Art Therapy Online: ATOL

Benefits of Art Therapy for an Adolescent living with HIV/AIDS

Sarah Soo Hon and Christine Kerr

Abstract

Universally, the diagnosis of HIV generates physical, psychological and social impairments. Throughout the literature, patients speak of experiences of stigmatization and isolation caused by this diagnosis. This article explores some of the benefits of a brief art therapy experience with an adolescent girl living with HIV in Trinidad/Tobago where art therapy is a new form of treatment. Art therapy was carried out by a trainee art therapist during her graduate clinical training. Although brief, the art therapy provided a safe, supportive environment for the client who was enabled to become more connected to her emotional response to her diagnosis, and to begin to decrease her social isolation. The paper provides an overview of the history and background of HIV/AIDS, with a focus on the context in Trinidad and Tobago, and the impact of HIV/AIDS on children and teenagers. It suggests that engagement in art therapy can be enabling for children and adolescents with this diagnosis.

Key Words: HIV/Aids, adolescent, art therapy, brief art therapy, Caribbean.

Introduction

Emily

I became involved in the brief treatment of this young woman during my clinical graduate art therapy training. Under the supervision and guidance of Dr. Christine Kerr, I completed a portion of my graduate clinical training in my native country, the Republic of Trinidad and Tobago. As I documented this clinical experience with Dr. Kerr, I began to further understand how art therapy might therapeutically benefit the artistic self-expression of a young woman with HIV.

When I returned to complete my graduate training in the United States, Dr. Kerr and I both felt that this therapeutic encounter would be important to report, noting that this clinical experience had been not only, important for this client but also, relevant for the practise of art therapy in The Republic of Trinidad and Tobago. Art Therapy is entirely new to this country.

At the time these sessions were held, I was an art therapy intern at a residential facility for individuals who were minors, diagnosed with HIV/AIDS. Emily was in her mid-teens, diagnosed as being HIV positive. When I met Emily, she was simply dressed. She did not smile often. Her parents had died of HIV/AIDS. She had no social supports, other than the current staff and her peers. She was quiet and reflective in nature. I had been offered an opportunity to work with Emily on a short-term basis. The treating staff had hope that through the arts she might be willing to open up more fully about her diagnosis. She had become more withdrawn over the months. We agreed to begin art therapy sessions. I thought that making art might be suitable for this young woman, noting the culturally strong traditions of this nation's love of the arts and performance art traditions. In my judgment, my main goals in working with Emily were to establish a safe environment, in order to engage both her verbal and artistic expressions. I endeavoured to help her to understand her own thoughts and feelings related to living with HIV in Trinidad and Tobago.

Initially in this article, it is relevant to acquaint the reader with the medical dimensions, both the etiologic and biological aspects of this devastating diagnosis. In both my past and current work in Trinidad as an Art Therapist, I hear repeatedly, patients speak poignantly about their experiences of stigmatization and isolation caused by this diagnosis.

Secondly, this article will address the psychological and socio-economic issues that directly result from HIV/AIDS. To date, in Trinidad and Tobago there is still a prevalence of stigma and discrimination attached to this diagnosis.

Concomitantly, it is also relevant to describe the gender and cultural issues surrounding HIV/AIDS in Trinidad and Tobago, including the challenges faced by children with this diagnosis.

The final focus of this article will explore some of the benefits of a brief art therapy experience for an adolescent female living with HIV in this Republic. I began these sessions wondering would Emily begin to engage with others? Would she begin to feel less hopeless? Would she begin to understand her illness? This is Emily's story. In looking at her art making, her story begins to be narrated through the lens of our cultural traditions.

History and Background of HIV/AIDS

Medical dimensions of HIV

Until the early 1980s, the epidemic known as acquired immunodeficiency syndrome or AIDS was largely unknown to scientists and the general population. The epidemic emerged in North America, within the homosexual community. According to Goudsmit (1997), homosexual males became ill with infections and tumours. The early onset of this disease was deadly. A virus was identified and then later observed in males, which resulted in an aggressive tumour, which caused lesions that spread upward on the body.

Physicians eventually realized that the development of these lesions caused impairment of the immune system. This compromise of the immune system resulted in the development of infections and tumours in patients. Furthermore, immunodeficiency was marked by the rapid decline of T-helper cells, which contain a molecule that assists in fighting off infections.

Between 1982 and 1983, Françoise Barré-Sinoussi, Jean-Claude Chermann, Luc Montagnier, and colleagues from the Institute Pasteur of Paris (Goudsmit, Ibid.) discovered the virus in a patient who had not yet developed AIDS, but had the same virus as patients with AIDS. This virus was soon known as human immunodeficiency virus (HIV). The medical community hypothesized that the impairment was not inborn but acquired. This led to the condition being referred to as; acquired immunodeficiency syndrome (AIDS).

