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Art therapy and atopic dermatitis: Making the invisible visible

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Abstract

Art therapy and atopic dermatitis: Making the invisible visible

A Research Paper by: Sylvie Marchand

By combining qualitative and quantitative research methodologies, the present study attempts to measure the impact art therapy might have on psychosomatic skin disorders and its symptoms. The "*Visible-Invisible*" model developed for this research is introduced and demonstrated through the case material of a woman living with eczema. The use of reliable tests such as the Beck Depression Inventory (BDI), the Anxiety State Traits Assessment (ASTA), the Millon Clinical Multiaxial Inventory - III (MCMI-III) and the SF-36 Health Survey are used to measure the effects of the treatment onto the eczematous symptoms and related factors such as anxiety. Following art therapy treatment, the Post-test scores indicated lower anxiety level and higher vitality, social functioning and mental health as rated by the participant. Although some of the results were found significant, they should not be generalized to the population living with psychosomatic skin disorders.

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« La peau tout en étant une enveloppe, une barrière, est l'organe le plus profond de notre organisme »

Paul Valéry

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Introduction

The present study intends to explore the complex and various issues at stake behind psychosomatic skin disorders, namely in this research, eczema; and assess the use of art therapy as an integral part of the treatment process.

A new perspective on psychosomatic skin disorders will also be proposed, namely the "*Visible-Invisible*" dichotomy model, which was observed and developed by the author. Because the field of Psychosomatics takes on a multidisciplinary approach and that treatment considers both the physical and psychological aspect of illnesses, the model brings together both the skin organ and some aspects of the Skin Ego concept, developed by Didier Anzieu (1985). Thus, the study will address some of the functions the skin organ and the Skin Ego endure, being physiological, cultural, social, or symbolic ones. Given the theoretical framework accompanying this model, the underlying approach of the qualitative research remains within a psychoanalytical understanding.

It is assumed in this research that body-mind connection need not be debated since emotional and psychological states can and do have an impact on a somatic level. Given this assumption, the term "psychosomatic" is used "to describe a group of disorders characterized by physical symptoms that are affected by emotional factors and that involve a single organ system, usually under autonomic nervous system control" (Fleming and Cox, 1989, p.170).

Combining qualitative and quantitative methodologies, this research attempts to answer the following question: "Can art therapy facilitate the healing of psychosomatic skin disorders by offering a "surface" (paper or other artistic support), that is envisioned as a tangible and visible substitute for the skin organ, a container of conflict expression?"

In other words, by comparing the role of the skin organ to the art product, in the context of art therapy, namely one of contact and expression, we will address the healing of cutaneous symptoms by assuming possible Skin Ego healing movement. Indeed, it is hypothesized in the proposed model that in cases of psychosomatic skin disorders, the Skin Ego as well as the cutaneous surface are 'wounded'. In this case, the Skin Ego concept is used as a psychical structure fulfilling similar functions to the skin organ, such as containment or contact with the external world, but on a psychological level. This aspect will be further developed in the second chapter.

The literature review on Psychosomatics in Chapter 1 will briefly address the visibility issue found in the field of Psychodermatology and, define and describe the reality of Atopic Dermatitis, generally called eczema, the skin disorder focused on for this study.

The functions of the skin organ and Skin Ego will be discussed in Chapter 2, as well as the relationship between the skin and the psyche. It is, however, beyond the scope of this paper to thoroughly discuss Anzieu's concept (1985) of the Skin Ego, but specific functions, specifically Traces Registering, are of particular interest for the topic of this research. The model developed by the present author, the "*Visible-Invisible*" perspective on psychosomatic skin disorders, will also be presented in the final section of this chapter.

The research data, combining qualitative and quantitative approaches, will be discussed in Chapter 3. Several images constructed by Nina (pseudonym) in the context of art therapy will be considered and interpretations are offered in relation to the notions discussed. Additionally, using a Single Case (N=1) Experimental Design, levels of

anxiety and depression will be measured to verify the impact, if any, art therapy might have on these variables. Finally, the self-reports questionnaires Millon Clinical Multiaxial Inventory - III (MCMI-III) as well as the SF-36 Health Survey have also been used in this research to better assess the clinical and personality traits at stake in this case. The results and respective diagrams will appear in the last Chapter in section 3.2.

A final discussion of the various results and possible conclusions drawn from this case and the suggested model will follow Chapter 3.

1. Psychosomatic Skin Diseases: Literature Review

Although it is beyond the scope of the present study to exhaustively review the science of Psychosomatic literature and history, chapter one will provide an overview of the main issues concerning the field, regarding specifically Psychodermatology, as well as describe the symptomatology, prevalence, contributing factors, and treatment of Atopic Dermatitis, otherwise called eczema.

The field of Psychosomatics[1] has gone through many changes in the past century. From Freud's first definition of hysteria and conversional model, to the now stress-related approach, the field of psychosomatics continues to be relevant to many forms of diseases and symptoms appearing in our industrial society, such as asthma.

Currently, the most accepted approach in the field of Psychosomatics remains a multi-dimensional, multi-factorial perspective, which considers the patient as a whole (Engels, 1988, as cited in Larouche, 1992). This particular model stated that the individual is not only composed of cells and organs, but the person is also a member of a given family, society; in other words, belonging to a larger system. That larger system which an organism is part of has to be considered when looking at disorders and illnesses. Within such a systemic perspective, therefore, the individual becomes a complex organism made of a physical body, comprising cells and organs, with distinct personality traits and character, a genetic baggage, but also an organism influenced by environmental factors who's learning and conditioning are part of a given culture and community. The

[1] The history and development of views within Psychosomatics can be found, among others, in Grenier (1999) and Kamieniecki (1994). See bibliography.

individual is a social organism, entering in relation with others, and affected or changed by these various contacts with the external world. When sick, treatment must also consider this relational aspect of that person.

To summarize, consider the words of Scheper-Hugues and Lock (1987, as cited in Synnott, 1993):

> Sickness is not just an isolated event, nor an unfortunate brush with nature. It is a form of communication – the language of the organs – through which nature, society, and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity and struggle. (p.235)

That eclectic avenue that helps define and understand illnesses sits at the core of Psychodermatology. Since the individual is a social being and the skin serves that social purpose, because it is an organ of contact, communication and relations with others, as we will see in Chapter 2, skin disorders need to be considered in its entirety.

1.1. Psychodermatology: A Skin Deep Dilemma

The latest perspective in Psychosomatics goes hand in hand with the approach found in the field of Psychodermatology in which skin disorders are no longer defined as solely biological. A psychological component is now recognized in most skin disorders but the acknowledgement, as we will see, took some time.

At the beginning of the 20th century, according to Weiss and English (1943), most skin disorders were seen as a medical condition. Although these authors could observe an increasing interest in the relation between skin disorders and emotional factors, it seems that the medical position would not conclude that an emotional component was in fact involved. Dermatologists were reluctant to hypothesize that psychological factors were involved in skin lesions, unless they were self-afflicted because of psychotic or delusional states.

One of the reasons contributing to the dermatologists' vision of that time can be found in the core of that science itself, that is, in the nature of the symptoms (Weiss and English, 1943). As the authors suggest, the "highly objective, highly ocular specialty" (p.17) that dermatology consists of, involves dealing with tangible, visible symptoms. The cutaneous lesions are in themselves superficial, lying at the surface of the skin, finding ground in the body. Hence, the physiological nature of the symptoms made it difficult to acknowledge possible psychological factors.

During the 1940s, only self-inflicted skin lesions were then considered as psychogenous in etiology. Sulzberger (n.d; cited in Weiss and English, 1943) stated in his book entitled "*Dermatologic Allergy*" (n.d.) that there was no proof of "nervousness" in skin disorders causation. It was argued that when psychological factors were involved in developing or maintaining cutaneous lesions, their presence were either purely coincidental or a result of concomitant factors such as the stress caused by the given dermatological lesions.

It was further argued that the possible psychological implication in skin diseases was due to the lesions themselves. In other words, the psychological impact or the social

consequences of the cutaneous symptoms caused psychological disturbances into the afflicted individual. The emotional component, which will be addressed in section 1.3.2, was a consequence of the skin lesions, not a causing or contributing factor.

However, although the debate is still ongoing as to what initiates and causes dermatoses, dermatology now occupies a special place within the field of psychosomatics because the skin is now recognized as manifesting strong psychological implications (Van Moffaert, 1992). Whereas past literature has linked skin illnesses to exhibitionism and sado-masochistic tendency, guilt, self-punishment, sexual tension, narcissistic traits (Alexander, 1950); inexpressible hostility (Alexander, 1950; Weiss and English, 1943) and, sexual maladjustment (Alexander & French, 1948), the current literature makes a correlation between dermatoses and stress and/or emotions (Buske-Kirschbaum, Geiben & Hellhammer, 2001). In fact, various studies have now shown that psychological and emotional factors play an important role in the etiology and maintenance of distinct skin disorders, such as psoriasis, eczema, urticaria, and many others (Alexander, 1950; Buske-Kirschbaum, Geiben & Hellhammer, 2001; Miller, 1948; Van Moffaert, 1992; Wahl, 1964).

It is now clear evidence that emotional life and psychological states, being conscious or unconscious, play a tremendous role in the emergence, course, duration and termination of psychosomatic skin illnesses and their symptoms.

We will now consider one of these psychosomatic dermatological disorders, eczema, general and familiar term for Atopic Dermatitis.

1.2. Atopic Dermatitis: Definition and Description

In the clinical field of Psychodermatology, there exists a classification of the various dermatological disturbances (Van Moffaert, 1992). The three main categories, based on Koblenzer's classification (1987, as cited in Pott, 1999) involve:

1) ***Psychocutaneous disorders strictu sensu***: defined as "dermatological symptoms based on an underlying psychiatric problem" (p.375). These would include self-afflicted lesions as in the cases of trichotillomania (hair-pulling), neurotic excoriations, or delusions of infestations (parasitosis).
2) ***Dermatoses with psychosomatic etiology***. Those are skin diseases that are mainly triggered by acute stress; and
3) ***Dermatoses whose course is affected by psychological factors***. This category deals with dermatoses that have biological roots but whose course is codetermined by emotional factors. Such diseases would include psoriasis, alopecia (e.g. hair loss) and eczema.

The latter category is the prime focus of the present research, studying Atopic Dermatitis, or otherwise called eczema. The case study presented in the Chapter 3 involves a woman living with eczema. But first, let us consider the reality of Atopic dermatitis: its symptoms, identified causes, contributing factors, as well as the implications and psychological consequences involved.

1.2.1. Atopic Dermatitis/Eczema

Atopic Dermatitis, or eczema, is a dermatological condition whose course is affected by psychological factors. In other words, both specific stress factors and life events can have a direct effect on the onset, duration, relapse, or response of the patient to treatment (Van Moffaert, 1992).

Atopic Dermatitis is "a chronic, pruritic inflammatory skin disease with increasing incidence characterized by eczematous inflammation of the skin, a chronically relapsing course and severe pruritus" (Buske-Kirschbaum, Geiben, & Hellhammer, 2001, p.6). *Eczema* is a general term for any type of dermatitis that causes an "inflammation of the skin". Atopic Dermatitis is the most severe case of eczema and is considered chronic.

The onset of eczema may take place during infancy, that is infantile eczema, but may well disappear by the age of 18 months. It is considered an allergic response to either an irritant or allergen. The term "*atopic*" is used to describe the allergic condition of the illness, which may be found in cases of asthma or hay fever. In fact, it refers to the excessive reaction by the immune system, specifically its high sensitivity, which produces inflammation and/or irritation of the given organ.

There is often a family history and/or predisposition, called an atopic sensibility, which fosters a sensitivity toward allergic conditions including asthma, hay fever and other allergy-related conditions, such as eczema. Often, people who suffer from one of these allergic reactions will show the other conditions referred to as the "atopic triad" (National Eczema Association for Science and Education, 2002; National Eczema Society, n.d.; Picardi & Abeni, 2001).

Atopic Dermatitis is a widely prevalent illness, accounting for 20% of all patients visiting dermatologists. Its frequency is increasing, affecting approximately 12% of urban communities (Buske-Kirschbaum, Geiben, & Hellhammer, 2001).

The eczematous symptoms include intense itching (or pruritus), skin redness or inflammation, rash, and dry, leathery-looking skin areas. Some patients may present blisters and/or weeping of the skin often due to the constant scratching. Eczema is neither contagious nor fatal but its prognosis provides little encouragement for the patients. Atopic Dermatitis is considered a chronic condition that people have to learn to live with by controlling the precipitating or contributing factors. There is no known prevention to eczema and the condition tends to run in the family. For most adults afflicted with eczema, it is generally a chronic, episodic, recurring disease.

1.3. Contributing and Confounding Factors to Skin Diseases:

Psychosomatic illnesses in general are more prevalent in women (Shorter, 1994) and may find their roots in stress, conditioned reflexes, socio-cultural determinants, parent-child relationships (Wolman, 1988), and/or, "consistent emotional arousal that therefore affects that organ system" (Fleming and Cox, 1989, p.170). These possible contributing factors or causal explanations are also true for skin diseases.

The possible causes of eczema are numerous and various, and depend on the particular type of eczema the individual has. Some types are emotionally related while others are caused by irritants such as chemicals and detergents, and allergens such as nickel, and yeast growths. The etiology of certain types of eczema remains to be

explained although strong links have been made with environmental and stress factors, whether of psychological or physiological nature.

Furthermore, when one considers the explanations associated to skin disorders, it is worth looking at it chronologically. Firstly, it was in 1943 that Weiss and English suggested the multiple causation explanation stating that skin disorders may be psychosomatic in its etiology and, therefore, may be caused by various psychological states, anxiety, or other concomitant factors.

Also, in reviewing different cases studies, Miller (1948) summarized the various emotional and psychical features correlated to skin diseases. In the past literature, dermatoses have also been associated with: sexual maladjustment; feelings of hatred, fear and guilt; sudden fright; conflict over masturbation; masochistic trends; exhibitionism; and secondary gains. Miller (1948) further argued that in individuals with skin conditions, the manifest content of their dreams is highly associated with "looking and exhibitionism"; that is, significantly higher than for individuals with ulcers, indicating, according to the author, an exhibitionistic tendency among people with skin-related conditions.

Currently, the etiology of eczema is seen as multi-factorial, recognizing the various factors: genetic, personality, biological, conditional, environmental, and psychological. In addition to these precipitating factors, one must also take into consideration the major influences the emotions and the psyche have on the onset and duration of the cutaneous symptoms.

1.3.1. Emotional Factor

In 1950, Alexander published an article entitled "*Emotional Factors in Skin Diseases*" recognizing the intimate relation between the skin organ and emotions. Even though the exact pathophysiology of eczema is not yet totally understood, the influence of emotional factors, as precipitating and/or maintaining cutaneous symptoms, is now well acknowledged (Buske-Kirschbaum, Geiben, & Hellhammer, 2001; Van Moffaert, 1992).

Different explanations have also been linked to the onset of skin diseases as well as justifying the *visible nature* of the symptoms and its underlying psychological process. Perry (1999), for example, in studying body-mind relation, suggests a powerful link between the skin, communication and memory. In his view, most skin disorders find their etiology in past, unexpressed emotions during traumatic or significant experiences. The author also suggests a dissociative aspect of cognitive-affective memory due to that particular traumatic or significant experience. This in turn affects how past memories may be stored. Perry reminds us that *all* experiences, in order to be remembered, must first go through the senses. The skin, being the largest of all the organs, covers the entire human body.

Cohen and Mills (1999) also corroborate the latter explanation as a possible cause for cutaneous illness. They suggest that traumatic events allow memory to be stored at a sensorial level, particularly when verbal expression was inhibited or unavailable (e.g. during preverbal stage). The skin is thought to be capable of such sensorial memory. Theses studies linking emotion to skin disorders suggest a form of "memory dissociation", occurring when any significant event cannot be processed through words,

because a traumatic event occurred, or an experience was first had during the pre-verbal stage of infancy when language remains inaccessible. The latter explanation also supports McDougall's view (n.d.; cited in Kamieniecki, 1994): "... la vulnérabilité psychosomatique est accrue chez les patients ayant été exposés à un vécu traumatique durant la phase (...) 'd'individualisation-séparation' " (p.102). As Pott (1999) suggests, bodily somatization is sometimes the only emotional language available.

According to these authors, psychosomatic skin illnesses may fulfill a symbolic role in expressing what has been repressed in the past. The skin appears particularly appropriate to fulfill such a role: "C'est la peau qui s'exprime à l'insu de son propriétaire dans un court-circuit de la parole et de l'émotion" (Bénazeraf, 1994, p.159). Thus, words and emotion may be intimately involved in dermatoses, as they both remain unexpressed.

