-workshop interview a week later. They had the opportunity to share their image with others while using it as a prompt and found it improved communication.

Being able to observe and describe and talk about their pain also appeared to help the women to manage or regulate their experience of pain. The women's pain was relieved significantly after the creation of the second mandala (see Figure 1). One woman described noticing the shift when "going into a place of flow, without boundaries, she calls freedom;" for someone else this occurred by focusing on something positive. For another participant it happened when she connected with her essence, recognizing this is what is inside her: "that it's inside me and around me and enveloping me and coming out from me all at the same time."

In addition to mandala creation, simply being in a group art therapy setting was an important aspect of the process. It provided the women with an opportunity to express themselves to others who understood them as the participants shared similar issues. The setting was safe; it eliminated the fear of being seen as one who complained and could be a burden. And so, the women could begin sharing and making sense of, or processing their experience of RA-related pain.

How Art Therapy Helped and Tapping into Resources

Listening to the women's narratives made it clear that a diagnosis of a major

illness disrupts the balance in one's life. The women's descriptions of pain revealed that their physical pain and related dysfunction resulted in further suffering on an emotional, spiritual and existential level. In seeking relief by coming to the workshop the women shared how they experienced the benefits from group art therapy.

Connection.

All attributed the reason that art therapy helped to the realization that art making connected them to themselves and helped process feelings. Reconnecting with feelings is important, because feelings inform us when to change, or to take action amongst other choices. As the women spent about one hour focused on their image they were able to explore and express their pain (and resources) in detail. When they painted, some seemed as if in trance, deeply focused, with some rhythmically moving their bodies to reflect what they were feeling, brushes in hand. Every stroke had meaning, as did every colour. One woman shared that the time she took to mix her colours was indicative how important it was to get the right mix to express precisely what she felt. Several of the women shared that they appreciated being given an opportunity to develop a metaphoric representation of their pain, "to get the picture." Art therapy can offer a helpful means of communicating when verbal communication is difficult. As noted by Rao et. al, (2009) art therapy "can lead to increased awareness of self, as well as improved ability to cope with symptoms, stress, and traumatic experiences" (p. 64).

Given that several of the women shared that their pain encompassed a sense of loneliness or even isolation, art making experienced within a group setting can also be viewed as beneficial. The participants shared that their anxiety was moderated by being around others to whom they could tell their story. One woman shared: "talking around

the room was wonderful." Meaning develops through engagement with other media, including interacting with others. Palmer and Shepard (2008) have described how art therapy helped family members of children with chronic pain understand each other and improve communication. They observed that the images the children created "provided something more concrete to talk about and helped participants to make sense of their experience as well as communicate that experience to others" (p. 19).

All the women in this study shared having a spiritual connection to their images. They commented on how they viewed this as an important resource and coping strategy. Some were taken by surprise when a sense of spiritual connection also appeared in the mandala they created to depict their experience of pain. Their stories drew attention to the constant need for adjustment to changes resulting from RA, making it important to find new meaning in illness. Ardelt, Ai, and Eichenberg (2008) considered how people found meaning after being diagnosed with a serious illness. They found that religious or spiritual beliefs helped participants cope by provoking comforting feelings, a sense of belonging, and also, for some, helped them to accept the illness as part of their life.

A different perspective.

Developing a new perspective helps us see things differently and can aid in finding better solutions to stressors. When the women explored their pain with the help of mandalas they found that they could expand and deepen their perspective. They had held certain thoughts and beliefs around their pain, yet when they drew the images, spontaneous and unexpected forms surprised them. Their conscious minds, the thinking minds, had stepped aside, creating room for feelings, emotions and insights. These responses were then made into unique lines and shapes to present a visible record. When

they reflected on the images some shared they discovered “they were more than their pain.”

Their work was characterized by both unique representations of the pain they experienced, and signs of hope, beauty, and spirit interwoven, allowing for the emergence of a new perspective. The emergence of a new perspective changed how they felt about pain, and in sharing their insights with others they experienced positive effects. Visual expression through art combined with verbal expression can facilitate an ongoing process of cognitive integration of one’s experience.

Some women shared that being engaged with their art was akin to being in a meditative state. Wachholtz and Pargament (2005) studied the effects of secular meditation, spiritual meditation, and relaxation techniques on pain and found that the meditation groups were able to withstand pain for a longer time span. People who engaged in spiritual-based meditation also improved their ability to cope with pain. Wachholtz and Pargament suggest that “In this sense, spiritual meditation may be a form of spiritual coping, and the increased tolerance of pain may be an indication of the efficacy of this spiritual coping method” (p. 382).

Distraction is often mentioned as an effective coping technique for those suffering from chronic pain. Distraction can help people attenuate their experience of pain by shifting their attention to other stimuli. As the women created art they built a bridge between their inner and outer experience. This task required their complete focus, as they attended to the nuances of colour, the forms of the images and where they want to be placed. The women who participated in this study shared that this experience helped them to forget their worries and concerns. The effect of distraction to minimize pain is echoed

by Shariff et al., (2009) who found that distraction was a technique that helped decrease distress for participants who were experiencing flare-ups (p. 1047).

In this study, the women described how their participation in a novel experience that provided a unique focus for processing their pain, along with just having some "me time" was needed and beneficial to them. An important part of healing requires loving and caring for oneself. Many of the women shared that they were concerned about not burdening others with their pain and therefore took care not to express what they were feeling and always tried to accomplish what others expected. Making art within the context of the mandala workshop provided them with the opportunity to create whatever felt right for them. They benefited from letting their voices speak, their bodies move, and creating their unique artworks. And they found that it was "fun."

Tapping into resources.

Spiritual resources.

Living with a chronic illness, its pain, and other attendant challenges, can cause people to question the purpose of their existence. Loss of what they have known in life, a job, relationships, and goals is cause for a major upheaval. In this state we experience a disconnect from self and others. Paul Jones (1989), a theologian who I first mentioned in Chapter 1, eloquently writes about our places of pain, which he calls obsessio. He talks about the feelings that we encounter when we are in a state of suffering, and describes these for the inhabitants of his five theological worlds as a sense of longing, anger, an ache (void), guilt, and feeling overwhelmed (p. 43). These were all feelings that the women who participated in this study described having experienced.