Etiology

Researchers, in dealing with this unknown epidemic considered how patients had acquired the disease. The US Centre for Disease Control found that AIDS had been transmitted through sexual contact. However, when AIDS was later observed in haemophiliacs and intravenous (IV) drug users, means of transmission were extended to include blood. This information suggested that the transmission of AIDS resulted from an infectious virus.

The discovery of the transmission process of HIV assisted researchers in understanding the development of AIDS as caused by a gradual, but severe weakening of the immune system. Viruses, unlike other infectious agents such as bacteria are parasitic by nature, and require a host in order to reproduce. HIV operates in the human body through entering T-helper cells and defender cells, which are used by the body to recognize infections and alert fighter cells. HIV ensures its survival by attacking the immune system, and enabling other infections, to thrive within the body and pose serious threat to the individual's health.

Biological Dimensions of HIV

Since its discovery in the 1980s, many researchers have examined the clinical progression of HIV infection in a range of individuals. The progression of HIV infection can been measured according to the patient's CD4 lymphocyte count (Pedersen et al., 1989; Havlir and Richman, 1996; Spira et al., 1999), which reduces as HIV infection progresses to AIDS.

In a study by Pedersen et al. (1989), clinical signs of acute HIV infection included oral thrush, trunk rash and herpes zoster (shingles), which all last for at least three days. Additional symptoms of primary HIV infection include fever, sore throat, dry cough, diarrhoea, weight loss, and arthralgia (joint pain). The study concluded that disease progression, indicated by CD4 lymphocyte count, was significantly associated with the duration of symptoms. Furthermore, progression of HIV infection was associated with the appearance of opportunistic infections such as pneumocystis jiroveci pneumonia, and oesophageal candidiasis.

Another study (Havlir and Richman, 1996), considered the reproduction of HIV in plasma, and peripheral blood mononuclear cells as infection progressed within patients. According to this study, the onset of primary HIV infection was associated with rapid multiplication of infectious units of HIV within an individual, which seemed to approach or exceed the number of units observed in individuals with AIDS. This proliferation of HIV then quickly declines over a period of one to two months, as the patient recovers from an initial infection, and leads to a period of clinical latency where little or no infections are observed.

Psychological Dimensions of HIV

Psychological illness in HIV-infected patients is often similar to other patients with life-threatening illnesses such as cancer. Studies have indicated a prevalence of major depression, alcohol use, and the onset of psychiatric illnesses, which may be enhanced by social stigmatization and a sense of isolation (Atkinson and Grant, 1994). In noting these depressive symptoms, the individual often experiences saddened mood, loss of interest or pleasure in activities of daily living, feelings of worthlessness, and suicidality. These emotional reactions are often fuelled by feelings of failure or sinfulness (Atkinson and Grant, Ibid.). Other somatic symptoms may include insomnia or hypersomnia, psychomotor agitation and indecisiveness (American Psychiatric Association, 2000).

Patients are often overwhelmed by their prognosis. According to Atkinson and Grant (Ibid.), patients with HIV disease may experience episodes of anxiety lasting several months, with a range of 15% to 20% prevalence rate of generalized anxiety for a six-month period. Patients report experiencing difficulty dealing with issues relating to disclosure of their status as well as significant social abandonment concomitant with enormous medical expenses.

In patients with advanced stages of HIV disease neurological impairments may lead to the development of HIV related dementia, delirium, mania and psychosis. The most prominent neurological impairment of these HIV related illnesses is dementia, which occurs, in 10-15% of HIV positive individuals with advanced infection (Sacktor et al., 2005). According to the American Psychiatric Association (Ibid.), HIV related dementia is characterized by forgetfulness, slowness, difficulties with concentration, and difficulties with problem solving. Behavioural manifestations of these neurological symptoms include apathy and social withdrawal, which may be accompanied by delirium, delusions and hallucinations. Other behaviourally observed manifestations of HIV related dementia consist of tremor, imbalance, difficulty with muscle coordination (ataxia), hypertonia and saccadic eye movements. HIV positive children may also develop dementia, which is typically accompanied by developmental delay, hypertonia, microcephaly, and basal ganglia calcification (Sacktor et al., Ibid.).