1.3.2. Cause and Effect Factor of Cutaneous Symptoms

In addition to the emotional factors contributing to the onset and/or duration of the cutaneous symptoms, one must also consider the nature of the symptoms. According to Van Moffaert (1992), the obvious visibility of the majority of dermatoses may also have great psychological consequences. The author argues that because the skin organ is exposed to the view of others, it explains both the reactions it may provoke in others and the relation the person develops with his/her own cutaneous symptoms.

First, the accessibility of the symptoms allows the patient to interact with them through different behaviors, accounting for a learned behavioral component in skin disorders, such as touching, scratching or various cutaneous care manipulations. This

aspect may exacerbate the itch-scratch cycle, which in turns, contribute to the symptom duration.

Secondly, the visibility of the symptoms, unlike other psychosomatic illnesses, may also affect the psychological health of the individual. Dermatological diseases are often wrongly perceived as contagious and/or associated with lack of hygiene, and trigger fear or disgust in others. The negative connotation attributed to skin disorders may lead the individual to isolate him/herself and feel rejected. In movies, for example, the characters with skin lesions or marks are often depicted as villains (Reese, 2001).

On the other hand, argues Van Moffaert (1992), the same visibility of the lesions may well serve exhibitionist purposes and fulfill narcissistic needs in getting attention from others for their readily observable symptoms. The cutaneous lesions, therefore, may come to possess some symbolic value. This aspect of skin disorders will later be explored in section 2.4.1.

1.4. Treatment: Psychosomatic Approach

There exists no cure for eczema but rather there are a series of preventative steps and care one may undertake. Overall, within the medical and psychosomatic approach, treatment must involve both a physical and a psychological aspect. Anti-stress treatment is recommended (Van Moffaert, 1992) as well as dermatological consultation and some attention to the triggering factors, whether it was an allergen or emotional event.

Secondary gains must also be considered as important triggering or maintaining factors. For instance, in the case of infantile eczema, home treatment seems to be highly effective. This is partly explained by the additional skin-care and attention the child receives from parents in the application of lotions. One study indicated that by lowering the active substances in ointments, and thus increasing the application frequency, resulted in highly effective treatment. These results were explained by the higher incidence of skin contact and cuddling between the child and the nursing parent.

Overall, the treatment for psychosomatic skin disorders needs to include both physical and psychological component. As stated by Van Moffaert (1992): "...psychopharmacological treatment should always be part of an integrative approach, combining medical and psychobehavioral management. It follows that the need for a combined approach with diverse psychotherapy is mandatory in psychosomatic dermatology" (p.387).

Within such perspective, medical consultation with a dermatologist or physician is required. Additionally, verbal psychotherapy has been the treatment generally offered to individuals with psychosomatic skin disorders to help them consider the mental and psychological contributing factors to the onset and duration of their symptoms. Given the possible alexythimic condition, which will be defined in the following section, verbal therapies might find limitations within such population. However, no research has been done, or published, with individuals who have psychosomatic skin disorders to assess the effectiveness of verbal or other psychotherapies. The present study intends to initiate the investigation.

1.5. Art Therapy in the Psychosomatic Field

Art therapy could well fulfill that psychotherapeutic component of treatment for psychosomatic skin disorders. The relatively new venue of art therapy within the field of Psychosomatics may well serve, in the near future, as a treatment of choice for patients with psychosomatic conditions. Including verbal and non-verbal approaches to psychotherapy, art therapy allows self-expression, whether through images or words.

Berry & Pennebaker (1993) found a significant correlation between inhibition of self-expression with autonomic arousal regulated by the brainstem. From their research, the authors found that increased electrodermal activity was measured when subjects were asked to talk about their most traumatic personal experience. They concluded that inhibition of self-expression, verbally and non-verbally, could have detrimental effects on health. They proposed that language, being spoken or written, not only brings clarity but also improves physical health.

As mentioned previously, words and emotion may intimately be involved in dermatoses, as they both remain unexpressed. Individuals with psychosomatic skin disorders may have difficulty expressing themselves and their feelings using verbal expression solely. Art therapy allows them, therefore, to use both paths of expression to healing.

It is suggested, furthermore, from a psychoanalytic standpoint that most psychosomatic patients present a particular syndrome, called *alexithymia*, which could be defined as an inability to verbally and symbolically express emotions[2] (Kamieniecki, 1994). Again, art therapy would therefore be a psychotherapeutic treatment of choice, as

[2] The reader may find more information on alexithymia, in the context of art therapy, in the work of Dolce (1999).

it offers a non-verbal component, and a creative process, that can very well help initiate the patient to self-expression without too much threat.

Art therapy has been used within the field of Psychosomatics in cases of gastric illness (Lacroix, 1995), breathing difficulties (Larouche, 1992), fibromyalgia (Grenier, 1998), alexithymia (Dolce, 1999) and many others. However, the present research on skin disorders is unique in the field of art therapy. In fact, Joron (1991) has already addressed the concept of the Skin Ego in the context of art therapy, but a link made to psychosomatic skin disorders appears here for the first time. Hopefully, this study will provide an initial opening to a whole new area for future research.

Having briefly reviewed the literature of Psychodermatology, described the condition of Atopic dermatitis, as well as possible treatment approaches, Chapter 2 will focus on the "*Visible-Invisible*" perspective on skin disorders considering both aspects, that is, the skin organ and the Skin Ego.

2. The "*Visible-Invisible*" Perspective on Skin Disorders:

As early as 1948, one can find a growing interest in the psychoanalytical literature for skin disorders for the readily observable symptoms, which occurrence is often associated with the patient's emotional state (Miller). This section of the present research paper attempts to, first, briefly describe the role skin plays in human development and communication; second, explore the relation between the skin and the psyche; third, briefly consider the role and three specific functions of the Skin Ego (Anzieu, 1985); and finally, present a new approach on skin disorders, in the context of art therapy, that is, the "*Visible-Invisible*" perspective.

2.1. The Visible Organ - The Skin:

The skin is the largest and most exposed organ (Wolman, 1988). Whereas the eyes are the organs for vision, the skin functions as a multi-functional sense, often referred to as "the senses of touch" (Cholewiak & Collins, 1991, p.23). The skin has the same organic origin as the nervous system. It is the first of all sensorial organs to develop, demonstrating its crucial role in human development and being. The sense of touch is also referred to as a sense of contact and proximity (Synnott, 1993) because, unlike the eyes, the stimulus must be close to trigger its perception. The skin, including hair, covers the entire body and fulfills numerous and vital functions.

2.1.1. The Skin Organ: Physiology and Functions

The total weight of the skin organ is 4 kg and its multilayered surface reaches 1.8m² in an average adult (Cholewiak & Collins, 1991). The skin is composed of three distinct layers: epidermis, dermis and hypodermis, which all together are as thick as a sheet of paper. Its internal constitution is however complex, for example, 1cm² of the hand skin contains: 1 m. of blood vessels, 240 pain detectors, 12 hairs, 14 heat detectors, 50 m. of nerves, 30 pressure detectors and 3600 nerve endings (Cholewiak & Collins, 1991).

The external layer, the epidermis, is made up of dead body cells, also called keratinized, regenerating every 6 weeks. The human being loses some 10 billion dead cells every day, constituting 80% of all home dust. Some 225 kg of dead skin cells will be lost during one's life (Cholewiak & Collins, 1991; Cohen and Mills, 1999; Wolman, 1988).

Through a complex physical and chemical system, the skin is capable of elasticity, flexibility and sensitivity. Depending on the body region, the skin may be thin or thick, loose or tight, and hairy or smooth (Cholewiak & Collins, 1991). It can also sweat or retain water in order to regulate salt-water ratio, help maintain ideal body temperature, and transmit pressure information to the brain within one-hundredth (1/100) of a second. Finally, the skin also metabolizes vitamin D from sunlight.

The functions of the skin involve mainly ones of protection and communication. In other words, the skin protects the individual from possible external threats as well as communicates with the outside world. The skin protects the body from dehydration, for its "water-proof" quality, becomes a shield from bacterial infection, and protects as well

as contains the internal organs. It also reacts to touch, pain, pressure, heat and cold, and hues in threatening or embarrassing situations (Cholewiak & Collins, 1991; Cohen and Mills, 1999; Thomas, 1997; Wolman, 1988).

Essential homeostatic functions are hence well served by the skin organ. But most importantly, the skin also plays an enormous communicative role, often revealing and expressing emotional and/or internal states of the individual.

2.1.2. Expression and Communication Through the Skin

As the skin protects and maintains the individual's well being, it also reveals the rich diversity of the human being experience. Individual and intimate information, such as race, age or physical state, can be revealed to the outside world through the skin.

In 1943, Weiss & English compared the skin to the eyes, since each organ plays an essential role as a point of contact between internal and external worlds. Both the skin, including the hair, and the eyes are truly organs of expression. Each organ, as the authors suggest, reveals the internal state of the individual by its sparkle, its glow and its color.

The skin endorses social and symbolic roles as its color is often associated with social or cultural identity and represents "the boundary between me-not-me" (Cohen, 1999, p. 206). Identity is therefore highly related with skin as, firstly, a clear delimitation between one person in relation to another and, secondly, through fingerprints, unique to each individual. The skin thus becomes the field of encounter as well as the frontier in our relations to others. It represents the point of contact with the external world where touching, or distancing, bares personal and/or social meanings.

Furthermore, the skin also plays a major cultural role. Ashley Montagu (1986), a well-known anthropologist, has compiled in "*Touching - The Human Significance of the Skin*", the different cultural baggage portrayed through the skin and its modifications. Rituals involving the skin organ, for example, imply a visual passage, an indisputable mark on the body of the initiated (Enriquez, 1984). In fact, the organ of the skin, unlike others, may be altered in various ways; the skin can be colored, perfumed, tattooed, cut, scarred, stretched, pierced, tanned, bleached, bathed, dirtied, shaved, and so on. The multiple alterations may reveal the individual's cultural background or fashion trend, and have deep meanings within one's community (e.g. female excision, male circumcision).

Hair, body hair and nails, which are extensions of the skin organ, can also highlight one's personality as they can easily be modified without too much pain involved. As one can see, skin plays more than physiological and biological roles. It is a tool for cultural and personal coded messages. Skin, in and of itself, possesses communicative skills. Anthropologist Anthony Synnott (1993) explains: "The human exterior is itself a sensory organ" (p.157). It is thus important to recognize the non-verbal component of the message sent to the outside world.

Through the sense of touch too, the human experience can be enriched: hugging, shaking hands, kissing, and so forth; or depleted, as in slapping, fist fighting, or mutilation. The different behaviors enter a coded communication depending on social context and meanings. Contact with "others" is at the core of the skin organ.

In addition, many emotions, feelings and even physical condition information can be transmitted to the external environment through the skin in particular. The skin organ can communicate emotional states such as embarrassment, excitement, shame, fear or

anger through blushing, pallor, or sweating (Alexander, 1950; Picardi & Abeni, 2001; Synnott, 1993; Weiss & English, 1943). Someone's pallor may also be a sign of an illness afflicting the body, or interpreted as fatigue. By sending coded messages, the organ of the skin "acts as an information-processing system" (Synnott, 1993, p.157).

Even our language is filled with skin-related metaphors and its underlying emotional, affective content. In English, for instance, expressions like "to be touched by", "to keep in touch", "to be out of touch", or simply "to feel", have a textural connotation attached to them. In French too, we find metaphorical expressions such as: "à fleur de peau", "être bien dans sa peau" or "être en contact", and many others, related to the sense of touch and its sensorial organ. As Synnott so eloquently puts it: "Visual metaphors seem to govern the worlds of reason and understanding [e.g. "I see", "it is clear", or "point of view", etc.][3] (...) but tactile metaphors are primarily concerned with our 'feelings', 'sensitivities', and emotions, and our interactions with other people" (p.158).

It seems clear, therefore, that symbolic meanings are attached to the sense of touch and, consequently to its responsible skin organ, and that our relation toward others and the external world must also consider the role and quality of the skin. When that particular organ is affected, via dermatological lesions, it may be that the patient's relation with the external world is affected.

The following model, the "*Visible-Invisible*" perspective, will address that issue but, first, let us consider the link between the skin and the psyche described in Anzieu's (1985) Skin Ego concept.

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[3] For more information on visual metaphors, see Chap. 5 in Synnott (1993).

2.2. The Skin and the Psyche

The science of Psychodermatology sits in a special place within the field of Psychosomatics because of a strong existing link between the skin and the psyche: "Not only do dermis and psyche share their embryological origin, but also are closely intertwined functionally" (Van Moffaert, 1992, p.373). The skin is intimately related to the central nervous system as they both derive from the same embryological source, the embryonic ectoderm (Picardi & Abeni, 2001). Although they find a common source in their origin, their split arises developmentally. The skin will be seen by others whereas the psyche will remain hidden.

The specificity of dermatological somatization, unlike others, lies in the *visibility* of the symptoms. The very nature of this somatization process involves reaching for the gaze of the physician, or the caring figure, onto the cutaneous lesions.

Within a psychoanalytical theoretical framework, the relation between skin and psyche is well recognized. Within a Freudian conversional model of psychosomatics, the somatic symptom holds a symbolic value, the expression of some repressed psychic conflict (Grenier, 1999). The body (soma) becomes the seat of expression of such unconscious repressed material, and the cutaneous lesions may serve symbolic meaning, which will be discussed in section 2.4.

According to Consoli (1985), the quality of cutaneous exchange is essential not only for normal human development but to form and build one's ego and body image. The skin is thus more than a frontier; it is an envelope defining one's self vis-à-vis the others. It is a zone of communication, a site eliciting the gaze or the touch of others (Sapir, 1985). The skin organ provides a location of choice for displaying marks and

scars as personal testimony of past and present history. Their subjective content may bare meaning to the individual as well as provoking external reaction. Marks on the body will often elicit the gaze of others as a way of recognition or fulfilling narcissistic needs (Anzieu, 1985; Bénazéraf, 1994; Enriquez, 1984). The nature of the cutaneous symptoms in itself reflects a tangible and visible proof of pain and suffering, often minimizing the underlying psychical pain whether of neurotic or psychotic nature. As Italian psychoanalyst Fabiana Weber writes: "La pelle: silenzi e grida" (The skin: silence and scream); indeed, the skin with its lesions can thus become a loud cry for help, through silent but nevertheless visible symptoms. In such cases, the skin becomes a stage for attention.

As suggested by Consoli (1985), moreover, the lesions, as in Atopic Dermatitis, disclose an unequal cutaneous surface, lacking integrity. The afflicted area portrays the disconnected, segmented quality of the organ. This, according to the author, is the "The price of the gaze"; that is, the necessary attention the gaze procures, also possessing healing capacities. What the skin reveals, on one hand, is in fact the suffering through which one seems to exist.

The gaze of the other, on the other hand, also possesses a confrontative quality. This aspect, according to Consoli (1985), demonstrates the profound disturbances of the individual with cutaneous symptoms in relation with others, as well as his/her poor ego constitution. Some individuals with dermatological illnesses are highly sensitive to others. They seem *permeable* in their contact with others, as their barrier remains delicate and sensitive. The need to be seen also fulfills one of fusion, in a desire to merge with the other, as the self has porous quality.

Contact seems to be the key word, lying at the core of the dermatological issues. The skin organ with its senses of touch and "feeling" bares symbolic meanings and the cutaneous lesions found in Atopic Dermatitis may serve that goal, reaching for the other, for its healing gaze, and longing for sense of wholeness, through the skin and the Skin Ego.

2.3. The Invisible Psychic Structure – Anzieu's Skin Ego (1985) Concept:

The concept of the Skin Ego was first developed by Didier Anzieu in 1974. The idea emerged from the actual functions skin play in human development, whether physical, psychological or symbolic. The infant's first experiences pass through the skin and the mother's, whether being breastfeeding, cuddling, or primary bodily cares. In the infant's experience, both parties are sensed as being one, in a fusional and stimulating relationship. Part of the infant's normal development is to make sense of the external world, realizing that he/she is a distinct body from mother's, without feeling overwhelmed or overly anxious by the threatening reality.

Thus, the cutaneous experiences trigger Skin Ego development. In fact, according to Anzieu (1985): "Every psychical activity is anaclitically dependent upon a biological function. The Skin Ego finds its support in the various functions of the skin" (p.40). The Skin Ego, therefore, serves as a psychical intermediate between the individual and the external world. However, "if the appropriate experiences do not occur at the correct moment, the structure is not acquired or, more usually, is distorted" (p.5). In the present study, it is assumed that individuals with skin disorders of psychosomatic nature possess

distorted Skin Ego that might be healed through the use of art therapy. This idea will be presented in the following section when the "*Visible-Invisible*" model will be presented and discussed.