When experiencing obsessio, pain and coping skills are needed to "move" toward

what Jones calls epiphania, or resolution. It is here that the women can experience a sense of reunion, vindication, fulfillment, forgiveness, or endurance, again theological terms that help express a sense of being whole according to Jones. In order to make the journey from suffering to resolution, the women were asked to create a mandala as a resource. In doing this, I essentially invited the women to reconnect with all that had supported them on their journey to date, in the hope that in doing so they might be able to make sense of their experience, and activate their healing, ultimately bringing transformation.

Recognizing and appreciating their resources and supports was truly an empowering experience for the women. For a long time mandalas have helped people travel on a spiritual path and so it was no surprise that during the creation of their mandalas, the women found a representation of what was a spiritual resource for them. Sparkles, gold and yellow colours were used in all the images to indicate a ubiquitous Presence, although in one woman's image this Omnipresence was compartmentalized, yet covered a large area. Busing et al. (2009) researched the reliance on spirituality as a coping strategy for patients with chronic pain conditions. They found that half the patients "had a strong belief that God will help them and prayed to become healthy again," while the other half mostly relied on medication. The women in my study did not specify prayer; they merely indicated that the Presence was an important resource that helped them feel supported. Art therapy, in this case mandalas, helped the women move from feeling stuck in a place of pain to an environment in which they could change their focus while supported by their sense of Spirit.

Personal resources.

Sharing personal resources within the group was exciting for both the women who

spoke (each in turn), and also for those who listened. When a woman began to share her story, within moments everyone felt drawn to take a careful look at the artwork she had created, to more fully appreciate the speaker's story of empowerment. The women left their seats and formed a circle around the artwork, which suggested the significance or importance of sharing resources that had been supportive to them, their approaches and coping skills. In contrast to their earlier created mandalas, the resource mandalas were characterized by space and lightness. They were luminous and dynamic. The feeling in the room also noticeably changed; the women were enlivened, they appeared to be more engaged with life. Creating mandalas that focused on positive resources and supports seemed to give the women a sense of control over their suffering. Indeed, the process of creating appeared to empower the women to transcend their pain and suffering.

My Artistic Response

Responding to the women's accounts and images through my own art-making practice helped me to connect to the experiences and accounts the women shared during the workshop. It also helped me to connect with my own feelings regarding what I had observed during the workshop. My first piece of art, Obsessio (see Figure 2) was drawn on a dark background, which represented the women's pain and a sense of opening to the unconscious. These representations were two central components that were present when the women started to work on their first image; they were about to focus on their pain, not knowing what might emerge from the unconscious through the use of lines and colours. I listened to the audio recordings of each woman's account of her pain while creating my first response and I felt drawn to incorporate what had hurt them the most. Consequently

my rendering of a few essential shapes, similar to ones found in the women's own images, can be discovered in my work. This particular representation of their pain helped me feel deeply, as I had experienced a disconnect from their experience in my role as a researcher/facilitator during the workshop. I found that by creating this image, I connected with the women's pain, as well as my own issues related to the experience of RA–my journey has not been so different from their journeys. I felt awe and appreciation for the women's willingness and courage to look at pain.

When I take in my entire image now, a few weeks after its completion, I am surprised to find that even though this art work is filled with everything that was painful to the women: the black dots, the compartmentalization, the borders, the white areas for the unknown, I see a huge seed, surrounded by the colour red, wanting to be noticed, in the middle of my image. I see new growth, flowers, purple areas representing Spirit and yellow areas pointing to hope. I remember that this is somewhat similar to what some of the women shared right after they created their first mandala. Expressing pain lessened their pain, and doing so created an opportunity for seeing beyond the pain, to discover that all along, we have always been more than just our pain.

In another art work, Epiphania (see Figure 3), I recalled the women's joy, their sense of feeling empowered and all the ways they felt connected when they used their resources. This image suggests a sense of lightness and movement; it's dynamic. In this, I recollect the need for the women to stand up, even move, and form a circle to witness and hear everyone's account of their second mandala. For me, this image evokes a sense of reunion, a "coming home." I recalled their love of family and friends, and nature, which the women expressed during the workshop. The Light in this artwork is omnipresent. It

reminds me that I always have a choice: Will I choose the Light or the absence of it? Perspective is everything.

Theological Reflection

Deriving meaning from a diagnosis and subsequent lived experience of RA can evoke an in-depth exploration of oneself. Often the experience of being in a relationship, one's beliefs around life and death, one's values, daily routine and even one's spirituality are affected in the face of a debilitating illness. RA, for the women in this study, often involved a painful and unique story. However, the experiences of all of the women bore common threads: the disease had changed their lives, it was unpredictable, and beyond their control. This begs the existential question: how can one find meaning in the face of RA? Verduin et al. (2008) define meaning as:

> On the one hand, "meaning" or "purpose in life" is considered to be a trait, an inner strength, as that which is ultimately responsible for the state of one's inner self, as that which has an inner hold on the moral and spiritual self, and as the why or the reason for living that motivates a person's life. On the other hand, "meaning" or "purpose in life" is also defined as a stable and generalized intention to accomplish something that is at once meaningful to the self and of consequence to the world beyond the self. (p. 900)

Concepts outlined by Paul Jones in *Theological Worlds* (1989), introduced earlier, can, I believe, enhance understanding of the women's experiences, particularly in relation to the findings of this study. Jones uses the phrase "theological worlds" to refer to five distinct worldviews. The worldview or "theological world" which I find most relevant to my thesis is Theological World Five, or "suffering and endurance." Each of Jones's

Theological Worlds has two poles, one being referred to as the "obsessio," or one's suffering, "the wound that bewilders healing," (p. 27) with the other pole referred to as "epiphania," or one's ability to endure, with the potential for "flowing back to redeem the whole" (p. 28). In life we move in between the two poles. There are times in the hour, the day, month, when we can feel weighted down, ensnared in the throes of suffering, while at other points the weight lifts, and we feel embraced by a sense of community, oneness, wrapped again in the strengthening energy of endurance.

According to Jones, (1998) those who live in Theological World Five view themselves as victimized and often feel overwhelmed when they are experiencing the state of obsessio. There is a sense of being transfixed; one feels as though the outcome is a forgone conclusion, that "this is the way things are" (p. 99). One believes that nothing can be done to change one's state of suffering, everything has the weight of fact. There exists the discomfort of powerlessness; one feels overwhelmed with "the apparent meaninglessness of the way things are" (p. 215).

