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Art therapy on a bone marrow transplant unit: the case study of a Vietnam veteran fighting myelofibrosis

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Abstract

At this time in history, the medical world is beginning to accept holistic approaches to aid in the psychosocial treatment of its patients. This is particularly true for cancer patients. Art therapy is one such psychosocial intervention that provides many possibilities for healing for such patients. This case study examines the art therapy experience of one such patient, a 52-year-old male in medical isolation after having received stem cell transplantation (SCT) to treat myelofibrosis, a life-threatening illness. The patient was a Vietnam Veteran and had a history of alcohol abuse. This study examines how the patient's history impacted his state of mind during hospitalization and isolation and how this was reflected in his artwork. Art therapy provided a means of examining this patient's past traumas so that he could then move into examining and living in the present moment. It also provides an example of how art therapy moves beyond the means of art making as healing to the world of metaphor and mental imagery as healing agents in a therapeutic process.

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Introduction

As the medical world begins to accept a holistic approach to the treatment of individuals with physical disease, more psychosocial interventions are being offered to patients in the medical setting, particularly cancer patients. While cancer patients in general experience similar psychological issues and needs, many of their issues will be unique to their particular disease and mode of treatment. Stem cell transplantation (SCT) and bone marrow transplantation (BMT) are two modes of treatment that are similar in both physical procedure and psychosocial effects for

the individuals who undergo them. Both procedures may be used to treat various blood disorders such as leukemia, Hodgkin's disease, lymphoma, as well as diseases such as breast cancer and multiple myeloma (Andrykowski & McQuellon, 1998; Andrykowski et al., 1999).

Andrykowski et al. explain the physical procedure and psychosocial ramifications for SCT,

Transplantation of hematopoietic stem cells obtained from bone marrow or blood is employed in the treatment of a variety of serious, life-threatening, primarily malignant diseases... Potential problems span the spectrum of QOL domains and represent a range of physical, functional, emotional, and social difficulties. In addition to the well known physical late effects of SCT, such as graft-versus-host disease, pulmonary problems, and rheumatoid disorders, problems with fatigue, sleep, sexual and cognitive function, and psychological and interpersonal adjustment have been identified. (Andrykowski et al., 1999, p. 1121).

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BMT is also a serious procedure with various ramifications for the individual undergoing the procedure. Andrykowski and McQuellon explain,

Bone marrow transplantation (BMT) is a complex medical procedure in which blood cells . . . in bone marrow are infused into a patient following high-dose chemotherapy and/or radiotherapy. Because BMT is associated with life-threatening physical morbidity, lengthy convalescence, and social isolation, the potential for significant psychosocial morbidity is high. (Andrykowski & McQuellon, 1998, p. 289)

While SCT and BMT are similar in nature, most of the research and literature in the field focuses on the psychosocial effects of BMT. Therefore, much of the research referenced in this article is related to BMT, however, it is widely accepted, and has been the author's clinical experience, that the psychosocial ramifications for an individual undergoing SCT are similar to that of an individual undergoing BMT.

Because of the serious nature of SCT and BMT, it has been found that with transplantation comes the potential for an increase in psychological distress such as anxiety and depression (Baker, Marcellus, Zabora, Polland, & Jodrey, 1997; Sasaki et al., 2000). Coping mechanisms, such as perceived personal control, have been correlated to psychosocial morbidity (Fife et al., 2000). While in isolation, the patient may have "severe side-effects of nausea, vomiting, and pain as a result of mucositis" (Gabriel et al., 2001, p. 114). The normal stay on the hospital floor for SCT patients and BMT patients ranges from four to six weeks, but if complications arise it can be longer.

While the SCT and BMT experience is clearly a time of psychosocial distress, few sources have examined psychosocial interventions with this population. Irene Rosner David and Shereen Ilusorio wrote about their experience working with tuberculosis (TB) patients in isolation and stated "Patients benefit from the artistic expression of their emotions not only regarding the disease and prognosis, but also regarding the unique experience of isolation" (Rosner David & Ilusorio, 1995, p. 30). The main difference between the isolation experience for SCT or BMT patients and TB patients is that SCT and BMT patients are being protected against the germs others may give them while TB patients are being protected from giving germs to others. This needs to be kept in mind when you are working with patients in isolation as the psychological ramifications of the isolation experience differ. Gunter (2000) wrote about the use of art therapy with children undergoing BMT. But only one study has examined the use of art therapy with adult BMT patients in isolation (Gabriel et al., 2001).

