Medical Art Therapy: Fostering Resiliency and Rehabilitation in Patient Care

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Art Therapy as a Resilient Profession

Since art therapy made its début as a professional practice in the United States in the early 1940’s it has both, remained rooted in the primitive healing potential of art for humanity, and shifted and adapted with the evolution of culture and understanding of health. Art therapists not only encourage the resilient spirits of their clients through art, they themselves must learn to become resilient professionals as they face the dominance of change in culture, technology and medicine. The survival of this profession comes not from the wide spread understanding and acceptance of its principles, but from the profession’s ability to create a new, to reinvent and to transform to fit the needs of the time.

The birth of art therapy in the 1940’s began with the influences of psychoanalysis and the interpretation of images as a diagnostic resource for the treatment of mental health. In addition to the psychiatric movement of the time, art therapy also has connection to movements in education and childhood development (Malchiodi, 2013). Today art therapy has evolved to fit the ever growing awareness of a more global picture of health, mentality and the issues of human rights (2013). Today art therapy can be found in many settings as a way to promote the growth, health and rehabilitation of individuals in many capacities including: hospitals, schools, nursing homes, correctional facilities, and mental health clinics. The growing awareness of art therapy’s potential as a social activist force correlates with the evolution of health as not just a physical or biological concept but a mental, emotional and spiritual one as well.

Resiliency as an Essential Trait

The theory of resiliency stems from a long standing interest in why some individuals that survive a traumatic life event can continue to lead a healthy and productive lifestyle; on the other
hand, others from similar experiences may develop illness or symptoms as a result of the event (Min et al., 2012). Norman Germezy, now a professor at the University of Minnesota, began the modern theory and research of resiliency in mental health over 40 years ago, when he looked into why some children raised with schizophrenic parents did not go on to develop symptoms themselves. He uncovered specific character traits that would now fall under the category of what it means to be resilient (Coutu, 2002). Resiliency and health are fairly new in western contemporary medicine’s understanding of pathology, health and healing. What role does resiliency play in mental health? To what extent does our physical health interplay with our mental health? These may be some of the most pressing questions of our time and they are also timeless in our search for caring and healing.

The individual traits that encompass what it means to be resilient, to stand up to adversity or to “bounce back” from hardship, maintain some variance across resources and cultures, nevertheless, a line of similarity can also be drawn. Traits that seem to remain a common thread in the nature of hardiness are: the ability to find and maintain meaning in one’s life, feeling connected socially or that he/she isn’t alone, spiritual traits such as faith or hope and creativity are among the most common factors when looking at measuring resiliency (Edward, Welch & Chater, 2008; Min et al., 2012; Metzl & Morrell, 2008). Measuring these important traits can help to provide insight into treating and rehabilitating in health care.

**Depression and Anxiety**

Depression and anxiety are two of the most common mental health conditions making them an important part of medical treatment today (Min et al., 2012). As treatment moves to address these mental health concerns in our medical environment, accurate assessment and efficient treatment become important factors in catching these symptoms early and diminishing
their effects on the individual’s overall health. Without an integrated understanding of these disorders, the biological or somatic symptoms associated with depression and anxiety often are treated with increased office visits to a physician followed by biological testing (Julliard, 1998). As new research guides a medical approach to these common illnesses, factors of resiliency can integrate into assessments and early intervention.

Researchers from the Catholic University of Korea (Min et al., 2012) conducted a study of a sample of 121 participants diagnosed with anxiety and depression to find how levels of resiliency related to other personality traits and life circumstances. Using scores from the Connor-Davidson Resilience Scale, participants were divided into low, medium and high resilience groups. Sixteen addition scales were used to look for factors that may contribute to variance across the spectrum of resilience and also between each individual level. This was achieved by averaging the scores of each resilience group and comparing the scores between levels. Some measurements considered in the study consisted of: traumatic life events, demographics, physical conditions and positive psychological factors.