When first introduced, Anzieu assigned the Skin Ego three main functions inspired by the skin organ functions, but in this case, on a psychical level; those were containing, protecting and traces registering functions. In 1985, Anzieu further developed the concept and presented a total of nine distinct functions Skin Ego fulfills. These include: maintaining, containing, protective shield against stimulation, individuating, intersensoriality, supporting sexual excitation, libidinal recharging, traces registering, and self-destruction.

Although it is beyond the scope of the present study to cover and discuss all of these functions, it remains important to briefly address three of them in the context of skin disorders. Of the Skin Ego's nine distinct functions Anzieu (1985) developed, we will focus on the ones that seemed most relevant to Atopic Dermatitis, and other types of dermatological illnesses, but also specifically pertinent to the case study presented in Chapter 3. These functions are: containing, individuating, and most importantly, in the discussion that concerns us, traces registering function.

2.3.1. Containing [*"Contenance"*]

The first of the three functions we will address concerns the containing role the Skin Ego plays. Just as the skin contains all the internal organs and covers the entire body, the Skin Ego serves a similar psychical function. The mental representation of the skin arises in the mother-infant relationship during which the mother's care and handling

will procure an enveloping feeling. Through bodily sensations and needs, and the attention received through those, the infant will develop a mental image of its own skin as container, or what the author calls bag ["*sac*"].

Although the Skin Ego does not cover the whole psychical apparatus, according to Anzieu (1985), it aims to do so. Failure to fully develop the containing function results in anxious and diffuse sense of self. Since the Skin Ego remains wounded and cannot fully serve the containing function, the individual hence attempts to confirm his/her own existence and feel "contained" by living within a painful and sufferable shell. It is believed, in the approach of the present study, that psychosomatic skin disorders may serve that goal, and provide some containment even though it is a painful one.

This Skin Ego function becomes an important consideration in cases of skin disorders and dermatitis, such as eczema, because it appears dysfunctional. The treatment must therefore attempt to re-establish or further develop the containing function of the Skin Ego, as we will see in the case study presented in the following chapter.

2.3.2. Individuating ["*Individuation*"]

Although not as specific to skin disorders per se, this function of individuation is worth mentioning for its relevance to the case study presented in this study in Chapter 3. This individuating function will be addressed in more detail later but is briefly described here.

This function developed by Anzieu (1985) relates to the unique sense of self one develops by awareness of his/her own skin, being its color, texture, smell, and so on. This sense of being and individuation first takes place when the infant recognizes its own

limitation as to where he/she begins and ends vis-à-vis the outside world. External agents must be kept outside the organism and only good foreign bodies will be admitted within. This function is necessary to identify both good external objects and the other as "other".

This sense of self and individuating is also fulfilled, according to Anzieu (1985), by the Skin Ego, providing a unique sense of self to the individual. Just as the fingerprints are unique to each individual, on a physiological level, a sense of uniqueness can also be reached psychically. Failure to fully reach this given Skin Ego potential leads to a flaky sense of self and oneness, as well as weak ego boundaries. The latter will be addressed in the following chapter, as Nina, presented in this case, is also a twin.

2.3.3. Traces Registering ["*Inscription des traces*"]

Finally, Anzieu also developed a Skin Ego function called traces registering. This function is of particular interest for the present topic of the study and will therefore be addressed in more depth.

Just as the skin organ is often used to display one's culture and sense of belonging (e.g.: tattoos, excision, marks and scars, and so forth), this Skin Ego function serves as a mental film of one's senses. In other words, through the "senses of touch" skin possesses, combined with other sensory information obtained from the external world, the individual is capable of processing and integrating all that information and make a mental image of the given reality. The incoming sensorial information, once integrated, sends back a mirror-like image of the external world. The Skin Ego, therefore, plays, according to Anzieu (1985), the role of a psychical pictogram.

This function develops primarily through the care of mother since the first sensorial information the infant receives comes from the skin organ. Cutaneous sensations are the primary sources of information the infant receives from the external world. These, in turn, have to be processed in order to obtain a mental picture of reality. Its function serves biological purposes, as it integrates sensorial information, but also social ones because the skin, with its various specific markings, also belongs to a larger community, culture, and religion.

Anzieu (1985) further describes that one of the first anxieties related to this function will have to do with shameful marks found on the body, onto the skin. In addition, if the anxiety related to the destruction of "mother-infant fusion" fantasy, that is the infant's fantasy that she/he and mother shares a common skin, becomes overwhelming, the Skin Ego is incapable of mental representation of the external world and its traces. It will hence produce its own physical markings to confirm one's own existence. These inscriptions, whether rashes, lesions, wounds or eczematous symptoms, reveal one's past and present history within one's community, and become a somatic substitution for missing psychical representation. The physical bodily traces, it is suggested, replace the mental film.

This function is of particular interest since it suggests that the individual is capable of making and registering its own physical marks to fulfill a psychical mechanism. To Anzieu (1985): "The Skin Ego is the original parchment which preserves, like a palimpsest, the erased, scratched-out, written-over first outlines of an 'original' pre-verbal writing made up of traces upon the skin" (p.105). This links a theoretical point of view presented earlier, stating that any trauma during pre-verbal stage will find its way

of expression, being, in this case, through somatic expression.

Eczema, with its cutaneous lesions, can hence be seen as serving 'traces registering' purposes as the psychical structure fails to do so, either due to unbearable anxiety or any trauma during the pre-verbal stage. This idea, developed by Anzieu (1985), also corroborates the perspective developed in the first chapter, suggesting that any event during infancy experienced as traumatic may be stored at the sensorial level.

From both perspectives, it appears that some skin disorders may serve the *inscription* of that event onto the skin as a testimony of the individual's past history. Just as the skin may reveal an individual's history, or a segment of it, by the revealing presence of a scar, the dermatological lesions may well serve the Skin Ego history. These cutaneous symptoms, it is suggested in the present research paper and its model, both reveal and conceal a wounded Skin Ego which requires healing.

These Skin Ego functions, particularly the last one mentioned, are of interest in cases of psychosomatic skin disorders. The next proposed model will consider these functions as well as already discussed issues into a "*Visible-Invisible*" dichotomy found in the context of psychosomatic skin illnesses.

2.4. A Proposed Dichotomy: "*Visible-Invisible*" Perspective

This section will address the "*Visible-Invisible*" approach, which was developed for the present research. The core idea behind this perspective lies on the *expression* of a possible internal conflict within a Freudian conversional model of Psychosomatics.

As early as 1950, Alexander suggested: "The skin, constituting the surface of the body, is the somatic locus of exhibitionism" (p.164). Psychoanalyst Didier Anzieu (1985), who has proposed the concept of Skin Ego, briefly covered in the previous section, also maintains that cutaneous disorders are often found in narcissistic individuals to meet their need to be seen. The author moreover notes how the skin keeps through the years the scars of the past, literally and symbolically. The individual thus wears its past history and story on its skin and, therefore, the skin affected by dermatoses, such as eczema, may have something to say to the outside world.

2.4.1. A New Model: Discussion and Diagrams

From a conversional model of psychosomatic, as firstly introduced by Freud and Breuer in the early 1900s, the symptoms may bare meanings in its location. For people who have psychosomatic skin diseases, one might hypothesize the symbolic, non-verbal communication implied in such condition. It may be the case that afflicted individuals, through the cutaneous symptoms, send a coded message to the external world.

Further, as mentioned earlier, it is thought that some individuals with psychosomatic conditions display difficulty in emotional expression, referred to as

alexithymia syndrome. The skin, as proposed in this model, through the symptoms often seen by others, symbolically and unconsciously speaks for the individual whose internal conflicts act as residues of past unexpressed emotions (Anzieu, 1985; Bénazéraf, 1994).

The internal and invisible conflict must hence find a path of *expression* being through somatic, bodily symptoms, if language expression is unavailable or dysfunctional. The relief of tension, again within a conversional model, which is adopted here, should liberate the body from its symptoms. The verb "*to express*" comes from Latin "*exprimere*", which literally means "force out"; with "*ex*" for "out", and "*premere*", roots of press, printing, striking (Webster, 1988, p. 480 and 1327). Thus, within such perspective, the skin is unconsciously used as a printable visible surface to disclose and display an internal invisible conflict to the external world. It unknowingly becomes a screen to be seen and read by others, like a parchment.

The following diagram (Table 1) displays the "*Visible-Invisible*" dichotomy for an individual who enters in relation with another person through its illness and its cutaneous symptoms.

The cycle suggests the expression of the invisible internal conflict through bodily organs, the skin, serving, by the same token, narcissistic needs. Indeed, the other's gaze serves the need to be seen and recognized, allowing attention to be focused on the patient's skin and its cutaneous symptoms. In other words, it is proposed in this model that the cutaneous lesions serve a possible maladaptive and/or distorted Skin Ego by, firstly, providing marks and, hence, fulfilling undeveloped 'traces registering' function, and, secondly, by attracting the gaze of the other.

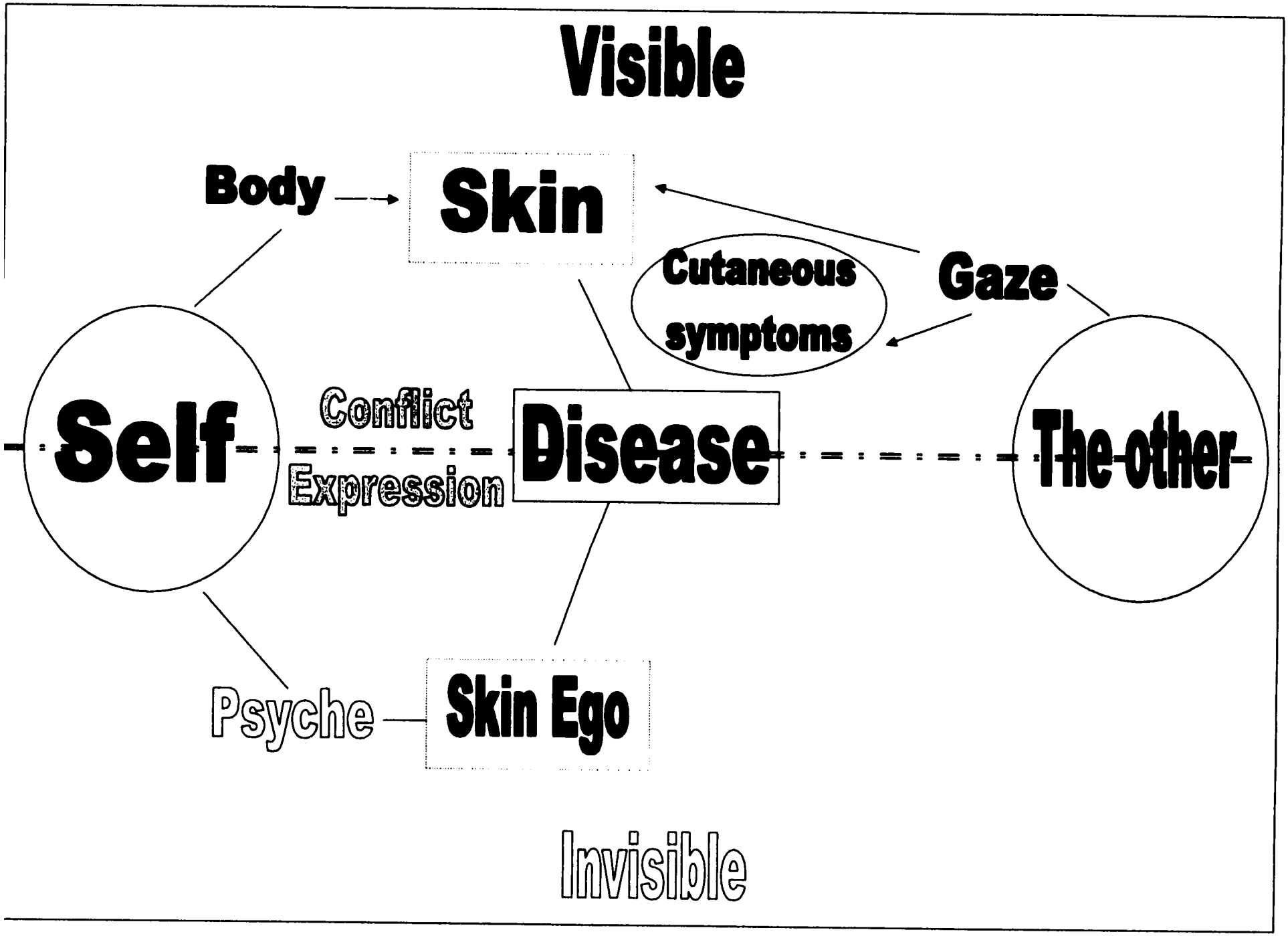
Visible
Body
Skin
Cutaneous
symptoms
Gaze
Self
Conflict
Expression
Disease
The other
Psyche
Skin Ego
Invisible

Table 1

As depicted in the diagram, both the skin and the Skin Ego appear fragmented and disintegrated (i.e. with dotted lines) because some Skin Ego functions, such as containing and traces registering, may possibly have remained undeveloped. A porous ego, as suggested in this model, brings the individual to define himself/herself in relation to "the other" through the dermatological disease, and, simultaneously, to reiterate its own existence through a painful shell. Thus, the need to be seen fulfills also a much primal need, one of existence: "I suffer, therefore, I exist".

The gaze of the other, it is worth noting, also plays a healing role for an individual whose sense of self may be distorted. That role continues and pursues the ones unmet by the maternal and caring figure. Since the Skin Ego, as hypothesized, remained unfolded in its capacities during infancy, the other's gaze and attention further enhance its developmental process. The need for contact can thus be met through dermatological symptoms as its treatment necessitates looking, touching and other mothering-like cuddling behaviors, so desired by the individual.

Within such perspective therefore, the skin becomes a visual site, a tangible ground, for invisible conflict expression. «Les drames de la profondeur montent à la surface et s'y reconnaissent en même temps qu'ils l'enflamment. C'est aux frontières qu'éclatent les conflits ! » (GIPSO, 2002). It is therefore at this frontier, between the "me-not-me" where the skin lies that the expression of this internal conflict becomes visible.

The next section will consider art therapy with its artistic material as a possible substitute for that external visible expression.

2.4.2. Skin and Paper: Conflict Expression in Metaphorical Uses of the Surface in Art Therapy

Certain people with psychosomatic skin diseases, such as Atopic Dermatitis, may have difficulty expressing feelings and internal conflicts through words. As mentioned earlier, words and emotions may intimately be involved in dermatoses because they both seem to remain unexpressed. The organ of the skin thus allows them to visually express that internal conflict and involve the other, often a caring figure, in the healing process. The opposite, however, may also be true; that is, when attention is lacking or ungratifying, the lack of contact, or its poor quality, may well precipitate or maintain the painful cutaneous symptoms.

Since it is suggested that treatment of psychosomatic skin disorders involve psychotherapeutic component, art therapy may facilitate the healing process as its means also allow visual and symbolic expression. Before words can be put onto the internal conflict, the creative process, and the unconscious mechanisms involved, may trigger new pathways of expression. Indeed, symbolic, artistic and emotional vehicles are intrinsic to the creative process and the gestures implicated in artistic expression and creation.

Once images, or any artistic products, have been produced, they become a new means of expression that can be explored and named, for and with the individual, to help resume the invisible internal conflict. The paper, as a tangible medium and delimited surface, may become a substitute for the skin, as it is also visible to the other. The artistic product, rather than the dermatological lesion itself, may become the new tangible witness of the patient's existence and pain.

In other words, it is my hypothesis that visible cutaneous symptoms symbolically express an untold, often unconscious and unrecognized, internal conflict. I am suggesting that by offering patients with psychosomatic skin disorders a new path of expression, which possesses certain similar qualities in its nature, that is, being tangible and visible, as a support for the conflict expression, the healing of cutaneous symptoms could be triggered and/or enhanced. Therefore, the use of a new surface, namely the paper or any artistic means rather than the skin area, can *hold* the expression of the individual's internal emotional conflict whether conscious or unconscious. This aspect of art therapy is crucial as it plays a 'containing' function which could symbolically be compared to the one fulfilled by the Skin Ego as described earlier.

The following diagram (Table 2) shows the relation between the client and the art therapist as a potential healing process in which the object of art becomes the focus rather than the bodily symptoms, and the surface for symbolic expression. Again, the artistic object may provide some "containment" for the client's emotional expression. Such role is desirable since the Skin Ego containing function, as discussed in section 2.3.1, may be dysfunctional.

Moreover, within an artistic therapeutic relationship, the individual may relearn to enter in functional relation with "the other" instead of dysfunctional merging as a mean of existence. It is hoped that the emotional pain felt in psychotherapy, substituting the somatic one, will be accompanied and released through both verbal and non-verbal means.