The work of Gabriel et al. (2001) indicates that art therapy with adult BMT patients in isolation "... can be used to fulfill a variety of needs: (a) to strengthen positive thoughts, (b) to resolve distressing emotional conflicts, (c) to deepen the awareness of existential and spiritual issues, and (d) to facilitate communication with relatives and friends" (p. 122). As a graduate art therapy intern working with adult SCT and BMT patients at a cancer hospital in New York City where the work of Gabriel et al. had taken place, I decided for my thesis to conduct a broader study examining the BMT psychosocial experience from the patients' point of view (Greece, 2002).

The purpose of this study was to explore what psychosocial interventions were appropriate for this population. Also important was to examine *how* art therapy should be approached when working with this population. A convenience sample ($n = 11$) of adult BMT patients consisting of five men and six women were interviewed regarding their isolation experience. Four areas of psychosocial experience were examined: verbal interchange, activities, body-oriented care, and self-expression. It was found that 82% ($n = 9$) of the sample stated a benefit from having someone to talk to, 73% ($n = 8$) stated a benefit from having things to do, 54% ($n = 6$) stated a benefit from body-oriented care, and 54% ($n = 6$) stated a benefit from self-expressive outlets. This indicated that there are several psychosocial interventions applicable to this sample including art therapy. It was also found that art therapy sessions with this sample should be verbally oriented, passive in activity, mindful of the body, and expressive in nature (Greece, 2002). The findings serve as a compliment to the findings of Gabriel et al. that art therapy with adult BMT patients in isolation can be an appropriate and useful intervention (Gabriel et al., 2001).

The particular case presented here is one example of how art therapy can be useful for an adult SCT or BMT patient in isolation. Mr. A's art therapy experience provides insight into the complexity of the human psyche when faced with a life-threatening illness and shows how eloquently one's psyche can display itself when given the opportunity to engage in the act of creation.

Method

Case history

This case study is based upon Mr. A who participated in individual art therapy sessions over a period of three months. Mr. A was a 52-year-old male who was admitted for SCT on September 10, 2001. The Patient Coordinator recommended him for individual

art therapy sessions. He did not have a strong social support system and it was thought that he would benefit from a psychosocial intervention such as art therapy. He was diagnosed in 1999 with myelofibrosis, a rare blood disorder. Mr. A was single and had no children. He lived alone. He was one of several siblings, but kept little contact with his siblings except for one brother who was his donor. His mother died when he was 16 apparently of a brain tumor, his father died a few years ago. A paternal uncle kept in contact with him at the hospital, calling and visiting occasionally. Mr. A was a Vietnam Veteran. He also stated that he had a drinking problem in the past and defined himself as having been a binge drinker. His most recent employment was in retail sales, a field in which he held multiple jobs as an adult. He did not fall into a specific diagnosis for psychopathology though he showed characteristics similar to that of various disorders including Post-Traumatic Stress Disorder and Depression.

Procedure

At the hospital psychosocial interventions such as art therapy were provided to the adult SCT and BMT patients such as Mr. A to aid in coping with the isolation experience as well as the ramifications of their illness. Like other professionals working with patients in isolation I took specific precautions in working with Mr. A in order to protect his health. Each time I entered his room I washed my hands, put on gloves, a mask, and when his immune system was particularly low, a protective gown. I learned to communicate with him through my eyes and my tone of voice as the majority of my face (mouth and nose) could not be seen because of the mask I wore.

Special consideration was also given to what art materials were used. To be as germ free as possible, Mr. A was given a package of non-toxic art materials in a plastic envelope that remained in his room throughout his hospitalization. This package contained markers, oil pastels, scissors, watercolors, paper, a glue stick, and a booklet of art therapy techniques entitled *The Creative Journey* (Luzzatto, 1997) which has been found to be useful with BMT patients in isolation (Gabriel et al., 2001). I brought magazines to his room each session to provide the opportunity for magazine photo collage.