Depression and anxiety are not only prevalent in mental health treatment; they also show significant reoccurrence and persistence (Min et al., 2012). Considering the importance of resilience in understanding patient needs could be significant in treatment and in fostering lasting growth. When looking at the results of the study conducted on the character traits associated with low resilience in these populations, some of the findings may help explain why some individuals meet higher levels of resiliency. When comparing, for example, the low and medium resilience groups the main character difference was the level of spirituality (measured by the FACIT-sp). Significantly higher spirituality seemed to be present particularly between low and medium levels. Spirituality showed higher rates in the high resilience group compared to medium
resilience in addition to the presence of physical exercise (Min et al., 2012). Understanding the interplay between resiliency and depression and anxiety may help to shed light on why some individuals are better able to recover after facing adversity while others may develop persistent symptoms. Utilizing and nurturing character traits such as spirituality (the ability to find meaning in one’s life) may also change the way we see and treat symptoms in caring for individuals with mental or physical conditions.

**Associated with Recovery in Heart Disease**

The importance of resiliency maintains positive mental health functioning while also promoting recovery in face of physical threats. Heart disease is one of the most widespread threats to physical health worldwide and treatment and recovery outcomes can vary (Chan, Lai & Wong, 2006). In a study conducted by the University of Hong Kong, researchers (2006) hypothesized that coronary heart disease patients who scored higher on resiliency ratings of optimism, self-esteem and perceived control, would also indicate higher ratings of posttraumatic growth and rehabilitation outcomes following an 8-week cardiac rehabilitation program. Using pre and post semiformal interviews and inventory assessment tools, 67 Chinese heart disease patients (with similar prognosis) took part in the study. The study found a statistical correlation between personal resilience, cardiac rehabilitation programming and posttraumatic growth, indicating the importance of cognitive traits in physical rehabilitation outcomes (Chan et al. 2006).

Another study (Helgeson, 1999) also cited the importance of cognitive adjustment as part of long-term recovery from coronary heart disease by conducting a four-year follow-up study with patients diagnosed with coronary heart disease (Chan et al. 2006). Using the Cognitive Adaptation Index (CATI), Helgeson (1999) found a low resiliency assessment score was a
significant predictor of long-term reoccurrence of new cardiac episodes. “These findings suggest that people characterized by high scores on self-esteem, perceived control, and optimism are truly resilient people, and more importantly, personal resilience is robust over time (Chan et al., 2006).”

**Described by People with Mental Illness**

As resiliency is a phenomenological experience that all people interact with in his or her own way, it is important to incorporate the voices of those who have the experience to narrate what it means to “bounce back”. In a study conducted by Edward, & Chater (2008), common phenomenological themes of resilience were explored through interviews with people who had experienced mental illness. In this study, three men and five women were recorded in an interview guided by the question “What is your experience of resilience after experiencing mental illness? (Edwards, et al., 2008)”. This interview was recorded and dynamic approaches, including image making, were included in the interview process as a way to offer communication that could not otherwise be expressed in everyday language. As common themes were taken from the collective interviews, supportive conclusions may help to indicate what strength traits aid in rehabilitating people who experience mental illness.

The concept and experience of resilience may hold the key to rehabilitating symptoms of mental illness. Common themes of resilience that were experiences in the rehabilitation process in the phenomenological study included: Faith, hope, humor, finding balance through coping tools, meaningful living, meaningful relationships, and self understanding (Edwards, et al., 2008). As these concepts were common threads in what resiliency meant to the participants, individuals from the study also narrated their rehabilitation process. To gain resiliency, participants described learning to adapt and being allowed to feel strong feelings such as anger
and loss. In feeling these emotions participants described learning to manage their emotions by letting go or feeling in control which allowed for healing (2008). This recollection illustrates how the rehabilitation of adverse life events through expression and healing can lead to the development of resilient traits and the recovery of mental illness.