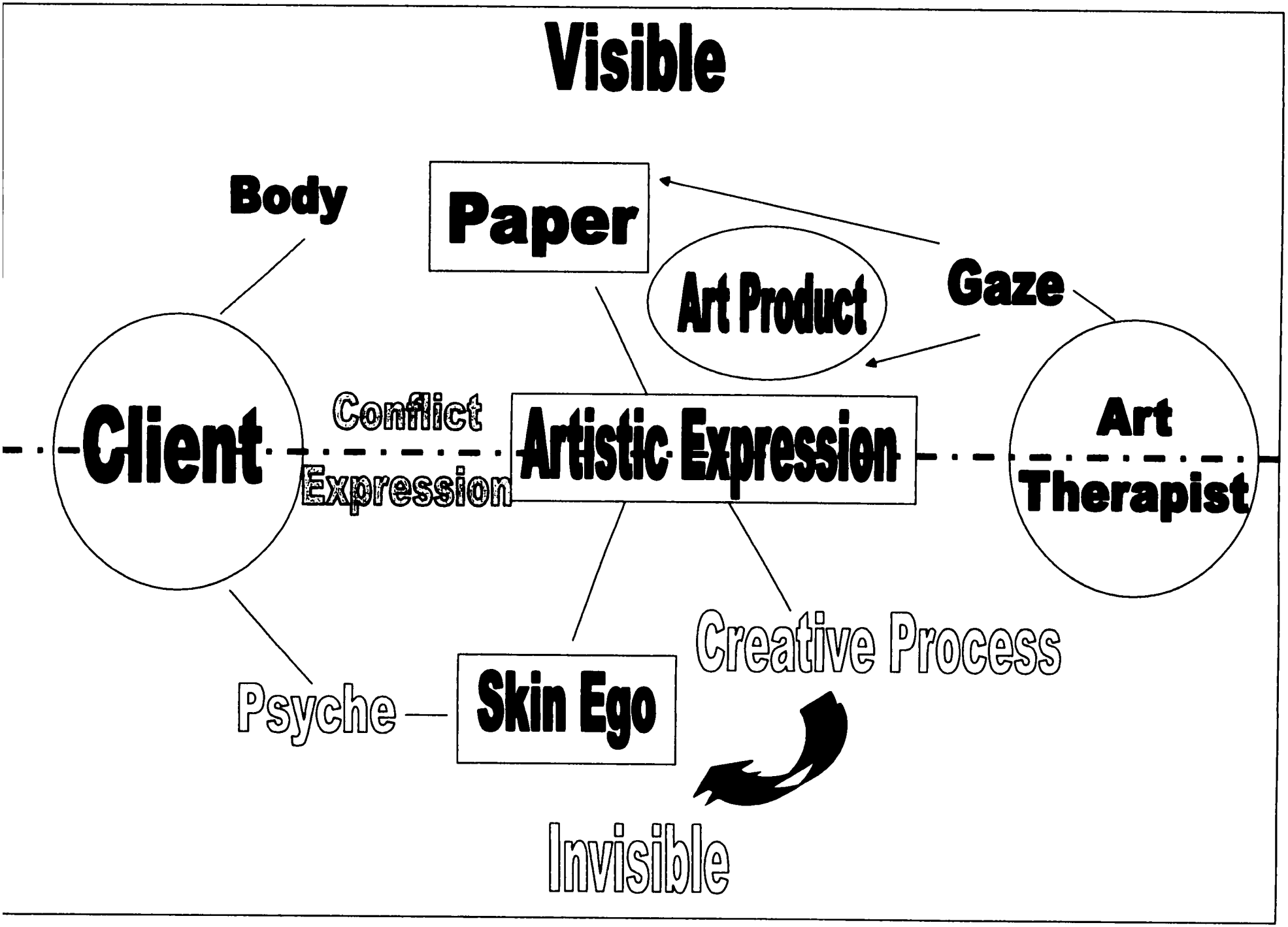
Visible
Body
Paper
Art Product
Gaze
Client
Conflict
Expression
Artistic Expression
Art
Therapist
Creative Process
Psyche
Skin Ego
Invisible

Table 2

The cycle in Table 2 is similar to the one found in Table 1 as the gaze of the therapist is also involved in art therapy. In this context, the gaze is directed in a more adaptive manner to the paper (or other artistic support), and the artistic product becomes the new tangible surface of the individual's expression. The internal invisible conflict might hence be shown to the outside world and remain visible as the artwork can become permanent. This new form of expression may not only fulfill narcissistic needs by the attention received in individual art therapy sessions but also plays a role similar to the traces registering function of the Skin Ego.

Intrinsic to the therapeutic relation, two distinct elements found in art therapy, and specific to this context, can enhance the healing of the psychosomatic dermatological condition. First, we can consider the creative process involved in art therapy as a potential healing movement accompanying the Skin Ego unfolding development. From this suggested "*Visible-Invisible*" model (see Table 2), the creative process involved in art making is believed to enhance the healing of the distorted Skin Ego and promote its growth (depicted in the diagram by the large arrow) by promoting the containment function. Although the model still needs further investigation, it is hypothesized that the limited surface of the paper, or the tangible quality of the material used in art therapy, offer possible containment to the Skin Ego. Furthermore, the object of art also provides new healing opportunities to the Skin Ego by promoting its traces registering function. It is believed within such model that the individual with psychosomatic skin disorders may experience new forms of 'traces' by witnessing his/her own art making and final product.

Secondly, another critical component of art therapy seems at stake in promoting the cure of the skin and the Skin Ego, and that is, the presence and the role of the

therapist. Indeed, the art therapist not only watches the client's expression unfolds, which gaze serves the individual's need, but may also symbolically play a "mothering" or containing role. This is seen in both symbolic and concrete ways. For instance, the art therapist provides adequate and sufficient artistic media and material. The client, whether adult or child, may interpret this as a 'motherly' attention and care. These behaviors, and the transferential projections involved in the alliance, can therefore provide an opportunity for the client to resolve past conflicts with mother, or caring figure; conflicts that might have paralyzed the Skin Ego development during childhood.

From this model, it is suggested that the distorted Skin Ego, through the use of artistic expression and the creative process involved, may heal, or further unfold its potential. The various factors involved in Table 1, precipitating and/or maintaining cutaneous symptoms, are again found in Table 2 but in a more healthy way. The most crucial component found in both tables are 1) the gaze of the other serving narcissistic needs and 2) a tangible and symbolic expression of the internal conflict, as opposed to the use of the actual skin organ.

This "*Visible-Invisible*" dichotomy perspective, therefore, provides a new way to approach and understand cutaneous illnesses, suggesting a possible treatment approach along with the existing medical treatment. The model uses the paper in art therapy as a possible substitute for conflict expression, promoting Skin Ego integration through the use of artistic creation; particularly the Skin Ego functions mentioned previously regarding dermatological diseases, those of containment and traces registering functions. The question at stake in this research concerns this issue: Can art therapy facilitate the healing of psychosomatic skin disorders by offering a "surface" (paper or other artistic

support), seen as a tangible and visible substitute for the skin organ, container of conflict expression? The following case study will attempt to answer that question by verifying and evaluating the suggested model and implicated processes.

This "*Visible-Invisible*" perspective, developed by the author for the present research paper, completes Chapter 2. Now that we have considered the role of the skin organ, the Skin Ego, and the relation between the two, we will look at some of the images produced in the context of art therapy in the next case study featuring Nina (pseudonym for the client).

3. Art Therapy Research – Making the Invisible Visible:

This last chapter covers the research process itself, combining both qualitative and quantitative methodologies, in assessing art therapy as part of psychosomatic skin disorder psychological treatment. The first section addresses the qualitative component of the study, presenting Nina and the images created in the context of art therapy. The Single Case (N=1) Experimental Design, and the various psychometric tests involved, will be discussed in the final part of this chapter, in section 3.2.

3.1. The Research: Case Study - Qualitative Component

This section involves the qualitative component of the research, presenting the case study material. Given the scope and the limitations of this research paper, transferential and counter-transferential material will not be addressed. Reasons for this omission are, firstly, the brevity of the therapeutic relation, and, secondly, and most importantly, the focus of the present research on the suggested model. In fact, the following case study presentation attempts to link the proposed "*Visible-Invisible*" model to certain traits and images Nina revealed during art therapy treatment. The case material presentation and suggested interpretations, therefore, are used to demonstrate the proposed model rather than represent a clinical vignette following a conceptual approach.

Thus, information concerning the participant, the therapeutic framework, as well as some of the images produced in the context of art therapy will be presented. Possible interpretations of these images considering the cutaneous symptoms and Nina's personal issues will be offered. Lastly, the establishment of a parallel between certain aspects of

the images and the discussed functions and concepts found in the proposed model will be discussed.

3.1.1. Presentation: Nina

For the purpose of the present study and to ensure that confidentiality is maintained, the name Nina is used as a pseudonym for the client.

Nina is a 37-year-old woman who has lived most of her life with Atopic Dermatitis, namely eczema. She consults a dermatologist on a regular basis and uses dermatological corticosteroid treatment to ease the cutaneous symptoms. After a second eczematous onset covering all of her body, accompanied by total hair loss, a phenomenon called alopecia, she consulted a psychiatrist and volunteered for art therapy.

Nina has no psychiatric diagnosis but rather has a history of psychosomatic episodes, namely, allergies, asthma, and eczema, known, as mentioned earlier, as the atopic triad. She also had two episodes of "*alopecia areata*", i.e. hair loss due to acute stress or intense emotions, and a known history of depression, namely professional burnout and "post-partum" depression. Given this possible additional clinical concern, which might influence the cutaneous lesions onset, the severity of depression has been measured and will be discussed in section 3.2, regarding the quantitative component of the research.

Finally, Nina displays narcissistic traits, an issue that will be discussed below. It is also worthwhile noting that Nina is a twin. She has a non-identical twin sister who is said to have experienced depression as well.

3.1.2. Art Therapy Framework

Nina was seen in art therapy for approximately 8 months on a once a week basis. A total of 25 sessions were done out of 27 possible encounters. The two missed appointments were because one session fell on a holiday, and this session could not be rescheduled, and the client canceled another session on the same day of the scheduled appointment.

During our first encounter, Nina identified her own therapeutic goals as follows: "to have better control over my eczema, avoid another hair loss episode, improve self-esteem and body image" (free translation from French). Later on, another goal was identified by the art therapist, that is the expression of emotions, as Nina's verbal and non-verbal expression seemed logical and quite rational.

Generally, the method I used in art therapy is non-directive based on a psychodynamic perspective, allowing the client to choose both themes and art media to express him/herself. It is also free of choice to use artistic medium during the session or not. In other words, client's free expression and spontaneity are favored over given themes or suggested format provided by the art therapist.

Lastly, it is important to indicate that throughout art therapy sessions, Nina showed interest in trying and experimenting with the different material and media available in the art therapy room. She often asked for a new medium, creating with oil pastels, water paint, collage, acrylics, or finger paint. This is significant for her willingness to try out new material because it may suggest a possible lessening of ego control when using fluid media, such as finger paint for instance, a medium known for its regressive potential.

3.1.3. Art Therapy Process and Images

Some of the images produced in the context of art therapy will be presented next. Since more than 25 images were collected during the therapeutic relationship, and given the limitations of this paper, a selection has been made, keeping the ones most pertinent to our topic of interest and the model proposed earlier. Indeed, these images have been chosen providing a possible parallel between Nina's profile and words, and the theoretical concepts presented earlier in Chapter 2.

Certainly, the first image produced in art therapy is significant as this is the one image the client consciously or unconsciously uses to introduce himself or herself to the therapist. According to Bénazéraf (1994), cutaneous diseases are « un masque de souffrance donné à voir aux autres » (p.157); and that sufferable and painful mask was spontaneously revealed during the first encounter with Nina.

Indeed, **Figure 1** shows a red face with the eyes looking down. Firstly, Nina did not expect to be experimenting with the art material during the first session. When invited to choose any material and make an image, she kept saying: "I don't know what I'm doing or where I'm going". Drawn spontaneously with dry pastels, Nina first seemed to play with the curves from which appeared eyes and a nose, whereupon the whole face appeared before us. Its red skin displays what Nina called the "core of her problem", that is, a suffering and sad face, her own she says, displaying a red eczematous skin.

When looking at her drawing, Nina talked about the gaze of others onto her skin and her need for people's response. She maintains asking people on a regular basis if they can see the scars or lesions in her face, and consequently, questioned me on that matter.

Figure 1

Within the shame she feels about the cutaneous symptoms, she also senses a need to ask, a need to be seen by others.

Furthermore, she reported, on one hand, having trouble looking at herself in the mirror but, on the other hand, searching for her reflection anywhere and everywhere possible. She further claims needing to look at her image to see if symptoms are apparent. This is how she enters in relation with others, particularly with men, that is, through the visible dermatological lesions by specifically asking others if they can see the lesions. Nina said that her father also worries about her cutaneous symptoms which may suggest the role her father, or her internal image of her father, might have played in the development of her symptoms.

As Nina left the first session, she shared feeling astonished by the unpredictability of art therapy, its format, means, and media.

Figure 1 is important not only because it is the first image done by Nina in the context of art therapy, but also because it displays, as she stated, the "core" of her internal dilemma: wearing a sufferable and visible mask in order to be seen by others, which, by the same token, serves narcissistic needs. Indeed, as Nina's self-esteem and self-appreciation both seem low, cutaneous symptoms assure her attention from others. The same lesions also bring her to look for her image in any reflection she can come across on her path. That vicious circle she referred to during our fist encounter reveals the maladaptive mode in which she enters in relation with others. Uncertain of her self worth, the need to be seen and recognized by others seems to be met through dermatological means.

These same cutaneous lesions, however, may also symbolically serve the opposite purpose. An unbearable psychical pain, which could not be processed or symbolized, takes concrete form onto the skin, at once revealing and concealing the internal invisible conflict. Showing an unequal red skin surface, possibly repulsive and/or shameful in her opinion, may keep the other at a distance. The self-punishing cutaneous symptoms may hence prevent further rejection or hurt since the individual isolates or feels unwanted and undesirable. The individual with psychosomatic skin disorders seems to push away 'the other' whom he/she actually and paradoxically longs for. This dichotomy will be exemplified with the following image (Figure 2).

The important role the gaze plays in skin disorders, as suggested in the '*Visible-Invisible*' perspective (cf. Table 1 and 2), can also be observed in *Figure 1*. In this image, the gaze can be interpreted as her own looking in the mirror, or other people's staring at her skin, or the gaze of a parental figure, possibly in this case, the therapist "watching" her draw. Although it cannot be confirmed whose gaze this drawing reveals, it underlines the "visibility" component of the psychosomatic skin condition, unlike any other forms of illnesses.

Moreover, the blue line behind the eyes could be associated with the father. As we will see, almost all masculine or father figures in Nina's images were colored blue. This suggests that perhaps behind this need for attention from others, Nina may deep inside be longing for her father's gaze. This issue will be discussed below.

Finally, it is worth observing the support used for this image, that is, the paper Nina has chosen. The skin-colored paper she picked was sitting among white blank papers. The

whole picture offers an interesting parallel between her spontaneous movement and her reality. That first image now appears like a mirror image, as if Nina was looking at herself in the paper sitting on the table, facing her reality. Face to face with her internal conflict, Nina begins the art therapy process.

During the second session, Nina painted "*Mise en quarantaine*" [Quarantine] (**Figure 2**) which represents, according to her, the way she often copes with eczematous onset, that is, by shutting herself up into a "bunker". After painting an orange figure representing her, using water paint, she covered it with black paint, creating a bunker over herself, with people (on the right side of the picture) waiting outside for her to come out.

She talked afterwards about her mixed feelings toward eczema. Nina explained how the skin disorder got her precious care from her mother as a child, and therefore more attention than her twin sister, but also made her feel unwanted by others. She openly discussed that "vicious circle" in which she feels stuck, going from isolation to socialization. Between that need to be seen and maintain contact with others, she reveals having low self-esteem and doubts about her body image. Thus, when wearing visible skin lesions, it is a tangible confirmation of her own beliefs regarding her self-image.

This picture also displays the behavioral consequences of skin disorders, as discussed earlier in this study. Nina may isolate herself when cutaneous symptoms appear onto her skin, preventing her from contact with others for which she craves. In other words, eczematous lesions serve both aspects of Nina's pattern in either reaching for attention from the other or preventing further contact by isolating herself.