Although mania is rare in HIV patients (Atkinson and Grant, 1994), it may be caused by neuromedical illnesses such as Cryptococci meningitis, which can result in organic mood disorders. Mania may also be induced by the use of medications in the treatment of patients with HIV. Manic episodes may be characterized by periods of abnormal and persistently elevated, expansive, or irritable mood (American Psychiatric Association, Ibid.).

The presence of psychosis in HIV patients is characterized by hallucinations or delusions that are not accounted for by another mental disorder (American Psychiatric Association, Ibid.). Hallucinations may involve multiple sensory

modalities and the complexity of hallucinations is typically influenced by environmental stimuli and the body's reactive response to impairment. Psychosis in an HIV-infected patient is typically found in late stage illness, often compounded by mood disturbance, and may indicate a prognosis of death within the preceding year (Atkinson and Grant, Ibid.).

Socio-Economic Dimensions of HIV

Poverty can be defined as a subsistence level of living attributed by the type of housing, level of literacy, access to health care, level of monetary income and provision of public goods received (Bourguignon and Chakravarty, 2002). Social environments experienced by the relatively poor, tend to expose individuals to sexually risky behaviour that may result in HIV infection. Economic disadvantage has been associated with increased incidence of unsafe sexual behaviour being practiced within developing regions. One study found that low socio-economic status resulted in increased likelihood of females engaging in sexual intercourse for money, males and females having multiple sexual partners and lowered use of safe sex practices (Hallman, 2004).

According to Hallman, poverty is also associated with the influence of males on female sexual behaviour. Low social and economic status resulted in women being placed at a disadvantage for sexual negotiations related to the use of safe sex practices, because of female dependence on male partners for survival. Many females in developing regions, such as South Africa, reported that boyfriends demanded sex as a proof of love and experienced four times the average rate of attempted and actual rape within relationships compared to females from higher socio-economic levels (Hallman, 2004). Such experiences resulted in high pregnancy rates and risk of HIV transmission through females engaging in sex for goods and favours, or engaging in relationships for financial support due to a lack of access to jobs, property, health, education and decision-making power.

Likewise, poverty has been associated with the tendency toward migration to urban regions for employment opportunities. As a result of this migration, populations tended to experience changes in sexual union patterns, increased sex work and STD prevalence (Parker, Easton and Klein, 2000). The effect of poverty on developing regions can also be examined from a wider scope of the region's economic ability to provide the necessary facilities involved in the treatment and prevention of epidemic observations of HIV infection.

HIV/AIDS in Trinidad and Tobago

According to the 2008 United Nations General Assembly Special Session (UNGASS) report on Trinidad and Tobago, the first AIDS cases reported in the country were among homosexual males in 1983. UNGASS (2008) also reported that by 2007 there were 18,378 HIV positive cases, 5,835 AIDS cases and 3,604 deaths as a result of advanced HIV disease. The most common mode of HIV transmission currently occurs through heterosexual relations, with females accounting for significantly higher numbers of cases than males between 15-34 years of age.

The proportion of new HIV positive cases, HIV non-AIDS cases, AIDS cases and death as a result of AIDS cases has steadily declined from 2005-2007 indicating some positive effect of the efforts made by the government of Trinidad and Tobago against HIV disease (UNGASS, Ibid.). Some of the efforts made by the National AIDS Coordinating Committee (NACC) of Trinidad and Tobago include heightening HIV/AIDS awareness through education, improving the availability of condoms, introducing behaviour change intervention programs, providing sexual and reproductive health services, implementing clinical management and treatment care, promoting acceptance of individuals living with HIV and creating legal protection for the rights of those affected by HIV.

Gender and cultural aspects of HIV/AIDS in Trinidad and Tobago

According to Gupta (2002) gender has been considered an influential factor in the spread of HIV within the Caribbean. Research on the knowledge of sex and HIV risk for individuals within Latin America and the Caribbean has revealed that males expected females to be uninformed about issues relating to sexuality and reproductive health. Many young women were found to possess little knowledge about pregnancy, contraception and the transmission of HIV (Gupta, Ibid.). Such lack of education among women often increased female risk of HIV transmission especially in a society where women are expected to remain passive and submissive in decisions relating to sexual interactions and negotiations of safe sex practices. Additionally, women were expected to remain loyal and monogamous in relationships, whereas males were expected to engage in multiple sexual relations as a means of proving virility, sexual prowess and machismo. Females on the other hand, were required to conform to strong norms of virginity until married, and motherhood in a socially acceptable relationship. Adolescent females often reported experiencing negative social repercussions as a result of engaging in premarital sex, but were often exposed to peer pressure from the opposite sex to engage in sexual intercourse. This dilemma often led to females avoiding gynaecological services and engaging in alternative sexual behaviours in an effort to safeguard perceptions of virginity. However despite this norm of virginity, initiation of sex reported in the Caribbean averaged between 13 to 15 years of age according to Gupta (Ibid.).