At the time of Mr. A's hospitalization, *The Creative Journey* was used as a guide for possible art therapy interventions to use with patients in isolation. The techniques of *The Creative Journey* served as a bridge to the unconscious and offered the patients a non-threatening art therapy experience. However, art therapists working with patients in isolation were encouraged to be flexible and to use image making in

new ways, ultimately being guided by the needs of the patient. In working with Mr. A I found that techniques from *The Creative Journey* were helpful in guiding the imaging making process.

Three techniques of *The Creative Journey* were used with Mr. A including Collage, Colors & Shapes, and Blind Drawing (Luzzatto & Gabriel, 2000). Mr. A and I met approximately 25 times for individual art therapy sessions between September 2001 and January 2002. Many of these sessions were short verbal sessions due to his weak physical state at the time. Artwork was produced and processed during three of our sessions. Verbal sessions often focused on his symbolism as expressed through his words.

When working with Mr. A three guidelines were employed to help the process flow:

1. *Establish a Therapeutic Relationship*—This important preliminary stage of the art therapy process involved listening, empathizing, and paraphrasing as a means of building a trusting relationship.
2. *Introduce Art Making When Appropriate*—I waited for the appropriate moment to offer art making as a possibility, keeping in mind that he would make it clear to me when he was ready to make art, which he indeed did. When working with patients in isolation an art therapist should not expect art making to occur at every session.
3. *Being Open to Using the Mind*—Since Mr. A was going through a hard time physically I respected that he might not have the energy for the typical art therapy process. However, I opened myself to the possibility of employing his mental imagery and metaphors within an art therapy perspective.

Clinical process

Before isolation

Our initial sessions were informal and took place in the lounge area on the unit before Mr. A was in isolation. Our first meeting was on September 11, 2001, my first day as an art therapy intern on the BMT floor at the cancer hospital in New York City. The events of September 11 greatly affected the climate in the hospital that day. Tension was in the air as the hospital prepared for a state of emergency. For the patients, much like many Americans, emotions included shock, fear, anger and sadness.

That morning, I saw a tall thin man walking in the hallway holding onto an IV pole. I introduced myself and asked if he were Mr. A I indicated that the Patient Coordinator suggested he might be interested in individual art therapy sessions. He welcomed the conversation and we sat down in the lounge to talk.

I explained briefly the process of art therapy and indicated that he could use the process for self-expression, inner peace, and to better understand his feelings in light of his current medical situation. He stated he would think about it, but that it sounded "... rather psychological..." and he did not like to put his "... emotions out there..." I reassured him it was his decision and that he could share with me only what he chose to. Quickly our conversation turned to the terrorist events of the day and the shock we were feeling. Mr. A shared that he was a Vietnam Veteran and that it was possible he contracted his disease as a result of exposure to chemicals, namely Agent Orange, in Vietnam. After talking, we agreed that we would continue to meet.

During the second session, which also took place in the lounge, Mr. A shared his drinking experiences, and stated that he had been a binge drinker. His experiences in Vietnam and his experiences of alcohol abuse became the main area of focus for the sessions that followed.

Initial sessions in isolation

When Mr. A was first placed in isolation I concentrated on creating a therapeutic relationship. During these initial verbal sessions, Mr. A shared not only about his Vietnam experience and life with alcohol but his family history as well. It was in discussing his family that his sense of hope became apparent. A proud man of Irish descent, he contended fervently that he came from "good genes." He stated that although his mother had died from a brain tumor at age 41, her father (his grandfather) had lived until he was 96. This statement was the first glimpse into Mr. A's use of denial, a defense mechanism that was prominent in his psychic structure. It was clear that it was important for Mr. A to believe that his mother came from good genes, even though she herself died from cancer at a young age. His belief in his mother as being good provided a glimpse not only into his defense structure, but his object relations as well. Mr. A's hope was certainly one defense I did not want to challenge.

"Fifty-two is too young to die," he stated. This statement indicated that Mr. A's will to live was indeed intact.