Jones (1998) informs us that there is little duality in World Five, no opposite end of the spectrum to go to, when travelling between dilemma and resolution. "Epiphania" brings no reversal as found in the other four Worlds. The only change that is available to the residents of this world is a change of perspective. The issue in "Obsessio" relates to being immersed in the experience of suffering, or holding a stance too close or near to the source of suffering. What might it look like from a distance when the whole picture is observed?

Jones (1998) suggests that an experience of epiphania in this world can be realized when we feel that even though things stay as they are, "we are all in it together."

He offers an example from a Christian perspective: “God is the sympathetic companion who anguishes with us in a communion of suffering,” (p. 217) portraying God through Jesus as a suffering companion, no longer omnipotent or omniscient.

When trying to understand how individuals stand in their world, we must further consider what Jones calls “temperament.” He writes:

> While the dynamic of obsessio and epiphania is universal, for some individuals, the emphasis falls heaviest on obsessio; for others, on epiphania. Expressed functionally, the dynamic for some is more characterized by absence and drivenness; for others, by pull and lure. For some the obsessio has the feel of entrapment or boredom; for others it exudes the energy of passion. (p. 40-41)

Asked in a simpler way: Is the glass half full or half empty?

The lived experience of RA is often a world characterized by suffering; we cannot rid ourselves of this RA experience. The women shared that suffering emerged from living in a place of pain, loneliness, fear, anger, loss, or depression. Add to this the experience of others not having an understanding of how the disease impacts those living with RA, plus their own ensuing inability to communicate how they really felt, with the result that one feels overwhelmed and isolated. Here, in the midst of their obsessio, there is no sense of community, no sense of suffering together, which is where they might have found comfort, or atonement. Jones explains atonement as “withness” (p. 224).

How might these women move from dilemma to resolution? According to Jones, (1998) the challenge is not so much the problem as it is the attitude towards it. It is here that hope is found. He states that, “Even though ’imprisoned,’ one’s inner attitude is free” (p. 105). One of the gifts of art therapy is the opportunity to discover

how we view a dilemma. Images show us both what is in our conscious and in our unconscious, providing a picture of the whole. One woman discovered that pain was not the complete representation of who she was, which expanded her perspective. Her image was imbued with a colour that for her represented hope. Another noticed symbols depicting her true essence being present throughout her representation of pain which changed the way she saw her pain. The session provided the women an opportunity to explore their experience of RA-related pain, and develop a new perspective that offered them hope for living with RA.

What brings comfort to those who reside in World Five is recognizing that they are not alone. There is comfort in knowing that there are companions on the journey; there is comfort in numbers. Jones (1998) states, “We rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us” (p. 232). The group art therapy workshop that they experienced offered the participants in this study that sense of community. It made them feel like they “were in it together.” Having spent time with others whose lives were also affected by RA, listening to one another’s stories, resulted in a feeling that a weight was lifted; they found connection in the strength of being with others.

It can be suggested through the revelations and reflections that making sense of a life experience with RA and finding meaning in such an illness is a complex matter. Some of the women do not look ill, yet they feel ill, which makes it a difficult and confusing journey for them and for others. Art therapy further helped the women connect to themselves where they discovered an inner strength. They enlarged their perspective,

which was empowering and necessary for transformation. Nothing changed in relation to having a life-changing diagnosis, but in many ways everything had changed. The women experienced themselves “anew” within their “old” diagnosis. They discovered that they were not only their pain and illness, they were more than this–this offered them a new beginning.

In order to find what is at once meaningful to the self and of consequence to the world beyond the self, one must find who the new self is, and group art therapy provided a vehicle.

Chapter 7: Conclusion

Summary of Results

This study demonstrated the potential of group art therapy to reduce existential and physical pain in women diagnosed with RA. An examination of the content of the workshop and interview transcripts, as well as written data produced by journaling during the workshop, revealed four major themes.

The women's initial imaginal expression, represented by the pain mandala, led to the first theme: physical and existential pain. This intuitive mandala gave them an opportunity to depict what suffering felt and looked like, which they freely explored with others in the group. Their sharing started with descriptions of physical pain, but eventually turned to exploration of related existential pain. For some this emotionally-laden pain included loneliness, anger, sadness, sense of loss, trying to be the person they were before diagnosis, and depression. For most the inability to talk about their disease or related symptoms to others in day-to-day life was a source of distress; some women commented they were concerned about being seen as a complainer, which might eventually turn loved ones or others away. These feelings led to non-disclosure and the next major theme of holding pain in.

Once the discussions around the first images were completed, the self reported pain rates started to move down slightly for most women, the reason for which was explained during the post workshop interview by each individual who encountered this reduction in pain perception.

The results of journaling and the creation of the second mandala image, "resources," resulted into the emergence of theme three, tapping into resources. The

women recognized two specific resources: spiritual resources and personal resources. Imaginal representations of both arose from the mandalas and sharing their stories around what was helpful and positive in their lives was powerful for all to hear and express. During their explorations and conversations about the second mandala, further insights developed around what was important to every woman; all articulated a connection to a Higher Power in addition to strengths found within themselves.

Looking at pain and resources through the lens of their art offered the women a new kind of seeing, resulting in the fourth major theme, how art therapy helped, which gave rise to two sub themes named connection and a different perspective. The women found that group art therapy had enhanced their awareness of connection to themselves, others, and a Higher Power. New kinds of looking were discovered which included the ability to gain insights not only through thinking but also through feeling; looking in a way that felt like one was in a meditative state–seeing as an observer, and using verbal and non-verbal communication. Some expressed that art distracted them from keeping their attention on pain; it offered "time out" and a new focus. Others called the artistic process relaxing, and for a few women playing with colours, mixing them to represent just the right shade to render a particular feeling, was simply fun. After the creation of the second image, self reported pain significantly dropped which the participants attributed to a number of aspects: the abovementioned, a focus on the positive, and emotional distance.

In conclusion, there is evidence that suggests that the participation in this group art therapy study for these women diagnosed with RA facilitated a decrease in their pain.

Revisiting the Literature

A wide range of topics has informed this research, varying from gaining a better

understanding of RA, the psychology of pain, meaning making and pain, to the use of art therapy, in particular through the creation of mandalas.

Turk, Swanson, and Tunks (2008) state that treatment of RA is complex and that the average duration of pain in people seeking treatment from pain is about 7 years, which results in compromised aspects of health for a long period. Psychosocial and behavioural factors play a significant role in the experience, maintenance, and exacerbation of pain; and because some level of pain persists in most people with chronic pain, regardless of treatment, self-management is an important complement to biomedical approaches (p. 214). In their quest for day-to-day pain management and relief the women were willing to turn their attention to an alternative therapy to complement their medical treatment. Psychological approaches, for example, insight-oriented therapies, (Eye Movement Desensitization and Reprocessing (EMDR), hypnosis, emotional freedom technique (EFT), are increasingly involved in treatment of pain secondary to an illness such as RA.