The pervasiveness of violence against women in the Caribbean has also contributed to the spread of HIV (Gupta, Ibid.). Fear of violence often presents as a barrier to condom use. Fear of violent repercussions may also inhibit the woman's desire to abandon the relationship or seek HIV testing and treatment.

Another trend noted in Trinidad and Tobago include females engaging in sexual relations with older men for material goods and gifts. Many young females often reported engaging in sex for clothes, cosmetics and food, with a

high incidence of unprotected sex, which put females at increased risk for HIV transmission (Gupta, Ibid.).

The impact of HIV on children living in Trinidad and Tobago

In approaching the prevention of mother-to-child transmission of HIV, the government of Trinidad and Tobago has offered voluntary counselling and testing services and has provided free antiretroviral treatment for seropositive mothers. However challenges are still faced where HIV positive mothers do not adhere to treatment as a result of stigmatization, discrimination, non-disclosure of seropositivity to family members and the inadequate provision of replacement feeding for HIV exposed infants. Other difficulties also compromise the low uptake of testing of HIV exposed infants and a lack of coordination between doctors at treatment and antenatal clinics. Nevertheless stigmatization and discrimination appeared to be one of the most prominent challenges to dealing with HIV infection and treatment in Trinidad and Tobago (UNGASS, 2008).

Stigmatization

In examining the effect of stigma and discrimination on persons living with HIV in the Caribbean, Aggleton, Parker and Maluwa (2003) discussed the interplay of HIV/AIDS stigma and discrimination within the context of a broader society that experiences stigmas related to class, race, gender and ethnicity. Stigmatization can be considered as possessing an undesirable difference, which is perceived as deviant. According to this study the protection and promotion of human rights were considered important elements in reducing stigma and discrimination related to HIV/AIDS (Aggleton, Parker and Maluwa, Ibid.).

Often people in the regions of Latin America and the Caribbean believe that persons living with HIV have deserved contraction of this disease due to taboo sexual practices or illegal and socially unacceptable activities. Men with HIV may be viewed as engaging in homosexual relations or engaging in

sexual activity with sex workers, whereas women may be perceived as sexually promiscuous. These perceptions are often viewed as reality, even though most women contract HIV through legitimate, monogamous relationships (Aggleton, Parker and Maluwa, Ibid.). Such premises and preconceptions have lead to discrimination, where a person living with HIV is treated unfairly as a result of seropositivity and the socially implied explanation for their contraction of HIV. This has lead to further ostracism of individuals' families due to perceived knowledge of the family also possessing a seropositive status.

In dealing with the issue of stigmatization, Rintamki et al. (2006) postulated the use of education in reducing the effects of stigmatization for persons living with HIV. The study also considered the importance of clinicians in providing infected individuals with quality care and offering social support to increase adherence to HIV medication regimens.

Art Therapy and HIV/AIDS

HIV research has extended from group and community studies to individual art therapy. A clinical trial conducted by Rao et al. (2009) examined the potential benefits of art therapy in relation to symptoms associated with HIV/AIDS. This study found that art therapy improved physical symptoms of the participants after a one-hour session. The researchers postulated that art therapy might be useful for enhancing the effects of pain medication through disassociation of the pain from the psychological distress. Results of the clinical trial (Rao et al., Ibid.) indicated that art therapy improved participants' abilities to cope with physical symptoms associated with HIV/AIDS. Additionally, it was suggested that art therapy might have provided an alternative focus and a forum for self-expression, for persons living with HIV/AIDS.

Art Therapy for use with AIDS dementia patients

Although there is no indication of Emily displaying symptoms characteristic of AIDS related dementia, I found the study by Wood (2002) to be useful in my formation of a therapeutic approach to sessions with her. In this study Wood investigated the benefits of art therapy for people suffering from dementia caused by advanced HIV disease. She was motivated to explore the patient's personality and lifestyle before the appearance of dementia, as a way of connecting with their loss. More relevant to my work with Emily was that Wood also considered the patient's experience of isolation and the implication of art therapy as an opportunity for therapeutic intimacy. Intimacy was further enhanced by the creation of a receptive location for patients to make art, where familiarity assisted in the reduction of their disorientation. (Wood, Ibid.)

Additionally, Wood (Ibid.) examined the art materials and the art product as a way of encouraging a sense of continuity and the retention of memory in patients throughout therapy sessions. This also led to her understanding and acceptance of the limitations of gaining the patient's interpretation and insight in art therapy, as memory loss often prohibits processing and self-reflection of the artwork.