Another embodiment of Mr. A's hope and will to live came in the form of colorful stories and memories he shared. He spoke in a most metaphoric way, often making associations through modern myths as defined by stories and movies he had encountered in his life. One story that emerged several times in our sessions was that of Superman. Mr. A preferred to sit in the sun when he was able to. He stated that it made him feel better. He did not like anything that took away from

his opportunity to sit in the sun, particularly medical procedures or staff.

"You know, the sun gave Superman his life," he stated in his New York accent. He went on to explain that Superman's planet had been destroyed and he had been put onto a ship by his parents and shipped to the earth. It is the sun and the earth's atmosphere that gave Superman energy and life, he explained.

Superman is a theme that has emerged with two other patients on the BMT floor as well. Perhaps Superman embodies the strength these individuals need, both physically and psychologically, to survive. By sitting in the sun, Mr. A could be like Superman. He could take action. He could get strength from the basic life force no human can live without, the sun. Mr. A demonstrated repeatedly his primal will to survive. His stories of Superman and the necessity of the sun are one embodiment of that will to live.

While Mr. A demonstrated a strong will to live, he also shared an opposing feeling, a readiness to die. He first exposed this when he shared his battle with alcohol and shared more descriptively the effect Vietnam had on him. He drank to numb himself, he said, particularly in response to his Vietnam experience which was quite traumatic for him. It was particularly hard for him to see other people die. He seemed to have survivor's guilt that evolved into a constant questioning of his purpose for being alive. He shared his story about being shot in Vietnam. The bullet deflected off his ID tags and hit him in the leg. "For some reason I lived through it," he shared. He would often look puzzled and then start discussing his luck at living as long as he had with his disease. "For some reason I am still here," was a common theme during our sessions.

Though Mr. A had not been diagnosed with PTSD, he had many of the characteristics of the disorder that are often found in Vietnam Veterans. These included substance abuse, depression, a wandering lifestyle with multiple jobs, outbursts of rage, and suicidal ideation (Golub, 1985). He explained that while he would never have committed suicide, he was done, finished, ready to die, even after giving up alcohol. He vividly described during numerous sessions that he thought he would "pop a blood vessel" one day and that was how he would die. He explained that he knew he was sick long before he was diagnosed, and that while he went to the doctor's regularly, he would neglect to tell the doctor his symptoms (bleeding). He was hospitalized after losing so much blood that he passed out. It was then that he was diagnosed as having myelofibrosis.

When asked if he still felt that he wanted to die, he stated no, he wanted to live, he was too young to die. Though on occasion Mr. A seemed fed up with his illness and his treatments, and unsure if he could

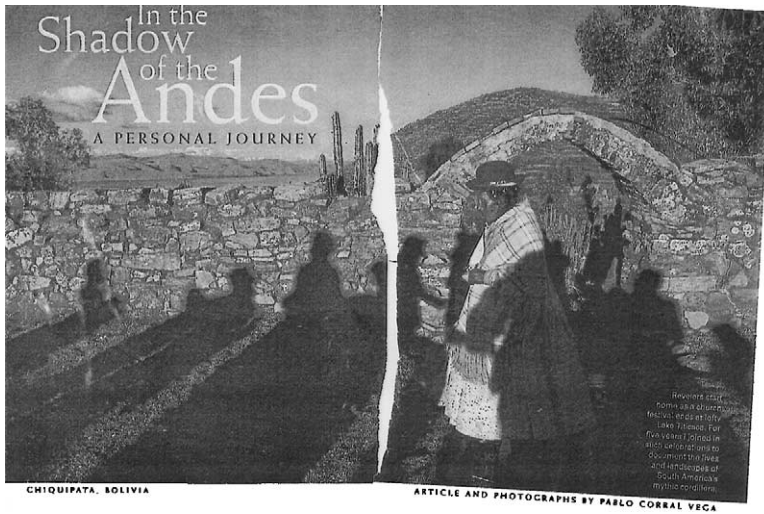


Fig. 1. *Rich Lush Terrain*.

go on, during his hospitalization his will to live far outweighed his readiness to die. However, it was my clinical assessment that the dualism in his psychic structure did not seem to change and was expressed in his artwork.

Imagery and the art therapy process

Collage

In early October, Mr. A created a collage on three pieces of paper. The first piece, titled *Rich Lush Terrain* (Fig. 1), was indicative of life.