Keefe, Lumley, Anderson, Lynch, and Carson (2001) discuss the relationship between emotions and pain. They suggest that research findings indicate "that the simple examination of 'stress' is insufficient," (p. 589) there needs to be an understanding of the emotional processes associated with stressful events, as well as the person's responses to these emotions. Group art therapy provided the women with a vehicle to better connect to and get new insight into their emotional stressors through deep reflection on what emerged from their images. They also learned from one another as they shared, listened, and responded to the stories about pain and what had been helpful to them.

Rao et al. (2009) suggest that art therapy may improve one's ability to cope with the symptoms of a major illness such as HIV/AIDS. "There are several mechanisms through which art therapy may have improved coping skills…providing an alternative focus for the patient. …providing a place where the patient can express their symptoms" (p. 68). Some of the women indeed conveyed that creating mandalas took their mind off of stressful thoughts. Even though they were painting a pain image, painting while deeply focused on colour and form enabled them to take on a different perspective. All participants invited comments from one another about their images and shared stories once a safe environment was established.

Areas of Potential Application of the Present Study

This study serves to benefit women who have been diagnosed with RA. In addition it provides knowledge and insights about the lived experiences of RA to all those who are in relationship with women, which may include partners, family, friends, and healthcare providers. Support for women with chronic pain, such as in RA, requires a multi-disciplinary approach. As this study has described self-reported therapeutic benefits, it is suggested that art therapy, and in particular the creation of mandalas, be regarded as part of such an approach. The workshop format is easily transferrable to future research and/or group counselling environments. It is further interchangeable with patients diagnosed with other diseases that have existential pain and/or (chronic) pain as their focus. At the same time one needs to be aware that the degree to which art therapy contributed to the overall effect of pain reduction is difficult to determine. The workshop provided a safe and inviting environment where participants were encouraged to share their RA-related experiences and feelings for a short time period. It

is possible that being part of a compassionate group where others listened and understood might have influenced some of the results.

Further Topics of Inquiry

More in-depth inquiries are required to help our understanding of how different factors contribute to RA pain, and how art therapy can intervene and help minimize related suffering. Further research might explore a study with mandalas and RA over a longer period of time. This study evaluated immediate change in symptoms and once again after a one to two week period. Longitudinal studies are needed to evaluate how group art therapy and its relationship to RA impact pain.

As it seemed that one theme led to another in this research, there is potential for further investigation. Holding pain in and Connection were themes that were unexpected and important findings in this study. Future research on their relevance to pain might meet additional needs of those with diagnosed RA. An interesting study might be one that would include a partner, an important family member, as a sense of isolation was apparent throughout this research.

As all the women's resources included a connection to a Higher Power, it would be interesting to look further into creating mandalas for the purpose of meditation to explore its impact on life with RA.

Personal Statement

Selecting the creation of mandalas as a basis for my study arose from having successfully used this circular form in the past in helping others as well as myself to gain new perspectives and move towards becoming "whole." In taking this creative process to the level of further inquiry, I hope that those who read the text in combination with

viewing of the art work will get a better feel for what it is like to live with RA, an autoimmune disease that is not always visible, yet often debilitating. Above all I hope that this research will convey the role of group art therapy as a vehicle to help reduce pain. Cole and Knowles (2008) write: “the central purposes of arts-informed research are to enhance understanding of the human condition through alternative (to conventional) processes and representational forms of inquiry” (p. 59).

I consider it a great privilege to have been part of the journey of five women, who were courageous, trusting, and above all willing to explore whether group art therapy might help reduce their pain. I came away with a deep knowing that group art therapy offered the women and myself that and much more. Through our art making and being in the group we all learned more about ourselves as we came to understand the importance of acknowledging our needs and what is truly meaningful to each of us. I believe that it opened us up to new possibilities, a sense of connection, hope, and transformation.

As a researcher/facilitator I certainly became aware of the impact that the art making, exploration, and discussion had on the women during the workshop. However I remember sensing a feeling of sadness after the workshop; in my role as a facilitator I had remained more of an observer of the women’s processes, feeling less connected than I have experienced in my role as a therapist. It was not until much later, when I deeply listened to each woman’s story about pain and resources, while creating my own mandalas as a response to their experience, that I felt connected. While looking at their artwork and hearing how each woman listened to another’s story, responded, and was touched, my own experience became raw and immediate; I resonated with them when

they talked about their existential pain, as I felt their joy when they spoke about resources to others in the group who understood them. I related to their experience because it was familiar. I too have struggled with the same issues as the women; whether or not to disclose that I have been diagnosed with RA, feeling that I was no longer “whole” or “healthy,” and trying to keep on going some days as if all was well in my body. I remember being in denial for the first year after my diagnosis, and it was not until I was asked during a hospital RA information session to practice walking with two poles through the hospital’s corridors, that it occurred to me I was really part of this population, not just someone watching other participants across the room. I was horrified. There is a lot to learn once diagnosed with an illness; fortunately there are also pearls to be discovered on the way.

The journey of conducting this research was not always an easy one. There were a number of occasions during which I felt a loss of control; this project required teamwork to make it possible and I was not always able to adhere to my time lines. This feeling was somewhat similar to the one pointed out by the women as being a component of RA, a feeling of powerlessness. Interestingly and certainly not surprisingly, these occasions immediately resulted in my own stress-connected RA flare-ups.

I am thankful for the knowledge I have acquired in doing this project; I discovered much information on the physical and emotional cost of this disease and became better informed about a plethora of coping skills. I know I will be a better therapist having had this opportunity to study RA.

I would like to end with the wisdom of a fellow traveller, a poet diagnosed with a serious illness, Christian Wiman, who said: "If you can give shape to despair–that's one

thing poetry is so good at–if you can give shape to despair, it can give you a way to manage that despair even if it doesn't ameliorate it." I believe this to be true for art therapy as well.