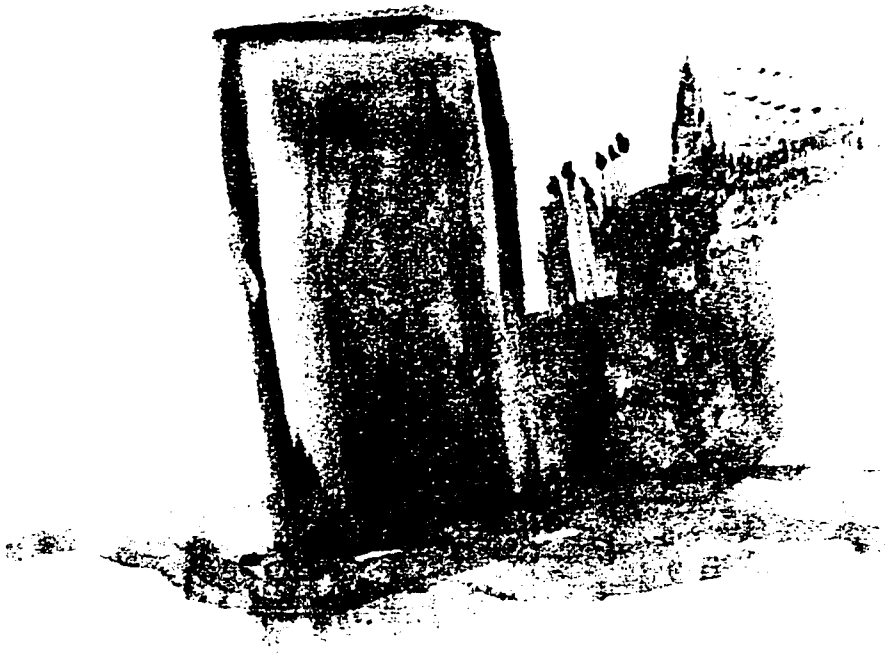

Figure 2

The next image (**Figure 3**) was also done with water-based paint, one of Nina's favorite mediums, during the sixth session in art therapy. This image displays her connection with others where she represents herself as being both the yellow and the red "stars". The three other "stars" depict her two children and male companion, the blue one. Her own two "stars", she further explained, represent her with or without the cutaneous symptoms; the red one being the eczematous self. Interestingly enough, the yellow "star", displaying her without the dermatological illness, is the only one that touches or even reaches for the others, merging the colors together. The different branches of the yellow star, particularly three of them, are painted long enough to touch the other stars of the picture, perhaps demonstrating her need for contacts with others.

Finally, Nina explained the orange and red layers surrounding the five "stars" as being the burning eczematous layer covering her skin. Although the image was painted on the horizontal, it was later turned vertically so to put the yellow star on top, to entitle it "*Mon âme soleil*" (French for "My Shiny Soul"). Nina could not explain why this drawing was her favorite. At the end of therapy, she named this picture as the most significant and positive one of all artistic products created in art therapy.

This image (Figure 3) is important as it touches the relational aspect of psychosomatic dermatological issues. It can be looked at as Nina's skin in a cross section perspective, suggesting an eczematous layer under which lay significant relations and a need to merge with others. This unusual view suggests that if her lesioned and fragmented skin was peeled off, one would find the crucial relational role skin disorders involve. Finally, the title itself suggests a burning sensation in living. The rays of the sun

Figure 3

reach for further contact but that need also symbolically burns her skin, her being, her soul.

Created during the ninth art therapy session, **Figure 4** represents Nina's attempt to express her emotion after breaking up with her boyfriend. Entitled "*Tristounette-Tristesse*" ["Sadness"], the image shows an ensemble of blue circles, painted with tempera, and a red face with an opened mouth on the top right side.

Although this image will be discussed further in section 3.1.4 for its particular title and possible meaning, it is still important to make a few observations. First, an interesting aspect of this image lies in the blue color fading away. As observed earlier, her male figures have often been depicted in blue. Since Nina's relation with her male companion ceased, it is worth noticing that the color too disappeared and that the blue color turned to white during the painting process. The red dots at the bottom may be interpreted as the eczematous stains growing on the skin as a way to cope with the loss. The red face, which can also be seen as a deadly/poisonous face, suggests a coping mechanism displaying red symptoms as a cry for help. Nina did in fact show some eczematous symptoms around her lips that day.

It is during the tenth session that Nina made a collage revealing how she perceives her body (**Figure 5**). The image presents a female body with segmented and cut off body parts added to hers. Nina talked about how people's comments about her body are not "nourishing" enough. She explained seeing herself as body parts that need to be assembled. One day, she says, she can put the healthy arm, the other day, use the one afflicted by eczema. Nina referred to her body as being a puzzle with many pieces that

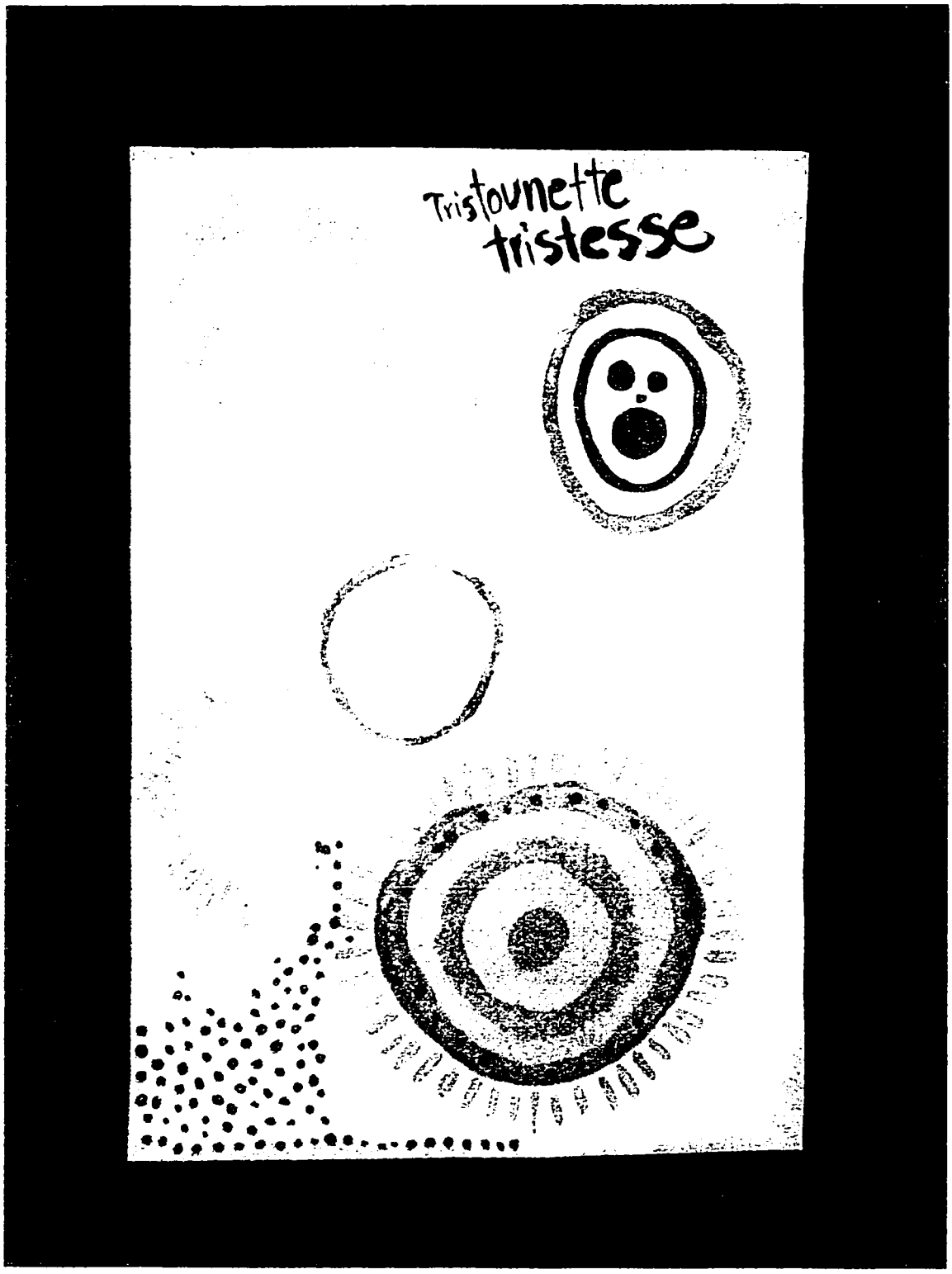

Figure 4

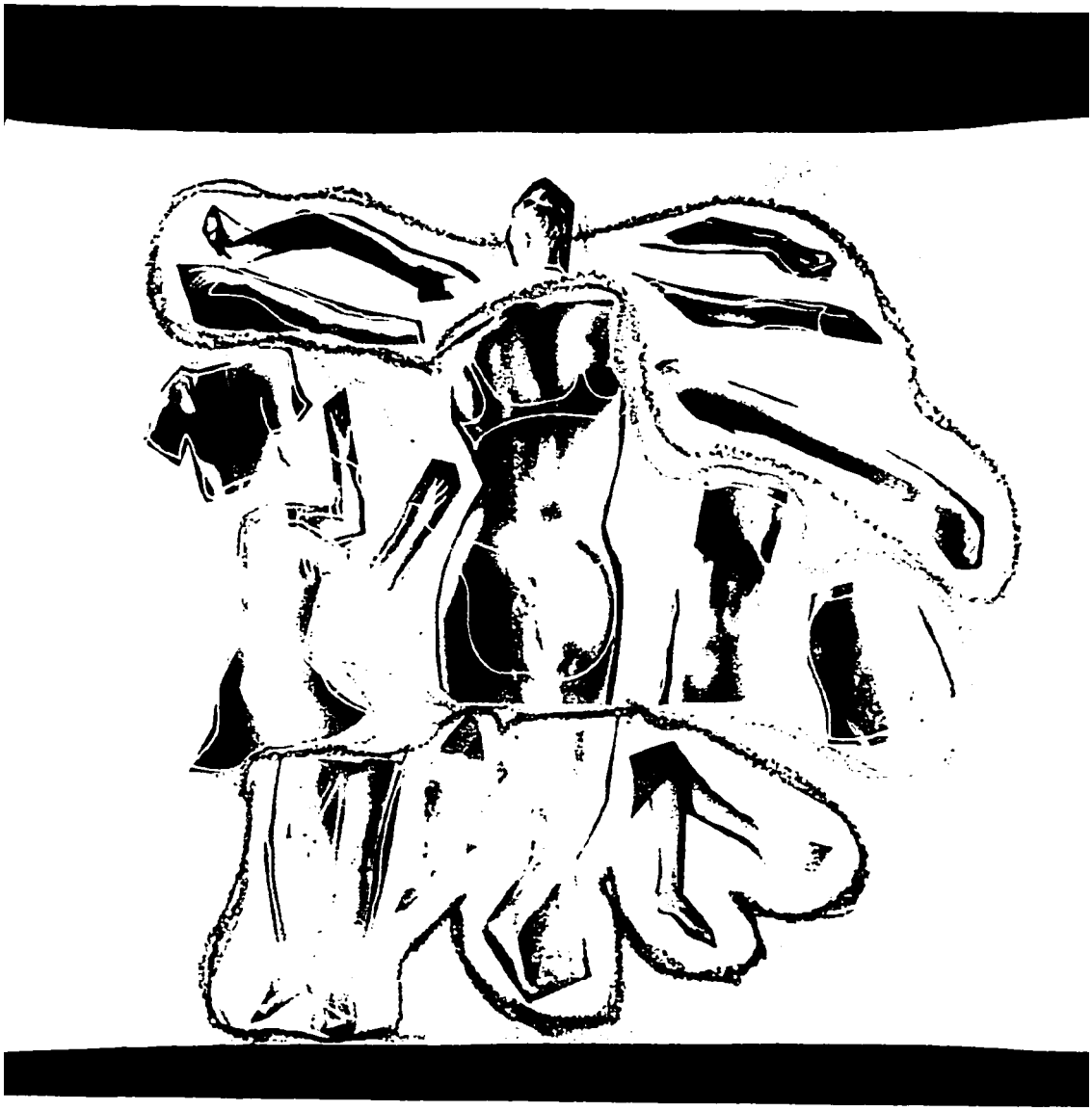

Figure 5

can be fit together. In her opinion, it is a constant physical ache she lives with when referring to her body and body image.

This untitled collage (Fig.5) displays the fragmented nature of her self. Constituted with poor ego boundaries, as suggested earlier for some individuals with psychosomatic skin illnesses, she looks for others to "nourish" her self and body image. The various dissociated body parts may also depict the fragmented container the whole body, and the skin surface specifically, Nina lives in. As the Skin Ego containing function, discussed earlier, may have been disrupted during development, it seems possible that the bodily mental representation never reached its fullest during childhood.

Now as an adult, the whole body feels disconnected and disjointed. The skin does not seem to cover her body as a soothing envelope but rather aches. One can observe, however, Nina's attempt to reassemble the body parts, and hence promote the containing function, by drawing a large yellow contour around the different parts of the body.

As previously mentioned, moreover, Nina is a non-identical twin. This image could be further interpreted as the undeveloped Skin Ego's individuating function. As seen earlier in section 2.3.1, this function helps acquire a unique sense of self, necessary to identify external objects as "other". What this image suggests is that Nina seems to have difficulty defining herself and her body. With a dysfunctional Skin Ego individuating function, if it is the case, it becomes difficult to identify what is "me" and "not-me".

Figure 6 is entitled "*Le monstre*" [The Monster]. Nina drew it with finger paint, which may have the effect of lessening ego control over rising psychical unconscious

material. Painted spontaneously while playing with the media, Nina made three pictures during the session showing her place within the family. In one of these images, she drew her father in blue (**Figure** 7) as the central figure. Within that family portrayal, Nina depicted her mom (small figure on right top), her two brothers (on each side of the picture; note that one is outside family frame as he has been excluded from family reunions) and herself beside her twin sister (small red figure on the right side of the drawing, at the bottom, with a red dot underneath). For confidentiality purposes, the role of the father cannot be detailed but one can clearly see the crucial position the father takes in Nina's life by the character's size.

Figure 6 represents herself, she says, being a monster. The red leathery quality of the eczematous skin is shown in this picture by the reptile-like monster. The monster figure seems ungrounded and also occupies a lot of space on the paper.

When looking at these pictures, Nina's comments about eczematous onsets are revealing. She acknowledges that cutaneous lesions may appear whenever she expects meeting with her father or significant father figure, like her psychiatrist. She recalled having to meet with a male physician who intimidated her; and most certainly, the night before the appointment, the cutaneous symptoms made their appearance.

Another significant image produced during the eighteenth session is a collage on which she worked for over three weeks. The different images were glued and then cut, and glued again on different surfaces of paper. The final artistic product can be seen in **Figure 8,** which contains at the bottom, a red face in the middle of a crowd. Nina