In this image, he stated he was drawn to the architecture and to the foliage. The man, he said, was

a “well-to-do Mexican.” The water was appealing to him and he eagerly stated that the land in the background was an island, perhaps *Treasure Island*. He talked about his attraction to the movie *Treasure Island* and his affinity for pirates as a child. The second piece, *Wide Open Barren Space* (Fig. 2), was quite the opposite of *Rich Lush Terrain*. It was “desolate,” he told me. I asked him what it reminded him of.

“Vietnam,” he told me, explaining that he was in a camp in the hills when he got hit with a bullet. “Vietnam was different though, there was foliage,” he said.

“Like that of *Rich Lush Terrain*?” I asked.

“Somewhat, a bit different though,” he stated. At that point, I made an informal clinical assessment that

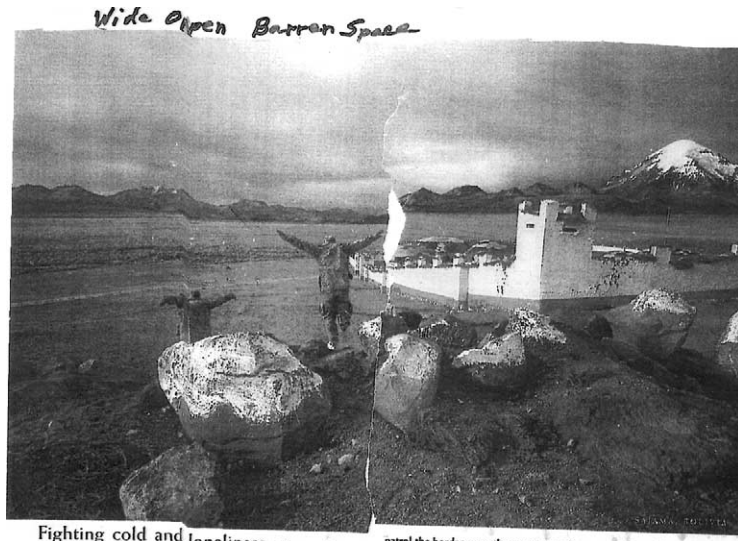


Fig. 2. *Wide Open Barren Space*.

both of these images related to his Vietnam experience, to his trauma experienced there. It is likely that they were also indicative of the trauma of living with a life-threatening illness.

The third piece created that day, titled *An Evening View of a Small Town* (originally titled *Run to the Hills*) was an image of a small town at the foot of mountains. It reminded Mr. A of the 1950s movie *Tarantula*. He described the movie vividly, stating that Clint Eastwood played a young Air Force pilot who came and sprayed the tarantula that was growing and growing and was attacking the town. The metaphors of the movie seemed to fit into his current life situation, with the image *An Evening View of a Small Town* and the movie *Tarantula* representative of his current experience with his disease. The spraying in the movie seemed to connect to the spraying of Agent Orange in Vietnam. I commented that it was a horror movie. He agreed, but noted that it was not gory, that it left a lot to the imagination.

He shared another movie that was on his mind, *The Day the Earth Stood Still*. He explained the movie as one where aliens who look human but are not human come to earth. He vividly described how they healed easily, getting shot and then getting right back up, and getting rashes and healing very quickly from them. Earlier in the session Mr. A had discussed with me a horrible rash he had on his body. Immediately my mind went to Mr. A's rash. Perhaps Mr. A was identifying with the aliens, in a hope that he could get better. His description of the movie was rich with metaphor.

Colors & Shapes

During a session a few weeks later Mr. A created an image (Fig. 3) using markers and paper.

