



Pain, attachment, and meaning making: Report on an art therapy relational neuroscience assessment protocol

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ABSTRACT

The experience of pain presents a complex interaction of neurological, emotional, cognitive, social, and cultural factors. A major public health concern, chronic back pain calls for adapted, short-term approaches as chronic patients may find lengthy assessments or long-term treatment a burden. An art therapy relational neurobiology (ATR-N) brief assessment protocol is proposed that demonstrates advantages for the assessment of the multiple psychosocial dimensions of pain experiences. As pain experiences are experienced in the body non-verbal visual approaches are often used for the assessment of pain. The shared neuropathways of sensory pain and emotional experiences suggest the advantages of employing a non-verbal sensory assessment and treatment approach. The sequential visual expressions of sensory, emotional, and cognitive pain assist in revealing coping skills and the potential for symptom reduction. Interpersonal neurobiology perspectives of the art from a protocol of a woman suffering from back pain further demonstrates how the interface of stress responses and adult attachment styles affect each individual's unique pain experiences. Understanding the shared neuropathways of pain also suggests the value of including attuned interpersonal interventions such as supportive witnessing of the art making. The role of strengths, such as awareness and creativity, in mitigating pain experience are underscored in the protocol's structure. Finally, the protocol approach holds the potential for future development of reliable art therapy measures of change providing a framework for advancing ATR-N research and clinical approaches.

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Introduction

Acute back pain can frequently be traced to a single cause and is easier to treat than chronic back pain, which is affected by multiple causes and often requires specialists and/or alternative therapies (Huffman, 2007; Kabat-Zinn, 1990; McCarberg, 2004). Around 50–80% of American adults experience lower back pain at some time in their life with significant physiological, social, and financial implications (Apkarian et al., 2004; Luo, Pietrobon, Sun, Liu, & Hey, 2004; National Center for Health Statistics, 2007).

Back pain may originate from the network of nerves, ligaments, tendons, and joints in the spine. Large nerves from the spine can spread pain to the extremities. Nociceptive, i.e., acute, pain is a physiological response to an intense stressor. In contrast,

neuropathic or chronic pain results from a lesion and/or a dysfunction in the peripheral or central nervous system (Brunton, 2004). Chronic back pain contributes to fatigue, helplessness, and depression (Achterberg, Dossey, & Kolkmeier, 1994; Hass-Cohen, 2003).

Risk factors for pain development and for poor treatment outcomes include stressful experiences, disturbing emotions, and pessimistic belief systems (Brunton, 2004). Therefore, patients' meaning making of pain may provide the only connections between physical aspects and emotional-psychological function (Trauger-Querry & Haghghi, 1999). Assessment of the frequency, intensity, duration, and onset (FIDO) of pain symptoms and their dimensions—provocative or palliative, quality versus quantity, region and/or radiation, and severity and timing (PQRST; Brunton, 2004)—also provide clues as to interpersonal and cultural contributing factors. However, assessment needs to be quick and effective as lengthy interventions may cause pain. The clinician should also consider whether cultural-religious upbringing prohibits or encourages expression of pain and the purgatory role pain may have according to various religious beliefs (Coakley, 2007; Scarry, 2007). Accordingly, understanding the intersection of the neurophysiologic mechanisms and the cultural, interpersonal, and

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emotional contexts relevant for pain assessment and management are invaluable for clinicians working with chronic and acute pain sufferers.

Expressive arts therapies have been used successfully alongside medical treatment, physical therapy, and cognitive behavioral approaches to treat arthritis, migraine, and cancer pain (Camic, 1999; Malchiodi, 1999). The visual arts also sustain positive meaning making, mindfulness, relaxation, and interpersonal attunement to support pain management (Camic, 1999). Moreover, a recent empirical study reported that art therapy significantly reduced pain-related fatigue for hospitalized cancer patients (Nanis et al., 2006).

The current authors seek to demonstrate how the application of art therapy relational neurobiology (ATR-N) principles such as creativity, relational resonance, and adaptability (Hass-Cohen, 2008b) illuminate the palliative potential of art therapy approaches. To that end, an ATR-N based medical arts protocol is described that can be used for the assessment of pain and that can be adapted for intervention purposes (Clyde Findlay, 2008). The media consists of oil pastels, markers, and water color dry blocks. The protocol includes four specific art requests adapted from Achterberg et al. (1994):

1. "If you were to draw the problem, what would it look like?"
2. "Draw an image of yourself."
3. "Draw an image or symbol for internal and external resources that help with the problem."
4. "Draw yourself as you see yourself now," or "Draw yourself without the problem."