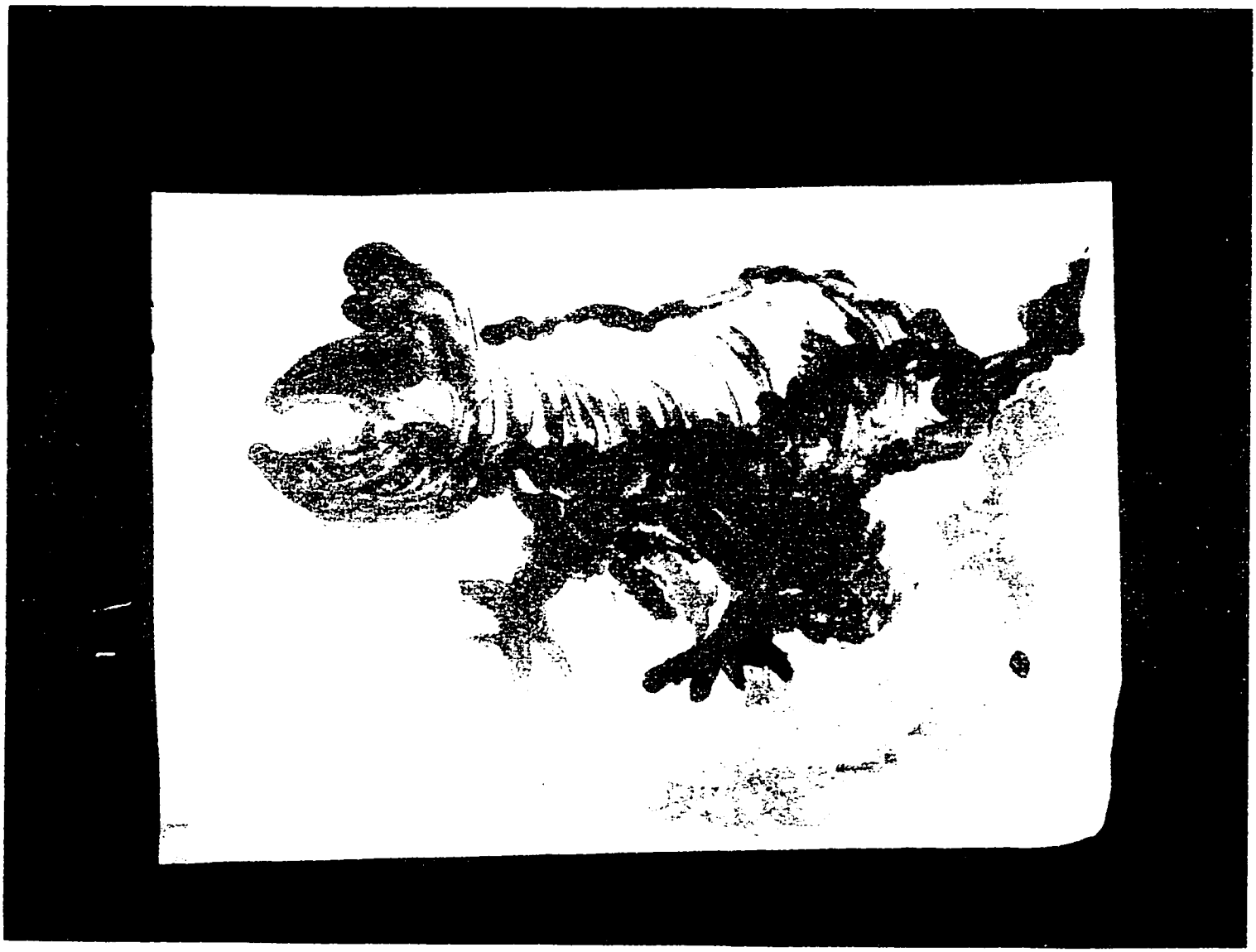

Figure 6

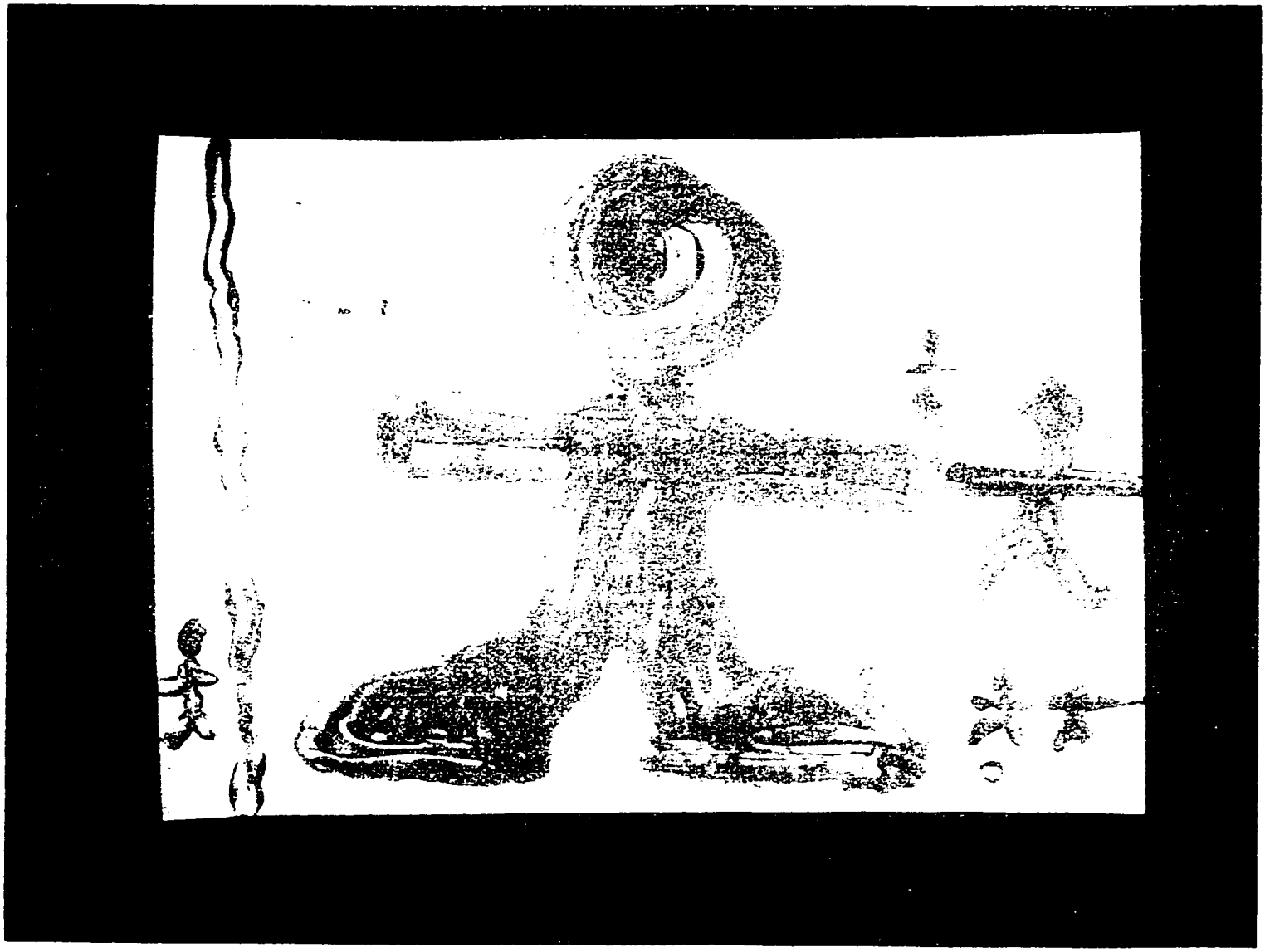

Figure 7

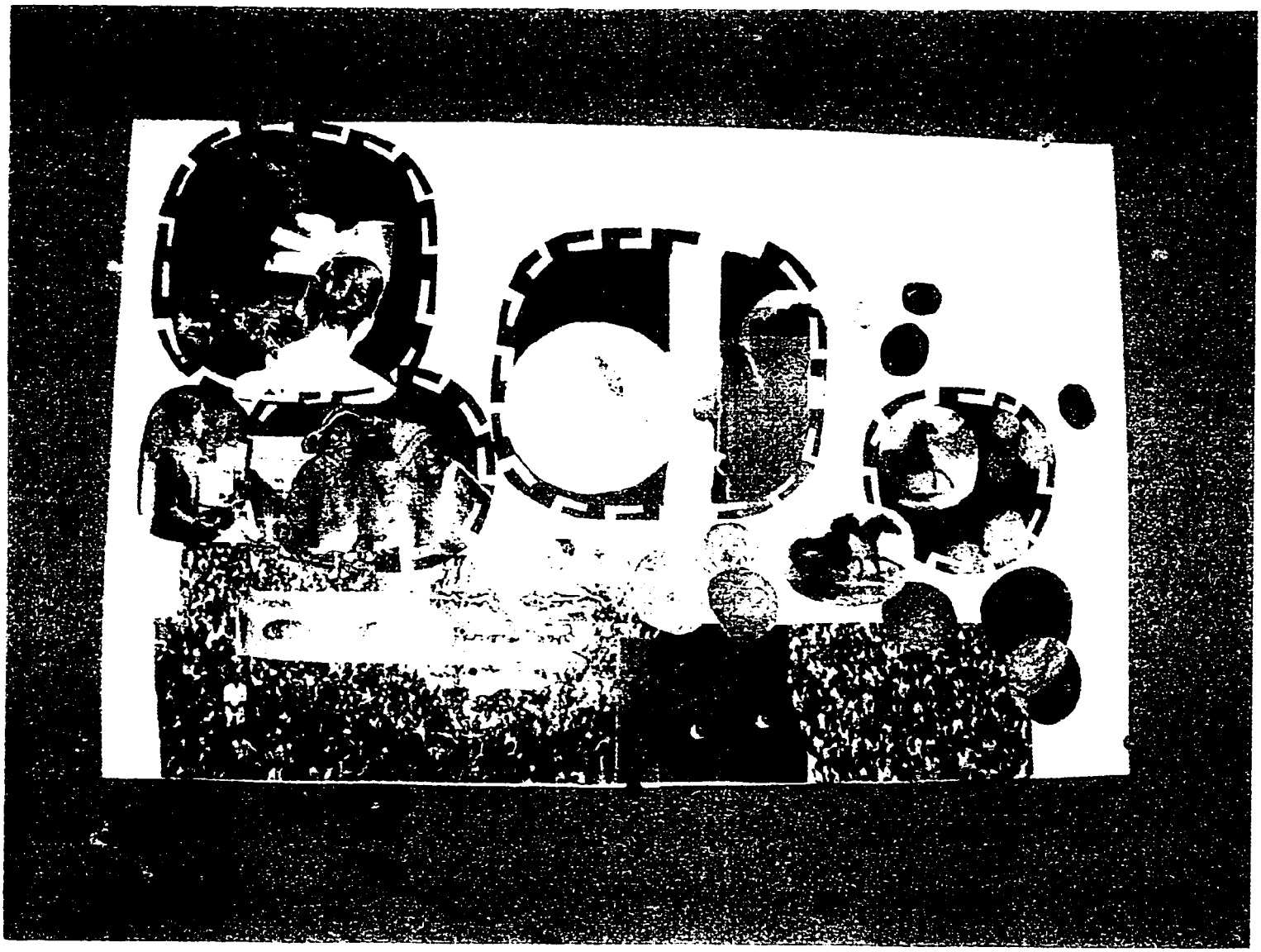

Figure 8

explained that she has to distinguish herself from the mass of people by having red skin. Without a visible distinguishable face, she feels she would remain unseen and ignored.

This image seems important as it reiterates the position presented earlier on the visible aspect of psychosomatic skin disorders. Rather than being "uninteresting", Nina would rather, partly consciously and unconsciously, distinguish herself through a red, visible, eczematous skin. The collage also underlies the importance the gaze plays in skin disorders. The eyes of the red face are tremendously present in the whole picture and, beside it, on the left side of the montage, sits another pair of eyes, a woman's. As discussed earlier in section 2.4, the gaze of others may fulfill narcissistic needs. It was a few weeks later, around Valentine's Day that **Figure 9** was made. Using acrylic and collage art media, Nina tried to display her feelings of loneliness. While working on the picture, she explained how society recognizes and gratifies couples only. Since she is single for the moment, she feels left out and disconnected from people.

The picture of a woman sitting alone at a table with a glass in her hand was taken from a magazine, and glued onto the paper. The red flames surrounding the lonely woman representing herself seem to depict Nina's angry feelings.

Interestingly enough, with her interpretation of the image, Nina mentioned that society at large gratifies couples when in reality it seems to be her parents who place special emphasis on couples. She once shared that her married siblings and their respective spouses received special treatment at the parent's house whereas, when single, she would not. Still, it seems clear in this picture that her anger enflames her being, her skin. Feeling alone and disregarded by people, and perhaps by mother and father, her need for visibility is not being met.

Figure 9

Love, in heart shaped forms on the right side of the painting, reaches for other individuals while she is consumed by red anger. The image remained untitled.

One of the last images created by Nina during art therapy treatment was **Figure 10**. It reveals an eye partially covered in red. Painted almost accidentally, the eye appeared before Nina. It reminded her of the first drawing she had done, the red face (cf. figure 1). As we were heading toward termination, she linked that image to the first one completed in art therapy. She stated that it was like getting closer to the problem because the focus was on one eye, one element of that first image, the red face. She offered two different interpretations for the water painting.

Either, she said, she was getting closer to the problem and hence to her cure, or she was too close to it, blinded by it, and cannot see anything else. Although not necessarily a conscious recognition on the client's part, this observation could be linked to the dichotomous nature of the symptoms: dermatological lesions may hence help keep the other at a distance, other who paradoxically is needed for self-recognition.

The image is significant not only because it is related to the first image produced during the therapeutic relation but also because it seems to further reveal part of Nina's internal conflict. Just as the first image seemed to reveal "the core" of her problem, as she suggested it, this last picture focuses on the eye, the organ necessary to see and be seen.

Although it remains solely speculative at this point to suppose the nature of the internal issue at stake in the case of Nina, given particularly the short duration of the treatment, it seems to point, as seen in the model proposed earlier in the study, towards an emotional issue. When Nina painted the "red eye" (fig.10), she also expressed anger and

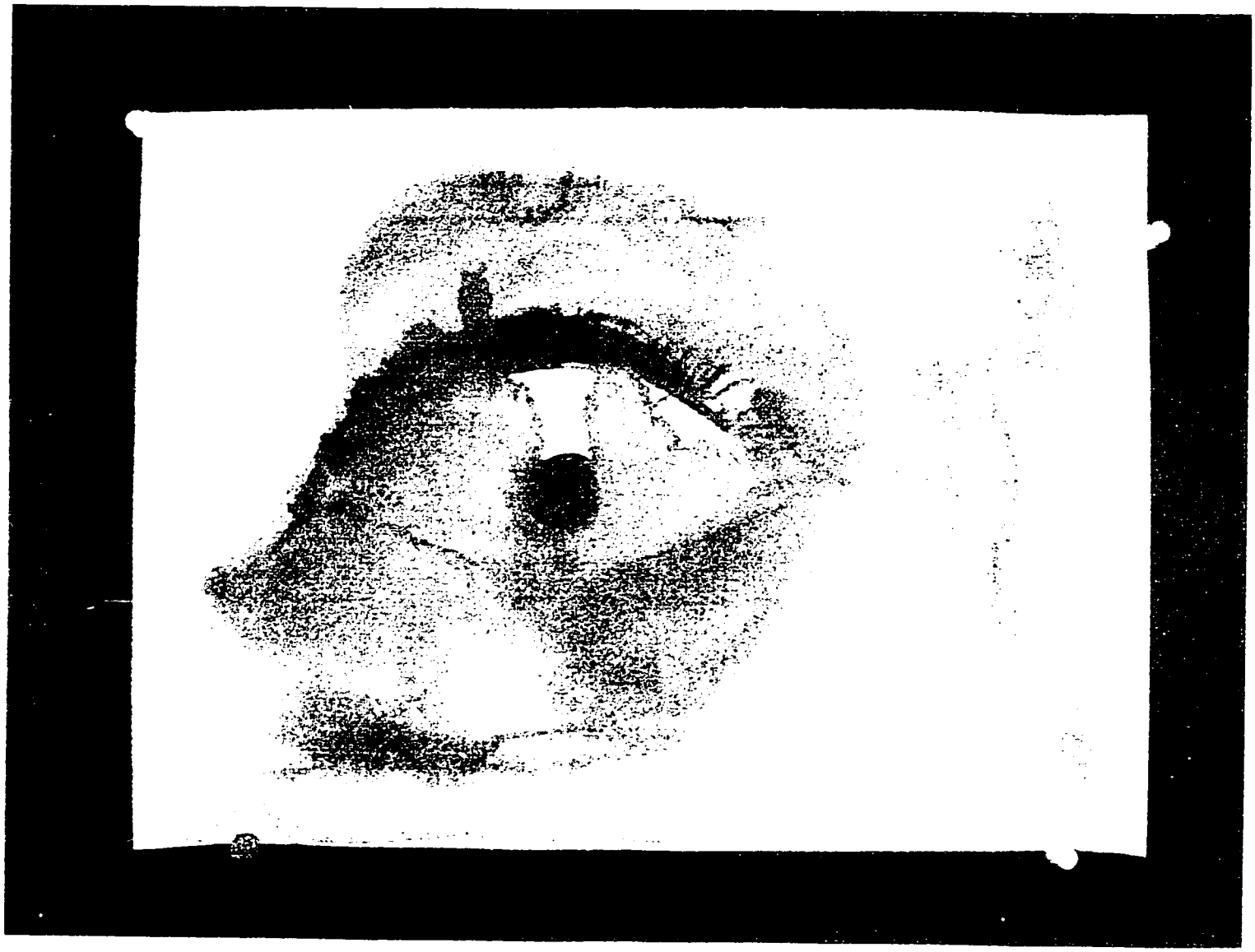

Figure 10

sadness toward the upcoming end of our therapeutic relationship. She said she was feeling abandoned. As Nina feels "abandoned" by termination, she may also unconsciously experience this as a "real" confirmation of her feeling of 'unworthiness'. She may as well feel anger toward the art therapist for being abandoned.

In sum, does this red eye contain the expression of her anger? Is Nina 'seeing red'? Can unexpressed anger also be at the core of the invisible internal conflict, affecting the onset and/or duration of the cutaneous symptoms she lives with? Many possible factors can be related in her dermatological condition. However, in the next section, I will propose two hypotheses based on the model presented earlier.

3.1.4. Discussion: The Invisible Conflict and The Visible Symptoms

As proposed in the "*Visible-Invisible*" dichotomy presented earlier, behind the visible symptoms may lie an invisible often unconscious internal conflict. In the case study briefly described above, two hypotheses may be drawn based on the suggested model.

First, we must recall that Nina is a fraternal twin. According to Proulx-Jodoin (1993) who has researched the concept of the self in drawings of twins, the notion of self, particularly in identical twins, develops later than most children. Thus, within the suggested perspective of the "*Visible-Invisible*" model, this aspect in itself could have affected the invisible part of the self, being the Skin Ego or not. Thus, by expressing its internal conflict through the body, namely in this case, the skin organ, the dermatological symptoms reveal and conceal its presence. If the Skin Ego development was affected, one

could easily hypothesize that the individuating function described above in section 2.3.2 would particularly be involved.