**Creativity and Resilient Healing**

Despite the many links between character traits, there is little documentation as to how concepts of creativity and resiliency intersect. Traits such as “flexibility, initiative, ingenuity, adaptability, spontaneity and originality” all contribute to the contextual relationship of creativity and furthermore could be the facilitating and predicting factor in developing resiliency (Metzl, & Morrell, 2008). The creative process as a fundamental component in art therapy allows the therapist to tap into a patient’s creative potential and apply that potential to the development of resilient traits (2008).

In addition to the creative process, the therapeutic interaction of the therapist also contributes to developing hardiness for the client. As therapist adapt to the needs and abilities of their clients, positive movement is created in face of adversity (Metzl & Morrell, 2008). The creative process combined with the relational experiences provides the context for rehabilitation. It can then be concluded, that by engaging in this context of the creative relationship, the outcome, or product, of such experiences is resiliency. The creative process as a rehabilitating tool and as a form of medical intervention may complement the future of health care and medicine.

**Changing the Culture: Heath Care Movements**

The culture of health care in western medicine has long focused on the biological factors of illness and that treatment of symptoms by “curing” a pathological infection (Bennett Johnson,
2013). If the Biomedical treatment fails, under this model of care, the result would most likely be death instead of cure (2013). Today, western culture is coming to understand the feedback loops of illness, that treatment is not so simple and that a person’s health is far more dynamic. As the institutional culture comes to recognize the source of biological symptoms, an increased role in the psychological, social and spiritual components can begin to take form (Bennett Johnson, 2013; Welzer & Markowitsch, 2005). Today the leading causes of death can be indirectly linked to unhealthy behaviors and coping strategies: smoking as the number one killer with obesity coming in a close second (Bennett Johnson, 2013). As these understandings begin to integrate into medical treatment, a more diverse picture of health can add complexity and efficiency to medical treatment.

The Bio-psycho-social-spiritual model is the latest approach to understanding and caring for patients’ health. Introduced in the late 1970’s by George Engel, the biopsychosocial model peeked interest among medical professionals but remained dormant in the overall biologically rooted system of health care (Bennett Johnson, 2013). Today however, the biopsychosocial model also integrates other health care movements including patient-center care and holistic practices (2013). Combined, these movements of patient care are also providing more accepted evidence as to how psychological and spiritual health effect biological conditions.

Along with the emergence of the biopsychosocial model, other studies have given way to the recognition of diversity in assessment and treatment in health care. Initially conducted at Kaiser Permanente from 1995-1997, the ACE Score is an assessment used to measure a person’s “Adverse Childhood Effects”. The study was first used to see what, if any, effects childhood trauma or neglect may have on the continued health of the individual. Today the ACE score is proven to be one of the highest predictors of the development of lifelong illness, providing
valuable insight for medical professionals (Statecheski, 2015). Despite its value in preventive and rehabilitative treatment, it remains a mystery to most providers as to how utilize this information in practice; making a point for creativity in the integrative process.

What if answering a 10 question survey with your doctor could help you reduce your risk of developing major health complications down the road? That is exactly the potential hidden in the ACE score assessment. As Dr. Felitti described in an interview with Starecheski (2015), when the ACE score becomes part of regular physical exams, it gives patients the opportunity to better understand his or her own health, and perhaps just as important, it gives providers the opportunity to recognize the dimensional components of health in medicine. While sparing an extra thirty minutes to have a conversation with patients may appear costly, the long-term health risks may tell a different story. In the short term, Dr. Felitti noted, the conversation is more spiritual than medical in that it elevates the shame of childhood trauma and abuse and reminds people that they are still worthwhile. So, what is the best medicine for adverse childhood effects? Dr. Shonkoff from Harvard University recommends “resilience built through close relationships” and “trauma informed therapy” including “art, yoga or mindfulness training (2015).”