He was asked to pick three colors and create a shape for each color and arrange them in an image. After creating the image, Mr. A shared that he was drawn most to the red shapes, that the blue and the

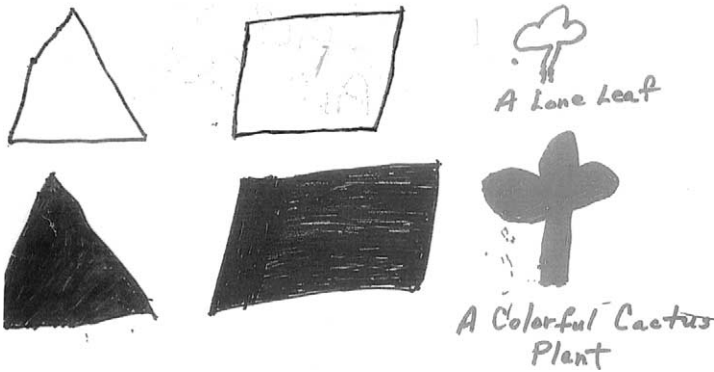


Fig. 3. *A Lone Leaf/A Colorful Cactus Plant*.

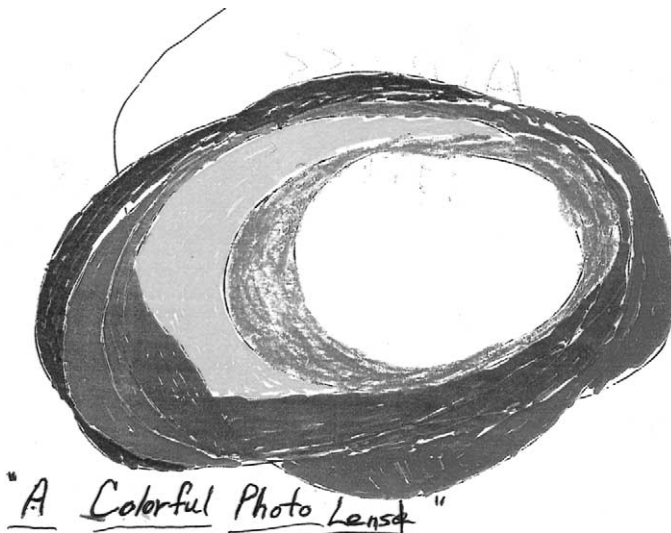


Fig. 4. *A Colorful Photo Lens*.

green were insignificant. Originally he desired the red shapes to look like shamrocks. The large red shape brought many associations for him, including a boy with a sombrero on as well as a cactus. The small shape he said was a leaf. He titled it *A Lone Leaf*. He titled the larger red shape *A Colorful Cactus Plant*. In this image, Mr. A's dualism was again displayed. However, there was a greater sense of loneliness in this image than in his others. Perhaps because of the title *A Lone Leaf*, as well as the emptiness of that leaf.

Blind Drawing

A blind drawing created by Mr. A a week or so after the creation of the Colors & Shapes image provided a look into the complexity of his character. *A Colorful Photo Lens* (Fig. 4), is a centralized image encompassing several colors.

Being given only a choice of six markers in his package of materials, Mr. A chose to use all of the colors except for black. He wanted orange and chose to use an orange pastel to bring more color into the image. When the image was completed, he associated to it readily, proclaiming that it was a colorful photo lens, although it also looked like an ear and a potato. I asked him what he might look at with this colorful photo lens.

"People," he said, "Crowds of people moving around."

The fact that he was in isolation with windows looking down at a busy city is likely represented in this image. Perhaps, it also represents his desire to be a part of the crowd, but his decision to distance (withdraw) himself from the crowd.

Discussion and reflection

When discussing Vietnam during the first sessions Mr. A often proclaimed wonder at why he was thinking so much about his past. I validated his thoughts by stating that in isolation he was given a large amount of time to think, and that it was quite normal for him to think about various parts of his past. It is also likely that the trauma of being so sick, along with the collective trauma from the events of September 11, rekindled the trauma of Vietnam for Mr. A. It is accepted that when a person is faced with a current trauma such as cancer, they will focus on other times they experienced trauma. David Read Johnson (1987) feels that art therapy is a helpful way for people to examine past traumas. Images are often able to represent the experience more readily than words. Johnson states, "The need to disown and deny the affects and memories of the trauma, and to remain in control of them, are more effectively accomplished when these images arise on paper, in a dance, or in playing music" (p. 11).