Every Riven Thing

by Christian Wiman

God goes, belonging to every riven thing he's made
sing his being simply by being
the thing it is:
stone and tree and sky,
man who sees and sings and wonders why

God goes. Belonging, to every riven thing he's made,
means a storm of peace.
Think of the atoms inside the stone.
Think of the man who sits alone
trying to will himself into the stillness where

God goes belonging. To every riven thing he's made
there is given one shade
shaped exactly to the thing itself:
under the tree a darker tree;
under the man the only man to see

God goes belonging to every riven thing.
He's made the things that bring him near,

made the mind that makes him go.

A part of what man knows,

apart from what man knows,

God goes belonging to every riven thing he's made.

(Wiman, http://www.pbs.org/newshour/art/blog/2010/11/poet-christian-wimans-every-riven-thing.html)

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Figure 4

Figure 5

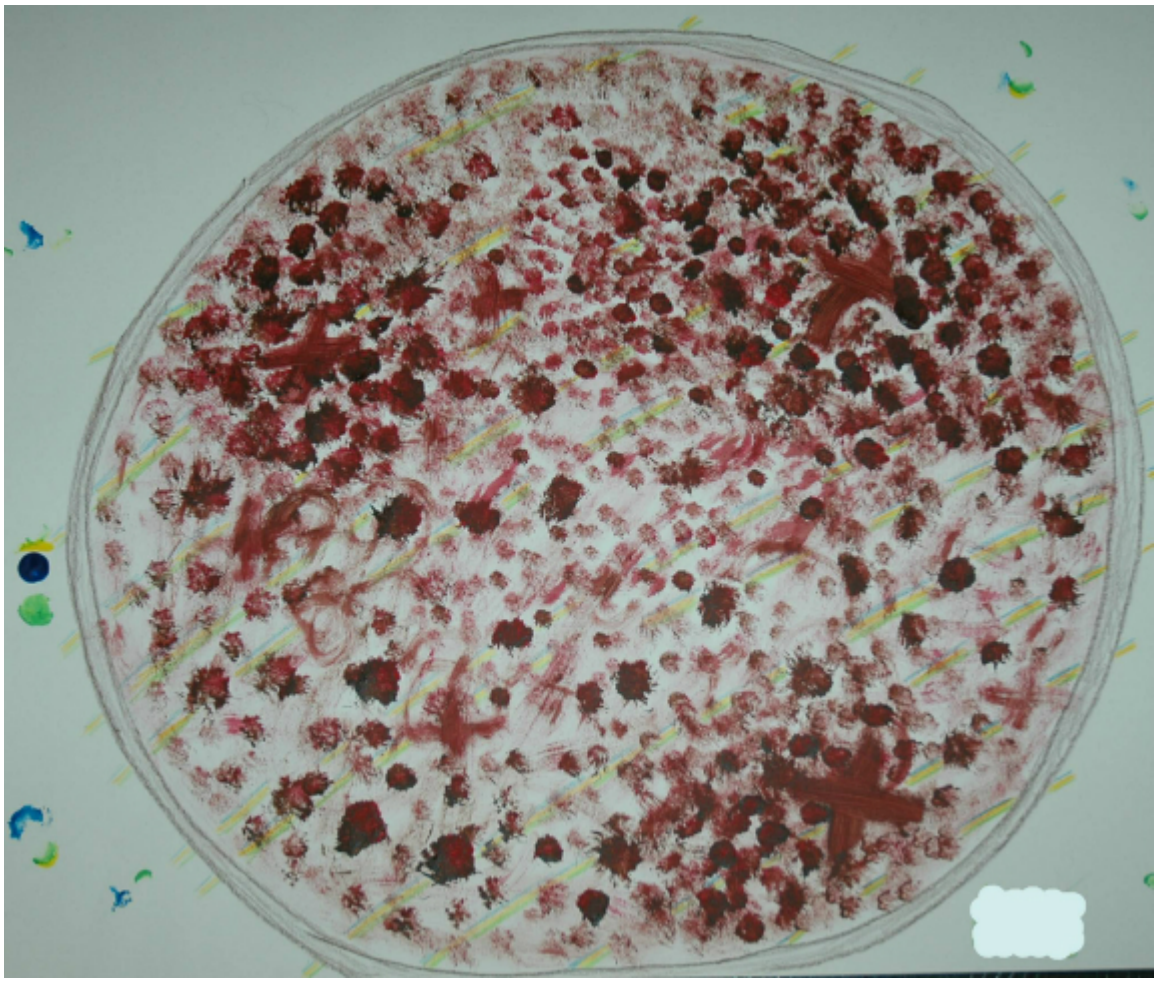

Figure 6

Figure 7

Figure 8

Figure 9

Figure 10

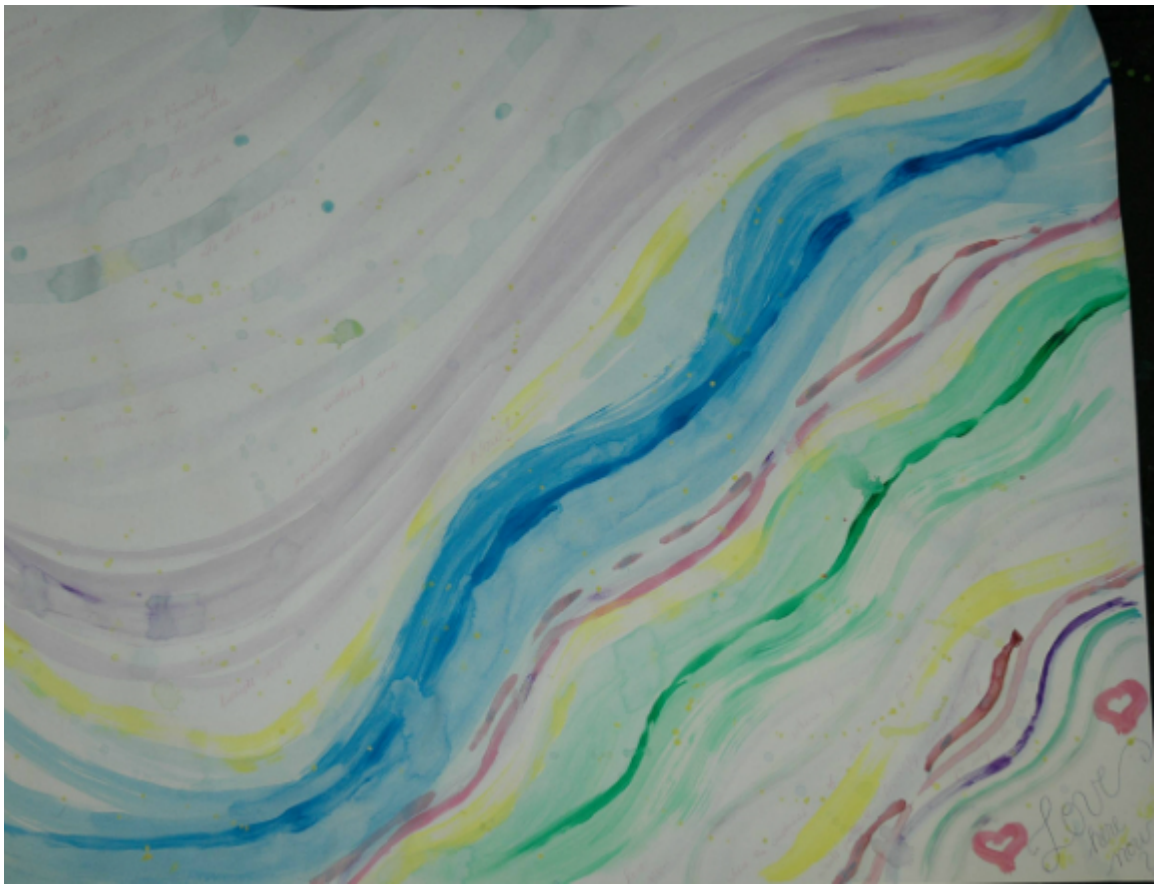

Figure 11

Figure 12

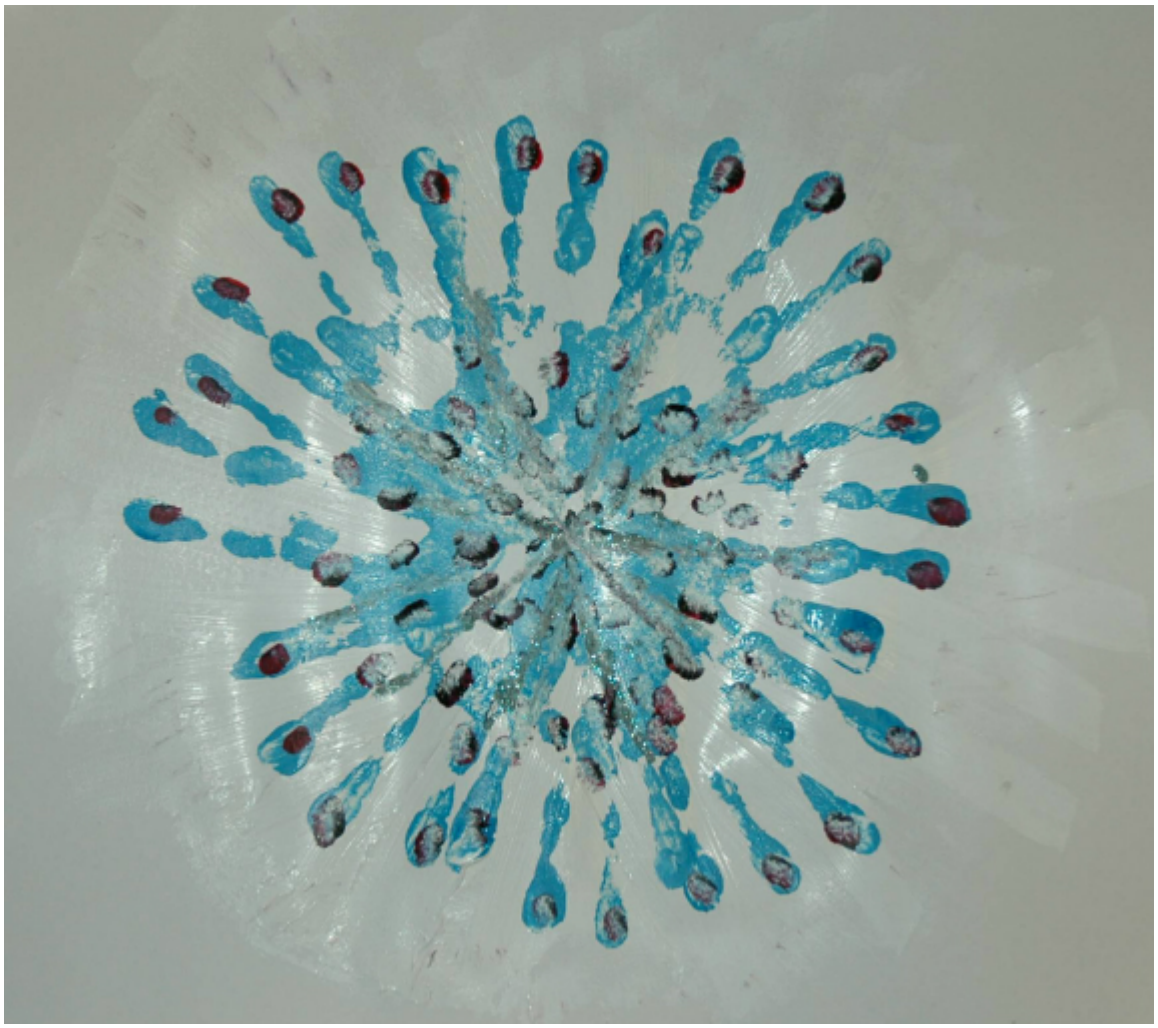

Figure 13

Appendix A: Workshop Details

Opening the Circle

Welcome and introductions

Discussion about format of workshop

Discussion around confidentiality issues while in session

Art Release forms

Measure physical & existential pain using scale 1-10

Discuss use of art supplies

Art making and directives:

1. Creation of first mandala: Draw symbols of your awareness around physical or existential pain
2. Journal about your inner resources that helped you cope with your physical or existential pain
3. Creation of second mandala: Draw symbols for what helped you cope with your physical or existential pain and for what you love and appreciate in your life

Reflect and time for journalling (15 min) after each art directive

Measure physical & existential pain using scale 1-10

Sharing of process, experience and art work

Measure physical & existential pain using scale 1-10

Closing the Circle

Appendix B: Tasks for the Co-facilitator

- Greet participants and help them get comfortable
- Be observant of participants regarding participation, body language, emotional states
- Ensure participants feel free to ask for assistance when needed and respond
- Aid with audio equipment, art supplies, camera
- Write up a summary at the end of the workshop which includes your observations of what took place during art making and during the discussions after image making

Appendix C: Information Letter for Alberta Arthritis Society

_____
(Date)

Dear Ms. _____

Please find enclosed information regarding the research project Art Therapy for Reduction of Physical and Existential Pain in Women Diagnosed with Rheumatoid Arthritis, which I will conduct as a requirement for my degree of Master of Arts in Psychotherapy and Spirituality (with an Art Therapy Specialization) at St. Stephen's College.