Wood (Ibid.) also explored feelings of patient helplessness, sadness, physical, social and cognitive loss and the impact of these experiences on the therapeutic relationship. This exploration and the premises of her approach to art therapy allowed for self-discovery and a realization of the necessity of flexibility in accommodation to this population. The insight provided by Wood in her work with patients living with HIV/AIDS alerted me to the importance of building a therapeutic alliance with Emily that would facilitate intimacy and provide her with a familiar and comfortable space to address her feelings of stigmatisation and isolation.

Murals for use with AIDS patients

In a study by Kaimal and Gerber (2007), mural making was utilized in the treatment of patients at an HIV/AIDS outpatient clinic. The art mural is an artistic expression, which allows for spiritual, emotional and productive purposes through group relations. The mural was presented as socially oriented art making, and this approach stimulated the spontaneous expression of patients and encouraged the collection of messages, thoughts and memories related to personal experiences impacted by HIV/AIDS. In working with Emily, I wanted explore the usefulness of mural making in allowing for spontaneous imagery that may reflect her personal experience of living with HIV.

Kaimal and Gerber (Ibid.) also considered mural making as a means of creating a supportive environment, which may serve to decrease isolation and encourage a sense of belonging for individuals who may feel alienated.

Furthermore, Kaimal and Gerber explored the psychological difficulties experienced by these individuals, which may include concerns with identity, issues of boundaries, denial, and feelings of helplessness, vulnerability, lack of control, instability, anxiety, agitation and anger due to social isolation and stigmatization. Patients also visually expressed desires and wishes of peace, happiness and symbolic imagery relating to healthy relationships and the achievement of an increased sense of self-worth.

Art Therapy for use with children affected by HIV/AIDS

A study by Hrenko (2011) further considered the use of art therapy with children infected with or affected by HIV/AIDS, in a therapeutic camp setting. The interventions focused on the provision of a safe, therapeutic environment for HIV positive children as well as children who may have lost one or both parents to HIV/AIDS.

Art Therapy interventions explored by Hrenko included memory boxes, draw-a-favourite-memory and a group mural. She proposed that memory boxes may be utilised as a form of containment for self-remembrance or remembering others. The draw-a-favourite-memory art intervention was

included as a camp project to bring significance to what was contained within the memory box.

In her experience, themes of creatively expressing thoughts and feelings, self-acceptance and acceptance of others, in addition to cherishing life memories were prevalent in the children's artwork. She postulated that the art product itself might serve to nurture and comfort them during difficult times in the future.

This study drew my attention to the possible impact of art making with Emily. Would the art product become a cherished memoir of her experiences? I was curious about Hrenko's proposition that the art product may become an item of comfort for Emily.

Emily

Emily lives at a residential facility for people living with HIV/AIDS in Trinidad and Tobago. The facility's program director required that most identifying information about the location be kept confidential to protect Emily's identity, given the relatively small population of the country. It houses approximately 40 individuals living with HIV/AIDS and encompasses a wide age range including adolescents. Medical assistance is provided by volunteering medical doctors and is supplemented by nursing staff who are available 24 hours, 7 days a week. Medication for the treatment of HIV is provided through the government implemented National HIV/AIDS Strategic Plan.

Emily was referred for art therapy by the facility's program director, as she displayed a natural interest in art making. I was aware of the short-term nature of this treatment as I was undergoing my clinical graduate art therapy training. My concerns regarding the brevity of this treatment were focused around the extensiveness of Emily's trauma. I wanted to be sensitive to her emotional fragility, while being careful not to delve into any issue that would require additional sessions. At the same time, it was important that art therapy sessions provide Emily with opportunities for self-expression and support her disclosure of personal experiences. Striking a balance between the depth of our discussions and the short-term nature of this treatment presented a challenge.

The facility did not typically provide art therapy for its residents, but it was provided as a voluntary service for a specified period. Art Therapy sessions were conducted in a space that is ordinarily used for art making, homework and indoor recreational activities. Emily agreed to engage in five sessions during her school holidays.

Psychosocial Functioning

Emily is an adolescent female. She attends schooling 5 days a week. Emily lost both parents to HIV in infancy and was referred to the facility by a social worker based on her HIV seropositivity. The facility specifically serves people living with HIV/AIDS. All of the residents are unable to receive appropriate treatment at home.