Additionally, on that same aspect, certain individuals with psychosomatic skin disorders may seek to re-establish, on a fantasy level, the fusional bond felt with mother when in infancy. In the case of twins, however, it remains unclear whether the fusion the infant craves is with the mother or the twin partner. This aspect relates to the view of Consoli (1985) suggesting that all infants see his/her own skin as torn apart when separated from mother, or its twin in the present case, with whom he/she shared a common skin.

Nonetheless, as seen in the model (Table 1), an invisible fragmented Skin Ego, as hypothesized in this case, may well disclose itself through the cutaneous illness affecting the skin which is seen by others. It is hence suggested from this model that the gaze of the other onto the cutaneous symptoms seems to bring comfort to the afflicted individual as well as recognition to their internal and external pain and suffering. The gaze may not only 'nourish' the visible part of the self, the body, but may also serve the Skin Ego in need of integration by further developing its various functions. Three of them have been shortly discussed in section 2.3 and will briefly be addressed in the discussion.

A second proposed explanation involves the difficulty Nina had expressing emotions, as observed throughout art therapy treatment. As mentioned earlier, this difficulty may possibly be related to the alexithymic condition discussed in our literature review. To illustrate this point in Nina's case, we will consider *Figure 4* once again. The picture was first entitled, as remaining in the final title, "*Tristounette*" [Little Sadness]. When an observation was made to Nina by the therapist about the title and its "nice"

sound and quality (i.e. not reflecting her harsh reality), she acknowledged having difficulty owning and naming the emotion. Yet, the word "*Tristesse*" [Sadness] was afterwards added to the title, on one hand, maybe showing her willingness to name the emotion at stake at that moment but, on the other hand, her wish to please the therapist.

Consequently, angry feelings were also difficult to own, and name for Nina. Nevertheless, a few images had to do with unrecognized or unexpressed anger she had felt and still feels today vis-à-vis conflicts. For instance, **Figures 11** and **12** are two images created by Nina in a conscious attempt to express angry feelings. As Nina tends to avoid conflicts, and rather promotes and longs for non-confrontational contact with others, many issues remain unresolved, leaving Nina with unexpressed feelings and emotions. The red eye displayed in *Figure 10* may indicate that we are in fact getting closer to the "core of the problem", just as the therapeutic relation was close to its end.

Although it remains solely hypothetical, it is suggested that in Nina's case, unexpressed anger sits at the core of her possible internal conflict which finds expression through the skin. These burning sensations Nina often refers to (as seen in Figures 3, 4 and 9) may well express the internal sensation of angry feelings. As discussed elsewhere[4], many women often seem to turn their anger inward hence displaying depressive states, which are socially more acceptable for women, rather than revealing their anger. Although the suggestion belongs to a hypothetical domain, Nina's medical background of depression also supports the hypothesis.

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[4] Anger-sadness mixed emotional response in women can be found in Marchand (2002).

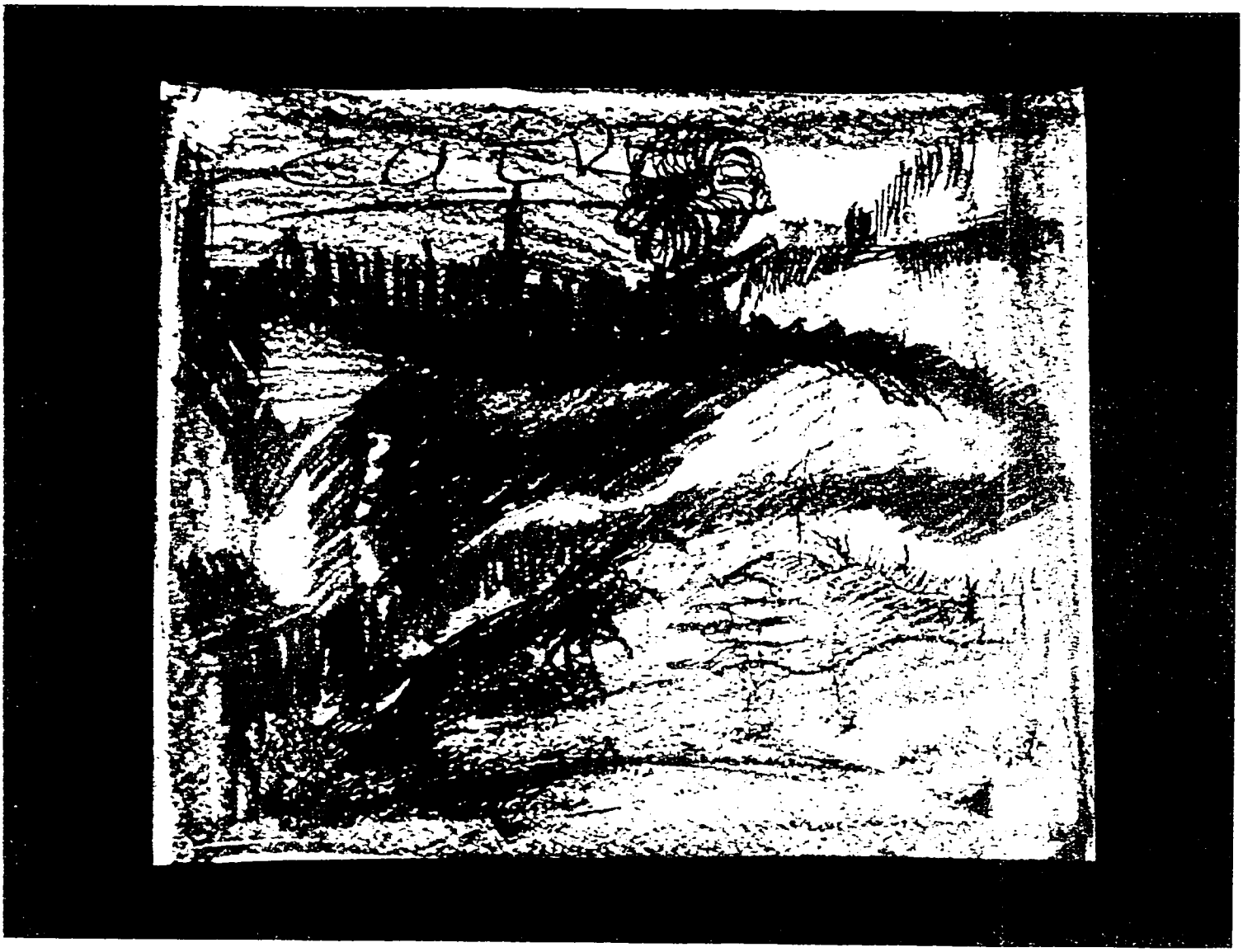


Figure 11

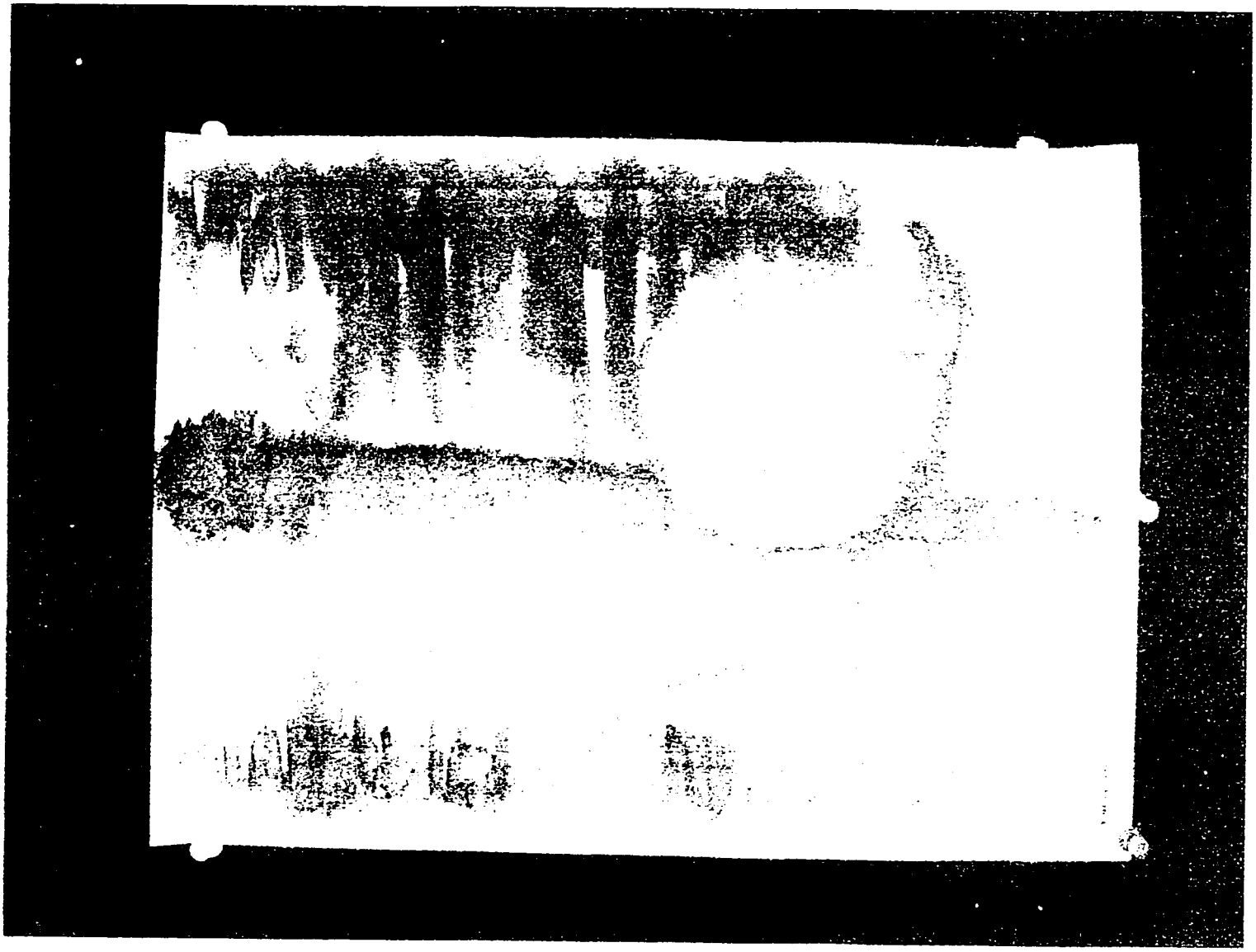


Figure 12

If unexpressed anger is at the core of the internal conflict, and following the "*Visible-Invisible*" perspective, it would suggest that the emotion finds its *expression* through the cutaneous disease to the outside world. The burning sensations felt by Nina, and well depicted in her images presented earlier, also burn the skin leaving it red and enflamed. The gaze of the other may play a soothing and healing role as it recognizes the pain, being both internal and external, serving at the same time narcissistic needs.

In sum, various issues may be involved affecting the eczematous condition Nina lives with. Besides the allergic predisposition she seems to possess, the atopic triad discussed earlier (asthma, eczema, and allergies), it may also be the case that unexpressed anger sits at the core of her invisible internal conflict, contributing to the onset and/or duration of the cutaneous symptoms.

Following the "*Visible-Invisible*" model (Table 2), therefore, art therapy should have contributed to the release of internal tension and conflict by allowing a new path of expression. In order to verify the model and suggested healing potential, measures of different variables, which are thought to be involved in Nina's case, have been taken and compared before and after art therapy treatment process.

The following section of the research paper, the quantitative component of the study, will focus on measuring the impact, if any, of the art therapy treatment on Nina and her cutaneous symptoms. By doing so, the research question stated at the beginning: 'Can art therapy be beneficial for individuals, like Nina, living with psychosomatic skin disorders?' will be addressed.

3.2. The Research: A Single Case (N=1) Experimental Design – Quantitative Component

The following section will discuss the quantitative component of the present research following a Single Case (N=1) Experimental Design. The dependant variables include depression and anxiety, using well-established tests: the Beck Depression Inventory (BDI) and the Anxiety State Traits Assessment (ASTA) (APA, 2000). The self-reporting questionnaires Millon Clinical Multiaxial Inventory - III (MCMI-III) and the SF-36 Health Survey were also used to further assess, respectively, the clinical personality style and main personality traits, as well as the subjective experience of the participant's health (APA, 2000).

3.2.1. Hypothesis

It was hypothesized that art therapy would be beneficial for patients with psychosomatic skin disorders and, hence, could have a positive impact on anxiety level. As mentioned earlier, the anxiety level has been related to the onset and duration of cutaneous symptoms (Picardi & Abeni, 2001).

Because the client had a known background of depression, the Beck Depression Inventory (BDI) was also administered to verify if she was clinically depressed during art therapy treatment. If the Pre-test rating indicated depressive tendencies, it was hypothesized that art therapy would decrease the severity of depression in the post-treatment assessment.

3.2.2. Methodology and Tests

The tests used in this research involved the Beck Depression Inventory (BDI), the Anxiety State Traits Assessment (ASTA), the Millon Clinical Multiaxial Inventory - III (MCMI-III), and the SF-36 Health Survey. These questionnaires are known as reliable and valid clinical tools used as self-reports of one's mental and physical health (APA, 2000). They are generally used with adults and are self-administered; involving no other person while the individual fills them out, minimizing, therefore, possible external bias.

3.2.2.1. Pretest-Posttest Design

The methodology used in this research involved a Pretest-Posttest experimental design. Each of the tests was administered before and after the therapeutic treatment, which consisted of a total of 25 art therapy sessions over an 8-month period.

3.2.2.2. Data Collection

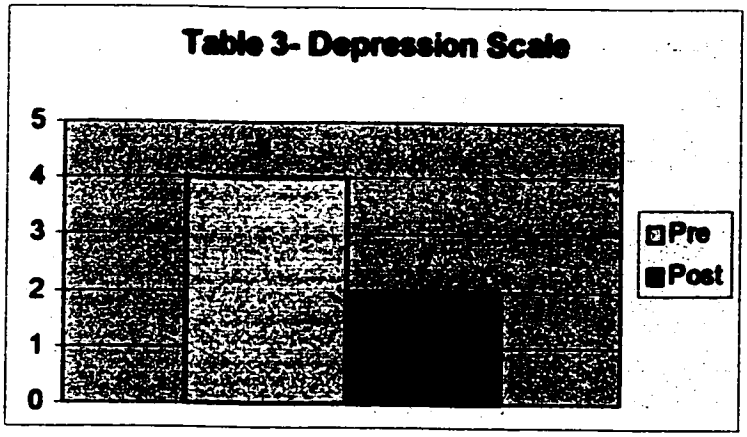
In order to minimize internal bias and avoid confusing and misleading roles of the experimenter, who is also the art therapist, the tests were administered and collected by the referring psychiatrist. The results were compiled by the psychiatrist and peers, assuring objectivity and neutrality in data collection, processing, and interpretation.

The researcher and art therapist in this study remained blind to the results, both Pre and Post, until weeks after completing therapy with the client. This assured that no knowledge of the participant's responses to the different tests could influence the course of art therapy, its approach and the identified therapeutic goals.

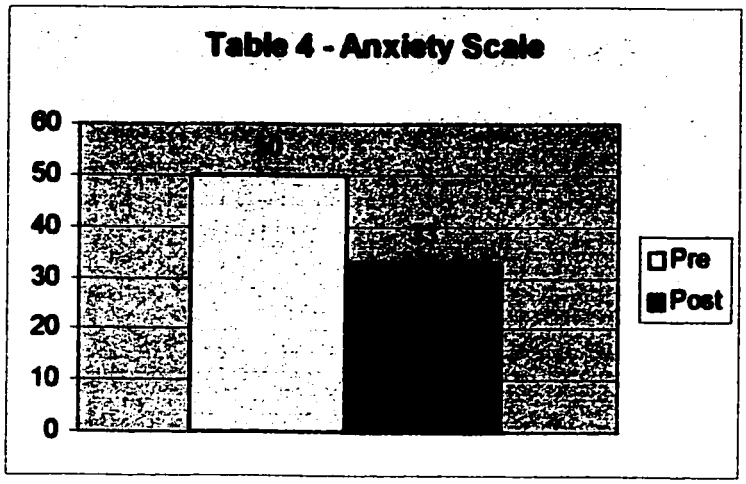
3.2.2.3. Data Analysis and Results

The data gathered from the Beck Depression Inventory (BDI), the Anxiety State Traits Assessment (ASTA), the Millon Clinical Multiaxial Inventory - III (MCMI-III) and the SF-36 Health Survey will now be addressed, analyzed and interpreted.