I would appreciate your support in the recruitment of participants for this study by posting my recruitment poster in your office and/or offering it to women who might like to be in the study.

I am looking for 14 women who have been diagnosed with rheumatoid arthritis, who are 18 years old or older, experience pain, flare-ups, or chronic pain, are able to speak and understand English, able and willing to engage in art making, and willing to have a post-workshop interview. Each woman will participate in a 4-hour art therapy workshop and a 1-hour individual interview a week or two after the workshop.

The project will begin on June 30, 2011 and end on March 31, 2012. The total time commitment for each participant will be 5 hours. Participation is voluntary; participants will not be paid. Possible benefits of participation include relaxation and meaning making. There are no foreseeable risks or discomforts.

The study will be conducted in accordance with the ethical guidelines used by St. Stephen's College for research involving humans and will be supervised by Dr. Pamela Brett-MacLean at the University of Alberta. Participants' names and all other personally identifiable information will be kept confidential. Participants may discontinue participation at any time with no questions asked and without penalty or loss of benefits. Although your help would be extremely valuable, your name will not be included in the final report.

If you have questions or concerns about this research project, please contact me at 780-x or x, fax 780-x .You may also contact Dr. Pamela Brett MacLean at x.

I thank you in advance for your support in the recruitment of participants for the study Art Therapy for Reduction of Physical and Existential Pain in Women Diagnosed with Rheumatoid Arthritis

Sincerely,
Mady Mooney

Appendix D: Information Letter for Rheumatologists

_____
(Date)

Dear Ms. _____

Please find enclosed information regarding the research project Art Therapy for Reduction of Physical and Existential Pain in Women Diagnosed with Rheumatoid Arthritis, which I will conduct as a requirement for my degree of Master of Arts in Psychotherapy and Spirituality (with an Art Therapy Specialization) at St. Stephen's College.

I would appreciate your support in the recruitment of participants for this study by posting my recruitment poster in your office and/or offering it to women who might like to be in the study.

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If you have questions or concerns about this research project, please contact me at 780-x or x , fax 780-x.You may also contact Dr. Pamela Brett MacLean at x.

I thank you in advance for your support in the recruitment of participants for the study Art Therapy for Reduction of Physical and Existential Pain in Women Diagnosed with Rheumatoid Arthritis

Sincerely,
Mady Mooney

Appendix E: Research Study

Research Study

Art Therapy
for Relief of Physical and Existential Pain
in Women Diagnosed with Rheumatoid Arthritis

Researcher: Mady Mooney

You are invited to be part of a research study that will explore the potential of art therapy to relieve pain for women with rheumatoid arthritis. The study will be undertaken by Mady Mooney as a requirement for her degree in the Master of Arts in Psychotherapy and Spirituality program (Art Therapy specialization) at St. Stephen's College.

What would be your role in the study?

If you participate in this study, you will take part in a four-hour workshop with 6 other women. With the guidance of two experienced facilitators, you will make two works of art (mandalas) using paint or colouring pencils. After the first mandala, you will do some journalling.

A week or two after the workshop, you will participate in a one-hour interview about what you experienced during the workshop.

Absolutely no art experience is required! If you've never done this kind of thing before, it's an opportunity to do something new that's easy and fun.

To participate in the study, you must be:

- female,18 years old or older
- diagnosed with rheumatoid arthritis
- experiencing pain, flare-ups, or chronic pain
- able to speak and understand English
- able and willing to engage in art making
- willing to have a post-workshop interview

Participation in this study is voluntary.

For more information please contact:

Mady Mooney, 780-x, x

Appendix F: Participant Inclusion Criteria

Selection of research participants will be subjected to the following criteria:

1. Females over 18 years old diagnosed with rheumatoid arthritis
2. Suffering from pain, flare-ups, or chronic pain
3. Able to use hands
4. Able to speak and understand English
5. Currently not receiving psychiatric support for experienced emotional distress
6. Willing to engage in an art making group process
7. Agreeing to a post workshop interview

Appendix G: Initial Telephone Screening Questions

- Have you been diagnosed with RA by a physician?
- Do you experience pain/flare-ups or chronic pain?
- Are you on medication? For how long?
- Are you able to use your hands?
- Do you live in Edmonton?
- Are you over 18?
- Are you able to speak, write, and understand English?
- Are you currently receiving psychiatric support for experienced emotional distress? (If so, I will suggest that the group session may not be suitable for her at this point)
- As a participant in this group workshop you are asked to create two pieces of art (no artistic skills are required). A post workshop one hour interview with the researcher will take place within one or two weeks of the workshop. Are you willing and able to participate in the workshop and the interview?
- Do you have any questions?

Appendix H: Letter of Information and Consent

Research Study: "Art Therapy for Relief of Physical and Existential Pain

In Women Diagnosed with Rheumatoid Arthritis"

Investigator Conducting the Research,	Mady Mooney (MPS 2011) - x
Principal Investigator/Supervisor,	Dr. Pamela Brett-MacLean – x (Asst Professor, Faculty of Medicine & Dentistry; Director, Arts & Humanities in Health & Medicine Program)

The purpose of this research project is to study the use of art therapy for relief of physical and existential pain in patients diagnosed with rheumatoid arthritis. The research study undertaken by Mady Mooney is a requirement for her degree in the Master of Arts in Pastoral Psychology and Counselling program (Specialization in Art Therapy) at St. Stephen's College.

The participant will take part in a four hour arts-based group workshop for which no artistic skills are required. A post workshop interview of approximately one hour duration will be conducted at a time convenient to the participant. During this interview questions will be asked about the participant's workshop experience of art making and processing.

Both workshop and interview will be audio-taped, information arising from the workshop, art making and subsequent interview will be treated confidentially and used solely for the purpose of Mady Mooney's research. The information will be kept in a secure area (i.e. locked filing cabinet). All or some of the data may be required by St. Stephen's College authorities (i.e. MAPPC Coordinator and/or Ethics Review Committee) to ensure the study's validity and/or compliance with standards. The recorded tapes will be destroyed once transcribed. Intellectual Property (Art-work) and use of Art-work: The participant will be the sole owner of the artwork created.