Not to be confused with the ACE score, the ACE project is a separate study with a similar intent. In this case, ACE stand for “Advocating for Clinical Excellence” and focuses on providing clinicians with the proper training to treat complex and multidimensional concerns (Otis-Green, Yang, & Lynne, 2013). As expressed by Otis-Green, (et al., 2013), very few providers are prepared to work at a high level of integration or to provide “comprehensive and collaborative support services.” The ACE project strives to promote an educational curriculum that can create leadership and advocacy for the subjective diversities in patient-centered care. Integrations that are often overlooked in treatment including: religion, spirituality, ethnic and
cultural beliefs. When these traits are sought to become core conversational components in providing ethical medical care, the professionals that provide integration can also advocate for a new culture of excellence in western medicine.

Further research seeks similar concerns in healthcare’s ability to create, maintain and measure quality at the bedside. Marry and Cargo (2001), explored the dynamic of a culture of “excellence-orientated aspirations” and saw this striving being diminished by a striving more orientated in blame and the adherence to minimum quality standards. The collaboration between providers in an integrative model, allows for all parties to take on the responsibility of reaching across professional lines. As psychological, biological and spiritual providers attempt to create collaborative relationships, often small things like proximity, common language and time get in the way of quality care (Ruddy, Borresen, & Gunn, 2008). In further note, a combined and integrated picture of health can help to create a culture of social interest and places a value-adding responsibility on the institution that often defines a culture’s picture of “good” health (Merry, et al., 2001; Lemonides, 2007). Quality of care not only has important outcomes for patient care, but also aligns with high ethical standards of excellence creating health within the culture of health care (Lemonides, 2007).

Evidence in Art Therapy: Structural Changes and Adaptations in the Brain and Body

Research outcomes are an important component in all aspects of health care and are important in determining the worth of services and the division of funding and resources to provide services (Julliard, 1998). As cost weighs heavily on medical treatment, limitations to effective, proven and evidence based services often miss the outcomes related to, less definitive, quality based services (1998). As both the culture of recognizing quality based outcomes and the technological ability to measure mind/body/spirit connections strengthen, the credibility and
worth of art therapy may begin to make roots in medical care (Malchiodi, 2013). Investigation into brain imaging and the ability to measure the body’s response to subjective experience are already gaining ground in providing evidence for art therapy as a medical intervention (2013).

Looking closely at the structure and function of parts of the brain, researchers have been able to locate key areas highlighting the medical significance of art therapy (Malchiodi, 2012). Through studies of imaging, biofeedback and cognitive adaptations, scientific evidence seems to be showing the wide range of possibilities art therapy can bring to a large range of populations (2012, p.16). Furthermore, expanding art therapy’s role with evidence based research may contribute to the overall medical health culture can aid in the growth of excellence and quality care.

Our fascination with the mysteries of the human mind drives great research and supportive evidence for effective treatments. A common misconception regarding art and creativity is that it is predominately located in the right hemisphere of the brain. The right hemisphere is seen as the creative “hub” whereas the left hemisphere handles more of the logical and organizational components of the mind (Chatterjee, Bromberger, Smith, Sternschein, & Widick, 2011). While this dose remain true on some level, the processing of creativity and art making cannot be confined to one hemisphere, nor one systematic pathway in the brain as illustrated by investigations into artist following brain damage (Chatterjee et al., 2011).

A study conducted by Chatterjee et al. (2011) makes a connection as to how art is processed in the brain by stuđding three artist who experienced hemispherical strokes. By studying pre and post art making processes and products, the team of researchers illustrates how changes in brain functioning and capabilities can change artistic styling, but in no way hinder the ability to make art. Individuals who experienced loss in either hemisphere were still able to make
art post injury, adding validity to the fact that even without the functioning of the right hemisphere art is still processed and created out of the left (2011). Stylistic implications are noticeable in aesthetics pre and post damage. For example, an artist who experienced loss in the left hemisphere displayed art styling’s more loose and spontaneous compared to art created when both hemispheres were in function. As Chatterjee writes, “The question is not: Which is the artistic hemisphere? As much as: How does each hemisphere contribute to art? (2011).”