Through the course of the therapeutic process it became clear through his words, artwork, and behavior that Mr. A used denial and withdrawal as his main defense mechanisms. When one's life is in danger, denial is often a defense mechanism that is used. "In crises or emergencies, a capacity to deny emotionally that one's survival is at risk can be lifesaving" (McWilliams, 1994, p. 102). With terminally ill patients, denial will be part of the process they go through. Robbins states, "Denial of one's impending death is a stage in the process of dying" (Robbins, 1987, p. 59). It is important to recognize this when working with someone who is living with a life-threatening illness.

While Mr. A seemed to use denial as a means of achieving hope in his survival, he seemed to use withdrawal as a means of coping with his more depressive type symptoms including his readiness to die, his loneliness, and his anger. Mr. A's history of drinking, which he stated he gave up cold turkey a few years back because he was deteriorating and could no longer handle the alcohol, as well as his decision to keep vital information from his doctor, indicate the process of withdrawal at work. McWilliams (1994) states that "A propensity to use chemicals to alter one's consciousness can... be considered a kind of withdrawal" (p. 100). Withdrawal can also be found in his relationships, he chose to live alone, keeping very little contact with family and friends. During our later sessions he described himself as a man quite different from the one I knew in the hospital, a man who hates his neighbors and goes outside and yells at his neighbors. "They're too loud," he said, "and they don't take care of the neighborhood." He confessed that he had a problem with anger; that he lashed out at the doctors sometimes, but that he felt bad about it afterward. Mr. A's life outside the hospital became clearer, a life touched by anger and loneliness, according to the information he shared.

Although Mr. A was not diagnosed as clinically depressed, his loneliness and withdrawal are characteristics that fall into the realm of a depressive character. However, Mr. A also displayed great energy, particularly in his vivid colorful speech. A major complaint of his was that he couldn't get up and walk around. Prior to isolation, Mr. A could be found pacing the hallways of the hospital floor. Although Mr. A was not clinically diagnosed as a hypomanic, Mr. A displayed characteristics similar to that of a hypomanic (meaning *somewhat* manic as opposed to someone who encompasses full blown manic episodes) rather than that of depressive. This is reflected in the dualism displayed in his artwork as well as his behavior. McWilliams (1994) states that denial, which Mr. A uses as a main defense along

with withdrawal, is often used by those who suffer from various degrees of mania.

Mr. A's complex psychic structure was further enhanced by his experiences in Vietnam. While he didn't exactly meet the classification of PTSD he held many similarities to those that suffer from it. One example was his binge drinking after returning from Vietnam. "Like conscious avoidance, drinking and drug use serve to insulate PTSD sufferers from awareness of their trauma" (Caffrey, 2000, p. 520). By numbing himself, Mr. A did not have to remember the things he saw in Vietnam.

Further, Mr. A's dualism, as portrayed in his words and his artwork, may be defined by some as splitting. Splitting is a common factor in PTSD (Johnson, 1987). While Mr. A was integrated psychologically, his will to live versus his readiness to die indicated a strong dualism, like that of splitting, at work in his psyche. In working with Vietnam Veterans, art therapist Deborah Golub (1985) has found that dualism is often present in the artwork of this population. "A sense of duality wherein vets simultaneously experienced opposite aspects of self permeated both art products and process" (p. 288).

Another area which links Mr. A to his fellow Vietnam Veterans is his quest for meaning.

"For some reason, I'm still here, I don't know why, but here I am," he stated time and again.

In her work with veterans, Golub found that many veterans are dealing with "a continual search for meaning" (Golub, 1985, p. 285). For those who are facing death, as well as those who have survived a trauma, making meaning of what is, or has, happened to them can be an important aid in the healing process. Feeling that one's life is worthwhile and has purpose is a psychological need for most; however, when one is faced with death this need increases.

Conclusion

Art therapy offers the chronic and terminal patient many avenues for exploration, from the mind-body connection striving for peace and positive thinking to the psychoanalytic process of re-examining oneself and integrating their experiences into a new life framework. The process will be unique for each individual. The goal of individual art therapy with Mr. A was to provide psychosocial support to aid in coping with the experience of isolation and the ramifications of living with a life-threatening illness. This was achieved by providing consistent support through art therapy, which included the building of a therapeutic relationship between Mr. A and the art therapist and providing the opportunity to create and process art-

work and verbalize relevant issues. Through art therapy Mr. A both verbally and non-verbally examined many facets of his character, which was shaped by his life experience. While his initial imagery (Figs. 1 and 2) was born out of his Vietnam experience and trauma, his later images (Figs. 3 and 4) were born out of his current experiences. By first verbally and visually working through some of his issues related to his trauma in Vietnam, Mr. A was able to visually and verbally delve into his current state of being.