Emily experienced extensive emotional and physical abuse during her early childhood. We both agreed not to discuss this earlier trauma during art therapy sessions. I agreed to this in part because of the time constraints of our allotted sessions. Additionally, in my judgment, Emily's diagnosis and the psychological implications of her diagnosis appeared to be paramount. Emily had no social support from extended family members. Her friends included fellow residents, and classmates who were unaware of her physical illness and social difficulties.

Emily was engageable with encouragement. She seemed to relate to her peers at the centre, but was guarded during discussion of any personal issues during our art therapy sessions. Emily was pensive when she spoke about HIV. During our art therapy sessions, she identified with many themes related to her self-concept. She spoke about her anxiety and feelings of stigmatization and expressed these sentiments in her artwork.

There was some indication that Emily was hospitalized for HIV infection during childhood, but the intensity of her treatment was not clear. Currently, she takes anti-retroviral medication for the delay and treatment of physical symptoms related to HIV. She did not appear to display symptoms

characteristic of AIDS related dementia (American Psychiatric Association, 2000), mania, psychosis or significant neurological impairment outlined by Atkinson and Grant (1994).

On the contrary, Emily was capable of problem solving, maintaining extended periods of concentration as well as insightfulness. However, she displayed a tendency towards negative self-statements and difficulty with social re-integration within her wider social community.

Therapeutic Goals of Art Therapy Sessions

My main goals in working with Emily were to help create a comfortable and safe environment, as suggested by Ainsworth (1969), in order to facilitate her verbal and artistic expression of self, as well as her thoughts and feelings related to living with HIV in Trinidad and Tobago.

I was curious about the impact of her seropositivity on her social interactions with others. This was especially of interest to me, given the public's misconceptions of persons living with HIV, as observed by Aggleton, Parker and Maluwa, (2003). I wondered, how is she able to cope or not cope with society's disapproval of her physical illness?

My sessions were structured to help her gain some insight on her perceptions of herself, as well as how she felt about others' perceptions of her. Furthermore, she wanted to learn more about her perception of her illness. Was her perception one of acceptance or did she too, disdain this intrinsic aspect of her daily existence? I too was motivated to learn more about Emily and her experiences. I felt it was important to act as a facilitator as she told her narrative, not as a statistic, but as an individual whose life is affected daily by a life-threatening virus.

The Art Therapy sessions

Emily arrived casually dressed on the day of her first session. She was pleasant, softly spoken but emotionally distant. Perhaps her guardedness reflected some discomfort with meeting a new person? I began by explaining the art therapy process. She began to relax. She expressed interest in exploring a wide range of materials and disclosed her level of school experience as a means of engaging in our conversation.

Emily's first directive was to create a 'free drawing' on a piece of white paper. I chose this directive as a means of engaging her in the art therapy process. I wanted her to feel relaxed. I also wanted to allow her to express whatever she felt was appropriate to the moment. I provided materials for her, which included, a pencil and a set of 16, washable, fine line markers. These materials enabled Emily to create a colourful and detailed piece of art based on a theme of her choice. Markers were also a familiar material that she was able to manipulate comfortably. She quickly set to work after confirming whether or not she was free to draw as she pleased. She worked methodically and quickly. She described her drawing as 'colours of the sunset'. She told me she loved colours. She spoke about Trinidad and the "calm and peaceful sunset".

Fig 1 Free Drawing 8_”x11”

Discussion

The first piece of art produced by Emily was a landscape of a setting sun in response to a directive that left the subject matter for open interpretation. According to Klorer (2003) a free drawing enables the therapist to build an understanding of an individual’s range of symbolic imagery, which may be of considerable importance from an assessment perspective. This type of spontaneous expression may reveal unconscious ideas and symbolic imagery (Malchiodi, 2003a).

In examining the recognizable elements of the drawing, the viewer is immediately drawn to the symbol of the setting sun. This symbol is considered an archetypal representation of the duality of nature; noting that the function of the sun both creates warmth as well as drought (Battistini, 2005). The cyclical nature of the symbol in its continuous rise and fall within the sky may be analogous to birth and death within the cycle of life. As such, a setting sun may be interpreted as Emily’s reflection on the transience of her life.

Another recognizable element of Emily's drawing is that of a coconut tree. This type of tree may be considered appropriate to the created environment and is commonly found on the islands of Trinidad and Tobago. Nevertheless, the faint outline of the trunk may suggest inadequate ego strength. This observation may additionally be supported by the downward direction of the branches, reminiscent of a weeping willow, which may suggest depressive associative value (Hammer, 1958; Ogden, 2001). Conversely, the sturdy presence of land may suggest groundedness (Ogdon, Ibid.). The inclusion of calm water may relate to a potential balance between consciousness and the unconscious (Hammer, 1958; Ogden, Ibid.).