In looking at how this study may play further into how we function in the health care setting, we can look at both trauma and degenerative damage to the brain. In creating art, the participants in the study where better able to explore and understand their thought processing and communicate underlying symptoms whether physical or emotional (Chatterjee, 2011). As part of a rehabilitation process art is a useful tool for communication no matter what area of the brain is missing and especially when verbal language centers are impaired. In further response, coping with degenerative disease like Alzheimer’s disease can be a slow process of decline. Through art making, individuals can continue to maintain optimum functioning while also displaying assessable changes in cognition (Stewart, 2004).

In reference to another example of brain injury and art, Giles (2004) writes about an unusual story of a man named Tommy McHugh, who after suffering a cerebral brain hemorrhage, began experiencing predominate artistic urges. This alteration of the personality is characteristic of loss of decline in certain areas of the brain involved in categorical thinking. McHugh lost verbal communication skills and many higher functioning areas located in left hemisphere of the brain. In other such patients studied in relation to McHugh’s case, left hemispherical damage seems to correlate to the onset of some of this artistic compulsive urges as the right hemisphere becomes less inhibited and awareness are no longer sorted internally
through the left hemisphere, but must be externalized for processing (2004). Not only can brain injury or loss trigger a desire to make art through loosened inhibitions, art can also become the bridge between realities and a sustainable practice.

A study highlighted by Zaidel (2009) explains how art making differs from other non-art activities. Studying the sustainability of certain activities vs. art making over a period of time for pre and post brain damage, there seems to be a link between continued abilities and art. While non-visual artist such as writers experience similar damage in the brain, the artists are far more likely to continue art making post damage, whereas, language or physical only activates are less likely to be maintained over lifelong changes such as cognitive decline, stroke, or physical ageing (2009). Insights from this study argue for the importance of art making as a lifelong coping mechanism that can create mental resiliency in face of change and challenge.

Further inquiry into the function and role of art in the brain reinforces “neither the functional specification of the left nor the right hemisphere, nor any specific lobe or one brain region, can explain art-related cognition (Zaidel, 2009).” Zidel’s systematic understanding of the brain takes into account biological, neurological and evolutionary perspectives on cognition and art making. In his investigations he drawing similar observations echoed by other research on art and the brain, that is that the deep primitive parts of the brain are highly significant in how art interplays with the way we experience our world and the way we communicate with it. Before there were words, as Zaidel explains, we exchanged body movements, gestures, as both artistic expression and communication (2009). From these gestures verbal language was developed as we paired the movements with sounds (2009). So which part of the brain should we look more closely to?
Perhaps the oldest part of the brain, the Limbic System, has long been evolved in artistic expression and is even at the core of how we perceive life today. The limbic system’s primitive functioning works automatically (with little conscious awareness) to process sensory input into a bodily response. In responding to non-threatening stimuli, the limbic system reacts by processing input into learned memory and higher level awareness (Malchiodi, 2012). When perceived threats are detected, however, the limbic system automatically triggers blood flow to the body to ignite the fear or motivating response of fight or flight. These allow the body to ward off invasive predators, quickly exit an unsafe situation, or freeze in stillness, furthermore, it is central to our motivation to survive.

**Art Therapy and Trauma**

The evolved and developed mind, as it interacts with primitive and survival processing, is far more complex in how threats are perceived. Today, feelings and emotional interaction are both taken in through the senses and encrypted in verbal and relational interactions (Zaidel, 2009). Emotional and mental trauma is far more complex than our primitive ancestors, but is nevertheless, processed in the deep interior part of the mind. The amygdale, a part of the limbic system responsible for emotional memory, is significant when looking at trauma in the brain (Malchiodi, 2012). During a period of sensory arousal the limbic system reacts. The amygdale then automatically stores information regarding the experience encoded in emotional long-term memory. The healing potential of art making also fills a significant gap with it comes to verbal language. As the amygdale (emotional center) in the limbic system, has no direct contact with the verbal language centers of the brain, art can connect to the emotional trauma in a way that words can’t (Hass-Cohen, 2008). Extracting this reactionary information in the brain is often a
necessary component to healing; however traditional methods of therapy are ineffective in regard to talk therapy.