Art therapy helped Mr. A move fluently from re-examining past traumas through his artwork (Figs. 1 and 2) and the verbal processing of his artwork, to examining through his artwork the current state of his life in isolation (Figs. 3 and 4). Art therapy also provided Mr. A with a strengthened support system by providing consistent psychosocial support through the relationship with the art therapist. As well, the art therapy sessions provided an increased means of communication between Mr. A and the team of professionals that cared for him as the information was shared with the social worker and other appropriate personnel. By becoming aware of the information learned about Mr. A through the art therapy process, team members were better able to understand Mr. A and interpret his reactions and state of being throughout hospitalization.

As an art therapist, I am able to gain a deeper knowledge of my clients through their artwork and use of metaphor, than through verbal interaction alone. This was the case with Mr. A as I described in detail in the "Clinical process" section. However, as is true with all forms of creative arts therapies, art therapy is not only about an individual revealing themselves to the art therapist through their artwork, it is about the individual communicating deeply with themselves as the unconscious reveals itself safely through the artwork. It is then through the processing of this inner communication that an individual begins to understand themselves clearer. Mr. A received many benefits from art therapy while hospitalized for his SCT, as stated earlier, which included an increased support system as well as an opportunity for self-expression and self-examination. However, there were limitations to Mr. A's art therapy experience.

The major limitation was that Mr. A was seen for art therapy on a short-term basis only. Because Mr. A was not given the opportunity to continue art therapy after being discharged from the hospital he was only able to scratch the surface of the many layers of psychological healing that long-term therapy can bring, particularly given the trauma he had experienced in his life. It is possible that Mr. A could have benefited more had his art therapy sessions continued after he

was discharged from the hospital. In particular, he would have been able to continue to explore his current state of being which had only begun to happen during his hospitalization.

There are also many other important issues, besides length of treatment, for therapists to realize when working with BMT patients in isolation. Therapists must remember that at times they may serve as a real object to the BMT patient, more so than with most populations. Nancy Postone (1998) states, “For cancer patients, the real relationship with the therapist in the present takes on particular importance as it provides a necessary anchor in the face of existential threat and fear of abandonment” (p. 420). Concerning countertransference with cancer patients, Postone reminds us, “The illness is a challenge to the therapist’s rescue fantasies and wish for omnipotence. ‘What can I do? What can I offer?’ are questions that often confront a therapist. Difficult feelings of loss and control, and those arising from becoming aware of one’s own vulnerability must be dealt with” (p. 420). In my clinical experience to date I have found that when you work consciously with as much information and as clear a mind as possible the countertransference issues can be used to the advantage of both the therapist and the patient.

Mr. A recently returned to the hospital for a routine visit. Now, one year after his SCT, he is physically strong and doing quite well. He spoke to me at length about the realization that he had come so close to death and surprised just about everyone with his continued recovery.

“The man upstairs,” he stated, as he pointed upwards and explained that this entity goes by many names such as nature, God, and Buddha, “is orchestrating his plan, we can’t control it.”

Later in the conversation he explained that he had made a decision long ago that he was not going to give in to his disease. “Mind over matter” is very strong he told me. I realized as I walked away from our meeting that Mr. A was happy to be alive. I don’t credit this to his art therapy experience or even to the brilliant work of his medical team, but to Mr. A himself, a man having lived through many hard experiences and still reveling at the mysteries of life.

Creative arts therapists throughout the world have the capacity to provide the opportunity for various levels of support to transplant patients in isolation. The experience of Mr. A is but one example of the power of art therapy to provide psychosocial support to those faced with life-threatening illness and medical isolation. The art therapy experience of Mr. A sheds light not only on how image making and the visual art process can aid in meeting the goals of individual art therapy, but how metaphors and mental imagery have the power to do the same.

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