In examining the overall gestalt of the drawing, one may consider the spontaneity of the line quality and heavy pressure, which may reflect some anxiety and tension (Ogden, 2001). Also, the drawing is centred; however the content does not encompass a thorough use of space. A small environmental press may suggest some feeling of inadequacy (Ogden,Ibid.).

Session Two The second session consisted of a brief review of the first session. It focused on art making and Emily's perception of self and identity. Emily was directed to create a 'mask' using a variety of media. Mask making can focus on issues of identity as experienced by patients living with HIV/AIDS (Kaimal and Gerber, 2007). According to Peterson and Files (1989) mask making also enables a person to become someone else. I felt this directive was appropriate to assist in understanding Emily's self-perception and future goals.

Materials provided were a paper mask, poster paints with brush, feathers, scissors, beads, sequins, tissue paper and white glue. Emily provided additional materials. These additional items were eye-shadow powder, eye-shadow gel, synthetic eyelashes, eyeliner and blush. These materials allowed Emily to explore a wide variety of media that may be mixed and altered to create a desired effect.

Emily began working on her mask immediately and expressed excitement about having ‘something to makeover other than myself (herself)’. She created multiple layers on the mask, using tissue paper, paint and makeup.

The first layer consisted of torn pieces of tissue paper adhered to the mask. Emily found this layer to be an unsatisfactory representation of her skin. She decided to cover it with paint. She meticulously mixed colours to create a skin tone similar to her own, although she denied the mask was a representation of her. The third layer consisted of adding make up to the mask. Feathers and sequins were also added to complete the mask. These elements are reminiscent of a masquerader during Carnival in Trinidad and Tobago and are often part of the costume.

Emily said “Somebody’s wearing a costume”. She stated that the mask can ‘hide your identity’. She was able to relate the mask to her culture as a symbol of beauty. However, she was hesitant to discuss how the mask related to her.

Fig 2 Mask 7”x5”

Discussion

The directive used during this second session focused on issues of identity, often eschewed for patients living with HIV/AIDS (Kamal and Gerber, 2007). According to Peterson and Files (1989) mask making enables a person to become someone else and therein titrates overwhelming affect while still assisting in an understanding of self-perception and future goals. I felt Emily's response to this directive informed the viewer, not only about her self-perception, but also reflected the way she chose to present herself to others. The most noticeable element of the mask is the creation of a female persona as a masquerader. This symbol is reflective of power and may be considered the reinterpretation of female identity in a male-oriented society, as according to Knörr and Meier (2000). Emily's creation of a masquerader reflects her femininity and may illustrate her desire to be placed in a position of power. She expressed a desire to 'do what you feel like'. This symbol of power may relate to having control over the circumstances surrounding her illness.

Emily expressed dissatisfaction with the first layer of her mask and found this initial layer to appear 'blue-black and burnt'. This description may suggest Emily's experience of somatic symptoms of HIV as noted in the drawings of children with life-threatening illnesses (Malchiodi, 1998). Additionally, the use of paint and make up over the first layer may reflect Emily's desire to hide such symptoms, or feelings of insecurity. The addition of feathers may also reflect Emily's fantasy and playfulness in the role of the masquerader. Feathers are often synonymous with freedom and escapism, as in the symbol of a bird (Burns, 1987). Features are often included in costumes for the celebration of Carnival in Trinidad and Tobago. This may be supported by Emily's expressed desire to 'get out of here', obtain employment and 'decide for yourself'. She seemed to desire more control over her life's circumstances.

Subsequent Sessions

In further sessions Emily was directed to create a mural based on *people, places and things*. The intention of this directive was to allow Emily to reflect

on her personal experiences in the context of a wider society. Emily was asked to identify those attitudes that created a positive outlook on life.

In prior sessions, I had observed Emily's tendency for guardedness, especially when she tried to discuss her emotions. I presented a wide range of media for this mural project to facilitate exploration and emotional expression through her process of art making. Materials used included poster paints with brush, watercolour pencils, oil pastels, an HB pencil and 20"x25_", white paper. These materials allowed Emily to create symbolic imagery through ingenuity and mastery of the new media.

Emily discussed this directive extensively with me. She wanted "to get it right". She talked about how difficult it was to speak about her hopes for the future. She reluctantly made the connection between her negativity and her HIV status.