Art therapy can be an effective way to tap into the deeper more primitive parts of the brain as a tool for communication and higher level cognition. Through the use of the body and sensory processing, an individual activates deeper level thought processing and can express and heal emotional responses to stress and trauma (Malchodi, 2012; Carr, 2008). If this underlying cause of emotional stress is not resolved, the brain will continue to automatically react and function in accordance with this fear of real or perceived threats (Hass-Cohn, 2008). This is most notably seen in cases of Post Traumatic Stress Disorder where a sound (or other sensory information) triggers an emotional response.

**Memory and the Brain**

In further note, the limbic system also connects to memory storage and retrieval in the brain; moreover, it can be linked to the use of art therapy as a tool for expanding and maintaining memory (Vance, & Wahlin, 2008). Understanding the different layers of memory storage can narrate how art may contribute to and strengthen this cognitive ability. Closely connected to the amygdala, within the limbic systems is the hippocampus which functions as a resource for long-term memory in the brain (2008). The way the hippocampus is structured and how it functions may help to draw connections between creativity and cognition.

The formation of new memories, as Vance and Wahlin (2008) describe, is “experience-dependent”. This meaning that such storage within the deep layered memory of the hippocampus requires sensory input to be stored more deeply and long-term (2008). Moreover, the use of this sensory information as part of memory retrieval strengthens cognitive connections, while non-sensory stimulation often leads to a decay of the memory as it becomes irrelevant to daily living.
In thinking about this important formational structure, art can hold significance in not only accessing long-term memories for retrieval, but also creating strong positive memories to reframe or override past negative memories, as well as maintain connections over time through continued use (2008).

Long-term memory structures can be broken down further as to look more closely at how memory interplays with consciousness. As one cannot possibly become aware of all of one’s sensory information, an individual is also not aware of all the memories stored in the brain. Breaking these structures down, implicit memory is used to describe those memories that are taken in through the somatic/bodily experiences and are attached to a certain feeling, emotional response, or mood (Vance & Wahlin, 2008). This “sensory to cognition” process is what Lusebrink (2010) labels the “bottom up” experience as information travels up the body and into the mind. This “emotional memory” is highly connected to the amygdale and is also stored and processed mostly without awareness (Vance & Wahlin 2008). This deep processing in the brain based on sensory experiences are believed to weigh into a person’s sense of self and personal identity (2008). Art can then be a way to communicate with these deeply stored memories, perhaps bringing them into awareness, or connecting on a subconscious level, through the body.

Implicit memory takes place on the right side of the hippocampus whereas; the left side is responsible for what is termed as explicit memory. Explicit memory, unlike implicit memory is mostly conscious memories (Vance & Wahlin, 2008). Lusebrink (2010), again, labels this function “top down” processing as the brain decodes information to communicate with the body. These memories are used to come to understand language as we learn to categorize objects into their proper title. In relation to art, these long-term association are not just important for general
intelligence, these memories are connected to visual or other sensory inputs that then gives language structure meaning (Lusebrink, 2004).

Art plays an important role in building different forms of literacy, and furthermore, it becomes significant in maintaining meaningful language structure that can perhaps override damaged structures present in decline or trauma (Lusebrink, 2004). The integration of implicit memory can be given meaning through more explicit memory processing by allowing the brain to provide leaned modifications and planning strategy to bodily movement (Lusebrink’s (2010) top down experience). By integrating the two memory systems through an experience, art therapy can nurture and strengthen an individual’s autobiographical narrative of resilience.