There may be no direct benefits to you as a participant of this study. The risk of mild emotional distress as you tell your story is balanced by the benefits that you are likely to receive in the form of relaxation and new insights.

THIS IS TO CERTIFY THAT I, _____ (PRINT NAME) HEREBY AGREE TO PARTICIPATE AS A VOLUNTEER IN THE ABOVE-NAMED PROJECT.

I hereby give my permission to tape record discussions during the workshop and

to record the interview. The tape recorder can be shut off at anytime during the interview at my request. I understand that, at the completion of the research, the tapes will be erased. I am aware that my personal identity will remain a confidential matter. I understand that I may withdraw from the thesis project at any time that I so desire and that at any point during the thesis project my involvement may be terminated by myself or Mady Mooney. I am aware that it may be determined that some or all of my information may not be used in this project.

I understand that it may be determined that some or all of my information may not be used in this project. The thesis will not use my full name and steps will be taken to protect my identity from anyone reading the thesis. The thesis will become available to students at the St. Stephen's College library and that at some later point Mady Mooney may choose to have her thesis published and circulated on a broader scale. The foregoing does not in any way alter the agreement with respect to confidentiality regarding my identity. I am aware that this thesis project has been approved by the Ethics Review Committee of St. Stephen's College, Edmonton, Alberta, Canada. I understand this project is being supervised by Dr. Pamela Brett MacLean and that she can be reached by email at x. I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

_____	_____	_____
Participant	Witness	Researcher

_____

Date

Appendix I: Demographics

Name: _____

Address:_____

Telephone:_____

Email:_____

Age:

What is your month and year of birth? (MM/YYYY) _____/_____

Race/ethnicity:_____

Marital status:

Are you:

- Married
- Divorced
- Widowed
- Separated
- Never been married
- A member of an unmarried couple

Employment status

Are you currently:

- Employed for wages
- Self-employed
- Out of work for more than 1 year
- Out of work for less than 1 year
- A homemaker
- A student
- Retired
- Unable to work

Education completed:

What is the highest grade or year of school you completed?

- Never attended school or only attended kindergarten
- Grades 1 through 8(Elementary)
- Grades 9 through 11 (Some high school)
- Grade 12 (High school graduate)
- College 1 year to 3 years (Some college of technical school
- College 4 years (College graduate)

- Graduate School(Advance Degree)

Do you have any creative hobbies?

Date completed:

year_____/month_____/day_____

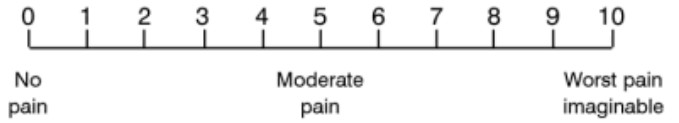
Appendix J: Pain Rating Scale

Printed Name:_____

Please rate your physical and existential pain on a scale from 1 to 10

Existential pain = feeling upset about how rheumatoid arthritis affects your life or beliefs

1.Physical Pain Rating:

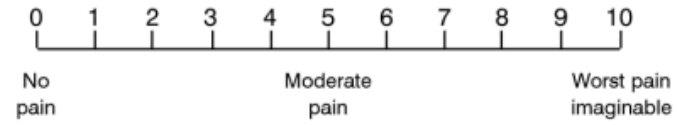


From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

1.Existential Pain Rating #:

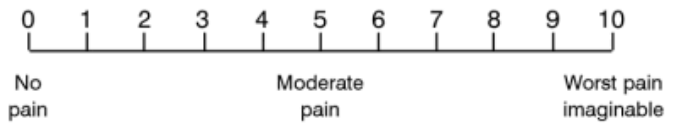
From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

2.Physical Pain Rating #:



From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

2.Existential Pain Rating #:

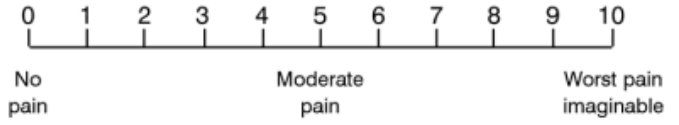


From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

3.Physical Pain Rating:

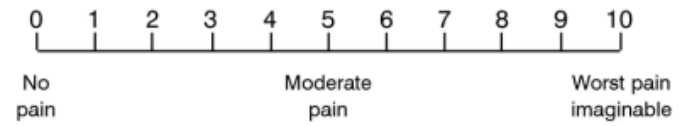
From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

3.Existential Pain Rating #:



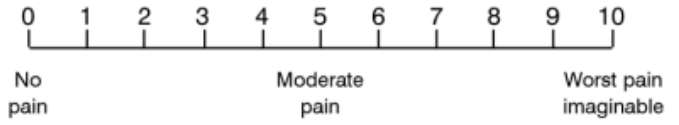
From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

4.Physical Pain Rating #:



From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

4.Existential Pain Rating #:



From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032: February 1992; Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

Appendix K: Post Workshop Interview

The participants will be briefed on the structure of this interview which consists of a discussion followed by giving numbers to their physical and existential pain using the pain questionnaire.

I will explain to the women that this post workshop interview is arts based and seeks to help answer my research question: Can group art therapy with a meaning making focus help relieve physical and existential pain for women diagnosed with rheumatoid arthritis? My goal is to find out if and how the workshop helped them.

The women are asked to elaborate on their experience of creating the mandala and reflective journal writing, reporting on changes in pain perception, meaning making and spiritual resources. The two art pieces and short journal will be used as prompts.
We will close by measuring physical and existential pain using scale of 1-10.

Appendix L: Thesis Art Therapy Art Release Form

Research Project:

Art Therapy for Relief of Physical and Existential Pain
In Women Diagnosed with Rheumatoid Arthritis

Name

Address Email

City Prov Pcode

I hereby grant permission to Mady Mooney to use originals/slides/prints of my artwork produced in the art therapy workshops for research related purposes and thesis supervision. The participant will be the sole owner of the created art work.

My name will not be revealed unless permission is granted and confidentiality will be maintained at all times.

Signature_____ Date: _____

Appendix M – Oath of Confidentiality

I, _____, participating in the role of _____,
(Please print full name) (Please specify role)

hereby agree to keep in confidence any and all information obtained regarding the research project *Art therapy for relief of physical and existential pain in women diagnosed with rheumatoid arthritis*, particularly participant identity and personal or identifying information of any kind related to the data collection and analysis for this project. I understand that by signing this document I am respecting the rights of the participants to the protection of their privacy.

_____ _____

Signature Date