First, in the Beck Depression Inventory (BDI), which is used to assess depression severity, the pretest result was a 4 whereas post testing indicated a score of 2, as seen in **Table 3**. Given that a score of 14 is necessary to confirm a depressive state, these results indicate the absence of depression. In other words, it appears from the BDI that the client did not clinically suffer from depression neither before nor after art therapy treatment. This result indicates that even though the participant had had episodes of depression in the past, the depressive state was absent at the time of the art therapy treatment, relating the issues observed to the psychosomatic condition more specifically. Nevertheless, the small depressive tendency observed in the pre-test phase still showed a decrease following art therapy treatment although no direct causation could be concluded.



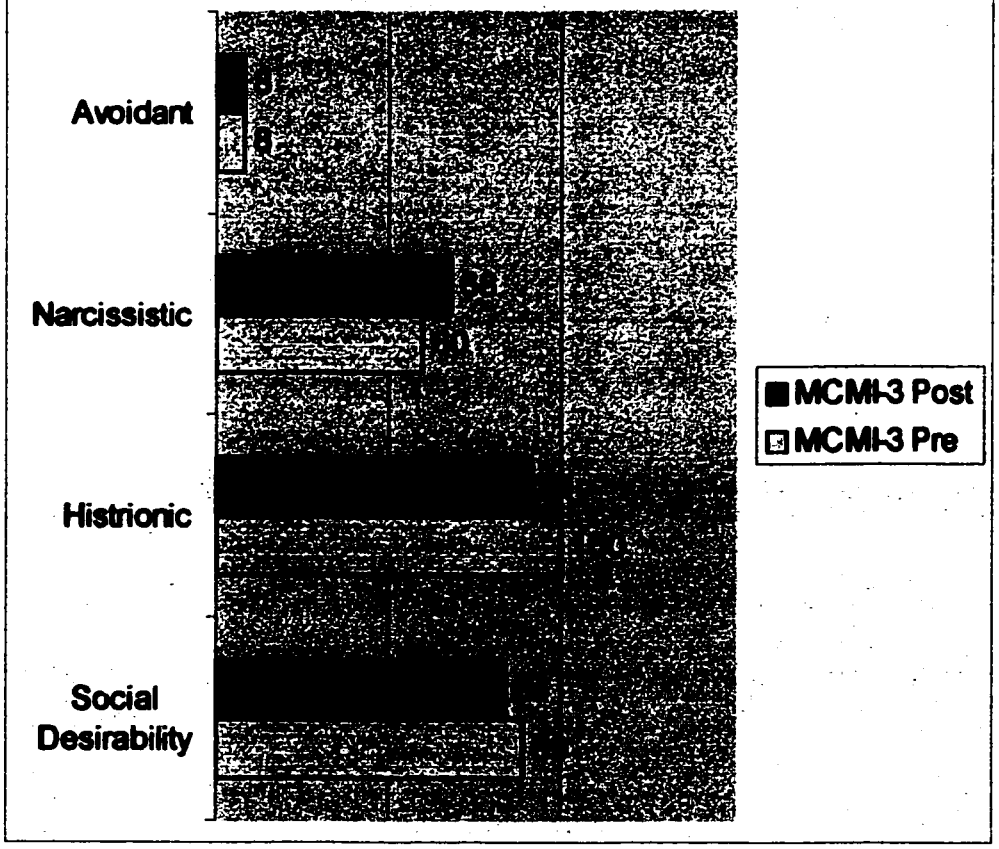
Another variable measured during this research was anxiety level. In this case, the Anxiety State Traits Assessment (ASTA) was used to evaluate and quantify anxious propensity of the individual. Given the gathered data, the results are interesting. As seen in Table 4, a score of 50 was obtained during Pre-test whereas Post-test measure indicated 33. These results indicate a **significant** decrease of the anxiety state, moving from 89 percentile to 48 percentile within the same age group. This decrease of anxiety is considerable as the anxious state leaves disorder level.



Again, although no direct causation can be established, there is a strong relationship between a decreased level of anxiety with the course of art therapy treatment. In other words, art therapy treatment contributed to this significant decrease of anxiety. More investigation would be needed in the future to isolate the treatment from the others. It is worth noting, however, that besides art therapy, it seems to be the case that the participant has maintained the same medical treatment throughout this study.

Thirdly, the Millon Clinical Multiaxial Inventory - III (MCMI-III), which was developed to evaluate personality styles based on Millon's theories of personality and pathologies, consists of true-false self-report questionnaire providing scores for 24 different scales. Within a range of 0 to 120, scores between 75 and 84 indicate the presence of traits, whereas scores of 85 and higher denote disorder status. Given the enormous quantity of data available through the use of this test, only the scales pertinent to the case, and the topic of research, are shown in **Table 5**.

Table 5- MCMI-III Clinical Features

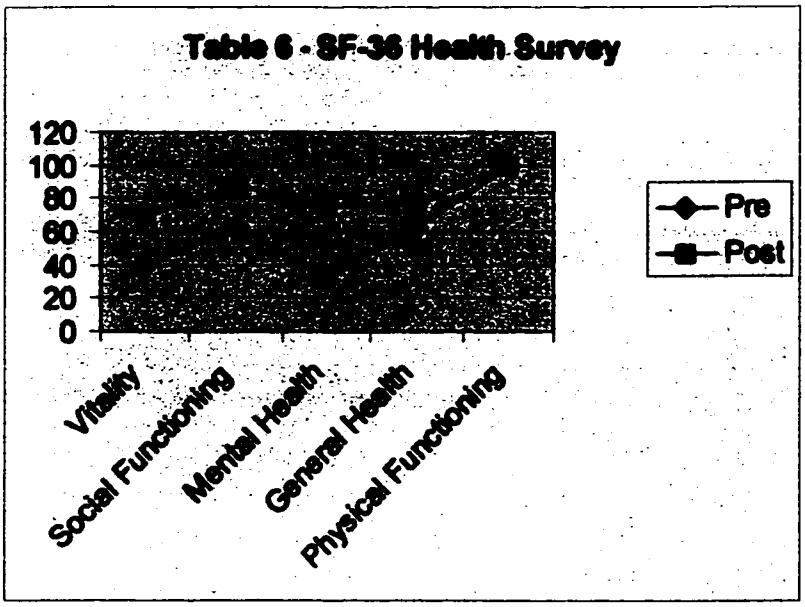


This test showed interesting trends, although statistically non-significant. *Social desirability* decreased from 89 to 84 (on a scale of 120). The score still remaining above

75 confirms the presence of the trait. This result is congruent with the position presented throughout the present work, that is, relational factors being at the core of psychosomatic skin disorders, like atopic dermatitis.

From the chart, we can also see that narcissistic tendency increased at posttest whereas social desirability and histrionic traits decreased, although in a non-significant manner, after art therapy treatment. The increase of narcissistic tendency may be due to the increase of attention received during art therapy treatment. But this explanation remains hypothetical at this point.

Finally, the results from the SF-36 Health Survey are shown in **Table 6**. What this test suggests is an increased functioning in perceived health status. Indeed, SF-36 Health Survey has been developed to measure subjective perception of the participant's health status. The self-report contains 36 different items forming 8 health related concepts scales. Those are physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional, and mental health.



On a scale of 100, indicating better health status perception, the gathered results indicated no changes in physical functioning, role-physical, bodily pain and role-emotional since the participant scored 100 in both instances. The other categories, however, are displayed in Table 6, demonstrating a significant increase in vitality, social functioning and mental health perception.

In fact, on the SF-36 Health Survey, vitality scores went from 40 to 70. Social functioning increased from 62.5 in Pretest to 87.5 in Posttest. Finally, the mental health scale doubled at Posttest assessment, going from a Pretest score of 32 to a Posttest score of 76

These SF-36 Health Survey results suggest that art therapy may have contributed to the participant's subjective health perception status, feeling more vitality and more healthy both physically and mentally after art therapy 8-month treatment.

3.2.3. Discussion of The Results

Overall, these results, although they cannot be generalized, indicate that art therapy may have been beneficial, alleviating Nina's symptoms and contributing factors. Not only did anxiety level decrease significantly, but the participant rated statistically higher on subjective perception of 1) vitality and 2) mental health.

Additionally, according to the participant's dermatologist, no consultation occurred during the art therapy treatment. In other words, it is believed that the participant's cutaneous symptoms were somehow controlled or in remission while doing art therapy. However, it is unknown at this point if the participant went to see another physician after more than 14 years with the referring dermatologist.

On the other hand, it appears from the different data gathered through the quantitative measures that other unexpected variables were involved. For example, histrionic traits rather than narcissistic ones, appeared at disorder level in both testing. Although narcissistic tendencies were confirmed with the use of MCMI-III, its score remained at traits levels (e.g. between 75-84) rather than disorder level (e.g. 85 and higher).

On that same scale of the MCMI-III, aggressive tendencies increased from 24 to 36, perhaps as suggested in the case study presented earlier, attributed to the angry feelings that may be at the core of the participant's invisible internal conflict. This interpretation however is only speculative at this point.

Although these tests results are overall interesting and significant, they cannot be generalized to other individuals with skin illnesses. They are used to provide a better picture of distinct personality traits and tendencies that may be involved in psychosomatic skin disorders such as social desirability, and narcissistic and/or histrionic tendencies. These data also tend to support the "*Visible-Invisible*" model presented in section 2.4, suggesting that art therapy may be beneficial for individuals with psychosomatic skin disorders. This issue will be discussed thoroughly in the following discussion and conclusion.

Further research is nonetheless necessary to assess art therapy as a treatment component for psychosomatic skin illnesses. Future research could extend the investigation by assessing the participants' main traits and anxiety levels before, during, and after treatment, adding follow-ups at 3 and 6 months, after art therapy treatment has

ceased. Such research could better evaluate the impact art therapy might have on individuals who live with dermatological illnesses, such as Atopic dermatitis. Finally, future research should include self-reports by the patients about his/her perception of the usefulness of art therapy. These additions would allow better assessment of art therapy impact on psychosomatic condition and symptoms.

This quantitative component of the study completes the research process. The following section will conclude the research paper by discussing the issues involved in psychosomatic skin disorders and the Visible-Invisible model developed for this investigation.

Conclusion and Discussion

This research paper attempted to assess the use of art therapy with an individual who lives with the skin disorder Atopic Dermatitis, generally called eczema. Combining qualitative and quantitative methodologies, a case study material as well as a single case (N=1) experimental design were used in this research.

As proposed in the brief review of the first chapter, illness is not just an isolated event, but may rather be a form of communication. The skin organ, with its complex physiological and social functions thoroughly reviewed in Chapter 2, can also fulfill an important communicative role, as it is an organ of expression and contact which enters into relation with others.

Since it is believed that some individuals with psychosomatic diseases may have difficulty expressing emotions, a condition known as alexithymia, it was suggested in this paper, that words and emotions may be intimately involved in dermatoses, as they may have both remained unexpressed. The skin, when afflicted by dermatological lesions, may hence be sending coded messages to the external world.

As suggested throughout this research, the *expression* of an invisible emotional internal conflict may be at the core of psychosomatic skin disorders. Although it is recognized that biological factors do play a role in many illnesses affecting the skin organ, psychological and emotional factors contribute to the onset and/or duration of the symptoms, as in the case of eczema.

The present research paper is an attempt to answer the following question: Can art therapy facilitate the healing of psychosomatic skin disorders by offering a "surface" (paper or other artistic support), envisioned as a tangible and visible substitute for the

skin organ, container of conflict expression? Considering the qualitative and quantitative aspects of the research, the answer to that question is twofold.

Firstly, the "*Visible-Invisible*" dichotomy model was presented, based on both the skin organ and some aspects of the Skin Ego, concept introduced by psychoanalyst Didier Anzieu (1985). Developed by the present author and presented in section 2.4, the "*Visible-Invisible*" model suggests the possible "integration" and healing of both the skin and Skin Ego through the use of art therapy. Based on this model, it was hypothesized that art therapy may be beneficial for individuals with psychosomatic skin disorders as it allows new form of expression. Indeed, visible and tangible artistic products can become a substitute for skin surface expression. In other words, by making a symbolic link between the skin organ and the paper, or any other tangible media used in art therapy, the client's expression may find its mean, that is its visibility in concrete material.

The art object can hence be compared to the skin organ as they *may* both bare symbolic meanings and contain 1) the emotion, and 2) the invisible internal conflict of the client. The paper, just as the skin and Skin Ego, can hence, in the context of art therapy, play a "containing" role as well as one of exchange. Just as Anzieu (1985) had proposed that function for the Skin Ego, we can further suggest that the medium paper in the context of art therapy will also allow and promote 'Traces Registering' function. Indeed, it is believed that all three functions mentioned in this research, 'Containing', 'Traces Registering' and 'Individuating', have been promoted in art therapy.

The first one can be seen through the use of tangible material able to 'contain' the emotional expression. The paper thus receives and holds the emotional expression of the client. The 'Traces Registering' function can be promoted, in the context of art therapy,

by the nature itself of the treatment. Indeed, the art product, the images and their content provide new opportunities for 'traces making'. The art object may leave permanent traces and become a concrete and tangible testimony of the individual's expression. The uniqueness of all artistic products, finally, further demonstrates and promotes the Skin Ego 'Individuating' function.

As suggested in **Table 2** (p.37) of the "*Visible-Inisible*" model, the art product rather than the cutaneous symptoms becomes the object of focus and exchange between the client and the art therapist. The artistic mean provides a new opportunity for the client to express him/herself and, possibly, heal from unresolved issues from the past. It also serves the Skin Ego 'Individuating' function.

Secondly, based on the results obtained in the quantitative component of the study, it seems possible to conclude that art therapy may be beneficial for individuals living with psychosomatic skin disorders. Although the results cannot be generalized to a larger population, they indicate a significant difference between the Pre-test and Post-test ratings.

Most importantly, the anxiety level decreased significantly from its initial measure, following the 8-month treatment. Since anxiety is thought to affect the onset and/or duration of cutaneous symptoms, this result indicates a possible relationship between art therapy treatment and anxiety decrease.

The participant, furthermore, rated subjective perception of mental and physical health higher in the Post-test. In other words, the individual involved in this study felt better after art therapy treatment than before entering the therapeutic relationship. Again,

although no direct causation can be attributed to the art therapy treatment alone, the results indicate a strong relationship.

Although the personality and clinical traits concern solely the individual involved in this case study, the presence of narcissistic traits reiterates the position taken in the theoretical and conceptual perspectives. As seen in the "*Visible-Invisible*" model, dermatological lesions may also serve narcissistic needs. However, more research would be needed to account for the strong histrionic tendency measured.

On the other hand, the research question cannot be fully explained, as it remains unclear if and how the participant benefited from the treatment. Although we know that the participant did not have serious eczematous onset and/or "*alopecia areata*" during the 8-month art therapy sessions, as it occurred in the past, the research was not designed to directly ask the participant her impressions and overall evaluation. Future research could overcome this limitation by including semi-structured interviews, for instance, assessing cutaneous symptoms onset as well as overall evaluation.

In sum, art therapy appears to be beneficial for individuals with psychosomatic skin disorders as the treatment seems to have an impact on anxiety and other confounding factors. More research is needed, however, to identify how it affects the individual.

Still, the use of a single case experimental design potentially offers more information as the various tests involved, being the Beck Depression Inventory (BDI), the Anxiety State Traits Assessment (ASTA), the Millon Clinical Multiaxial Inventory - III (MCMI-III) and the SF-36 Health Survey, provide some clinical and quantitative data not only supporting the clinical traits involved in psychosomatic skin disorders but also indicating the benefits of art therapy.

Finally, the "*Visible-Invisible*" perspective presented in the present research paper seems to find limited support in both qualitative and quantitative aspects of the research. The model suggested a possible tangible substitute in art therapy for the conflict expression, rather than through somatic symptoms. Even though the model needs further development and testing, its theoretical framework seems consistent with the results found in this study as well as the images created by Nina (pseudonym). Further investigation would allow developing the model and its components, in an attempt to explain psychosomatic skin disorders and the role art therapy can play in treatment.

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Appendix 1

Formulaire de consentement/Consent Form

Je, soussigné(e) _____

I, the undersigned _____

autorise/*authorize*: Mme. Sylvie Marchand

	OUI/YES	NON/NO
à photographier / *to take pictures*	❑ oui	❑ non
à filmer / *to film*	❑ oui	❑ non
à enregistrer / *to tape-record*	❑ oui	❑ non

tout matériel produit dans le cadre des sessions d'art-thérapie et à les utiliser à des fins éducatives et/ou publications futures et ce, tant que des précautions raisonnables soient prises pour conserver l'anonymat.

any material done during art therapy sessions and to use them for educational purposes and/or future publication, given that sufficient measures are assured to protect the confidentiality.

J'émets cependant la/les restriction(s) suivante(s):

I made, however, the following restrictions:

_____

_____

_____

Signature: _____ **Date:** _____
client(e)

Signature: _____ Date: _____

(parent ou témoin si nécessaire)