**Hormones and the Release of Oxytocin**

Exploring neurological connections and the benefits of art therapy in research can also integrate brain pathways with the biological effects in treatment. In an investigation by Springham, Throne, and Brooker (2014) the question as to how Oxytocin (a feel good hormone and neurotransmitter) and art therapy treatment might affect the mind and body, is used to provide evidence for art’s use in medicine. By investigating the anthropological source of Oxytocin the research explains that Oxytocin’s roots in sexual reproduction and intimate relationships may help to explain how to increase this neurotransmitter (effecting the brain), and hormone (affecting the body) (2014). One key ingredient needed for Oxytocin to be released in the brain and body is a person’s experience of feeling at ease and a feeling of trust (2014).

The next question in this investigation is how can treatment come to nurture or repair trust after adversity leads a reduction in the release of Oxytocin. One important way is through the bonding process of play (Springham, Throne, & Brooker, 2014). To an art therapist play is a powerful tool that can nurture and grow trusting bonds in therapy while also contributing to an
important mind/body connection. In balancing the intricacy of building trust and interactive play, the art therapist not only provides a safe context for attachment, they also contribute to the cognitive, biological and emotional wellbeing of their patient’s through the release and regulation of Oxytocin (2014).

**On the Horizon: The Future of Medical Art Therapy**

The profession of art therapy continues to grow in the ability to reach out to medical care and provide insights and evidence into how art can become a vital tool for rehabilitative medicine. One way art therapist can continue to grow this connection is by becoming a force in community activism (Kapitan, Litell, & Torres, 2011). Through social and cultural awareness art therapist can continue to provide visible activism in the medical community to promote quality care. Within a collaborative context, art therapy may also continue to gain recognition through the continued evolution and acceptance of evidence based research promoting value and funding within medical institutions (2011).

Ethical standards and educational initiative are also important to the growth of art therapy. In competing with other arts-in-health initiatives, the institutional training and ethical standards becomes crucial in the sustainable practice of art therapy as an intervention and treatment form (Malchiodi, 2013). Supporting institutional training promotes quality standards of medical care and assures that no harm will come to patients in treatment. These values are fundamental to art therapy and to the evolution of excellence in medical treatment (2013).

While the concept or resiliency in contemporary health care is a relatively recent conversation, our culture and human nature has long been drawn to the idea of resiliency. As we look back on our history, the figures we admire and the visionaries we continue to study carry, with them a resilient narrative (Welzer & Markowitsch, 2015). We remember and record
resilient individuals and their stories of triumph over the adversity with which they were called to transform. Today we may begin to notice and integrate the idea that triumphant narratives are not just for elevated heroes and that resiliency in people does not just exist inside the person but is nurtured form within a social context (Metzl & Morrell, 2008; Welzer & Markowitsch, 2015).

As healthcare moves toward a more integrative approach to care and leaves the restrictive biomedical model behind, the importance of rehabilitating adversity and frosting resiliency will grow as patient need (Wezer & Markowitsch, 2005). The process of forming new memories and integrating these memories into an identity, or a person’s “autobiographical memory”, is a key concept in comprehending how a more inclusive bio-psycho-social model supports the use of medical art therapy (2005). Art provides a patient with an outlet to explore the many dynamics that go into a human experience, and allows them to integrate these experiences by tapping into diverse areas of the brain (2005). It is through this creative experience that patients can find rehabilitation and preservation of dignity in face of adversity.

When faced with medical limitations or illness it is not only a person’s biological health that is under attack but his or her emotional and spiritual wellbeing as well (Thomson, Ander, Menson, Lanceley & Chatterjee, 2012). Understanding the dynamic component of the rehabilitation process can help to strengthen his or her resilient narrative (Michaels, 2010). Art therapist use skills in adapting to patient’s abilities and encouraging contained growth to support posttraumatic, or rehabilitative, growth. This process also restores patient dignitary and in turn creates resiliency. Art is an important rehabilitation tool for trauma and deep emotions (2010). As the art therapist nurtures multidimensional self-expression they also provide rehabilitation and foster resilient narratives: medicine for the mind, body and spirit of patients in search of healing and growth.
References