The first two directives call for a representation of the sensory experiences and the emotional and cognitive perceptions of the problem. The therapist asks participants about any increased pain symptoms after making the first self-portrait and may propose a brief relaxation exercise, such as taking a few deep breaths or imagining a safe and/or painless place. The third drawing brings coping strategies and resources into awareness and permits the therapist and participant to discuss these strengths. The fourth request assesses whether the person can now envision the problem or perceive herself differently. If the participant questions that she has already drawn a self-portrait, the therapist gently repeats the request, emphasizing the word now: "Now that we have explored your resources..." At the end of the protocol the therapist and client may deconstruct the art and the experience.

Exploratory interviews with persons with and without an art background have been used to develop this protocol (Bridgham & Hass-Cohen, 2008; Clyde Findlay, 2008). Intended for a brief 1–2 h assessment, the protocol art requests can also be adapted for short term treatment (Clyde Findlay, 2008). There is a need to develop brief assessment and intervention protocols for the medical arts therapies as people challenged with pain, illness, and stress often find it hard to make it to long-term therapy sessions and may often need to be seen in the hospital (Malchiodi, 1999).

The current study consisted of a one-time assessment meeting with a follow-up interview two years later. The purpose of the follow-up was to look at the viability of repeated applications of the protocol over time. A baseline of visual representation of the chronic pain and resources for helping the pain can be obtained in the first protocol, and subsequent protocols can indicate post-treatment influences. Here the visually rich art protocol and expressive narrative of Erica, a 64-year-old Caucasian artist, assists in understanding the neurophysiology of pain, the connections between fear and the stress response and pain, the role of attachment in pain, and the cognitive and emotional factors in the modulation of pain. Erica's noted and self-reported positive changes also suggest the potential value of the ATR-N pain assessment protocol as a treatment intervention. The integrated description of the relevant clinical neu-



Fig. 1. If you were to draw the problem what would it look like: "The Mother Vulture of Pain".

rosience research and interpersonal neurobiology concepts with an art therapy analysis of the Erica's imagery clarifies the complex information and provides a brain based approach to art therapy case conceptualizations.

The Mother Vulture of Pain: a chronic back pain experience

Erica completed the art therapy protocol in two interviews of 2 h each. An artist, she was curious as to how art making could help with her constant pain and volunteered to participate in the interviews. Erica reported triple scoliosis and chronic back pain, describing the "anguish" in her middle upper back. Erica initially said that her disabling back pain started in her early 30s. She attributed it to what she called a body culture of physical fitness and isolation: "I lived alone as a single mother with two kids; I'd have to crawl, in seizure, on my hands and knees to prepare food." She also attributed the problem to a grueling media career and inappropriate romantic relationships. She stated that her pain corresponded to "chewing the cud, dwelling on mistakes and grievances. . . sometimes it is so hot, like being burned at the stake. . ." Burning sensations are often reported with neuropathic pain (Scholz & Woolf, 2002).

Erica found little relief in conventional medical care, refused surgery, and reported taking up to 10 aspirins at a time for pain relief. However, she reported helpful sessions with a Sikh masseuse in the past. Originally attributed to the function of fast and slow pain pathways (Melzack & Wall, 2004), the current understanding is that the pathology of pain involves a dynamic interface of reactive systems rather than a single route (Deleo, 2006; review). Such complex reports are typical for sufferers of neuropathic pain. Pain, normally a functional warning, can become chronic and non-functional.

Erica described her pain as "something menacing and fearful in my world. . . it is really black with radiant pain at the center," and in response to the first request drew an image with a bursting orange and red center surrounded by black scribbles (Fig. 1).

The convergent interpersonal neuroscience of pain experiences

Processing pain involves three convergent experiences. The first is the sensory processing of pain, the second is emotional-cognitive bottom-up processing of pain, and the third is cognitive-affective top-down modulation of pain. Sensory pain sensations are transmitted to the spinal cord dorsal horn and from there to the brain by afferent, i.e., incoming nerves (Melzack & Wall, 2004). Pain sensory neurons, nociceptors, do this by releasing the excitatory

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