Emily began the mural by dividing the paper into two sections using a pencil. She allotted the left section to negative experiences and the right section to positive experiences. Then, Emily used a pencil to draw a single, free-flowing line in the right section. This continuous line produced intersections and smaller-contained segments. She then began to fill in each segment with varying colours of poster paint. She mixed many of the colours to obtain the optimal effect. She experimented with the watercolour pencils at times, but was unsatisfied with their transparency. She returned to poster paints and enhanced each quadrant with oil pastel. Then she outlined and smudged these sections in varying shades of black, blue and grey. Emily also used a white oil pastel to create highlighted areas on the coloured segments. She explained her process as the creation of 'shadow and highlights' to make each segment 'more pronounce(d)'.

Emily completed half of the mural during her third session. She discussed her intention of including "*meaningful words"* within each painted segment. She told me she would complete the mural later. I encouraged her to reflect on her artwork until the next session.

Fig 3a Mural approx. 5”x6.5”

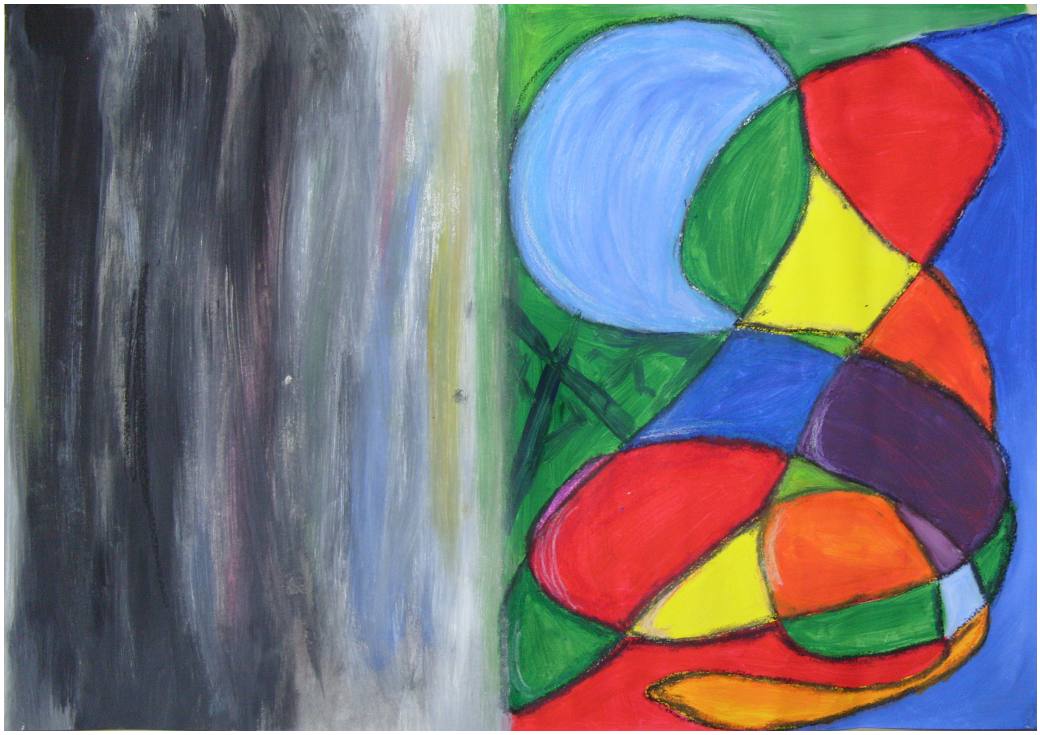

Fig 3b Mural 10”x13”

Discussion

In observing the first completed section of Emily's mural, one is immediately drawn to its linear and abstract quality. The colour is intense. Emily stated that this portion of the mural symbolized her positive life experiences. Her decision to work on this aspect of her mural first may reflect the intensity of her desire to feel "more positive" and think about the possibility of a future. Her choice of colour tends to remain constant and vibrant. This is perhaps a cultural phenomenon of Trinidad and Tobago aesthetic. However, from a more universal vantage point, the colour red is often associated with life, warmth and wounds (Malchiodi, 2007). Malchiodi notes that orange may relate to warmth and energy, whereas yellow relates to warmth and hope. Additionally, she suggests that blue may be associated with rituals of cleansing or relaxation; purple may suggest spirituality. And the colour green, may indicate growth and renewal (Malchiodi, Ibid.).

Another noticeable element of Emily's mural is the formation of shapes through the intersection of a single line. Many of these shapes possess organic and abstract attributes. However, the formation of shapes through compartmentalization may indicate abuse (Klorer, 2003). A further indication of abuse and or emotional deprivation may be Emily's thematic use of only colour and shape for her mural (Malchiodi, 2007).

The Mural's Completion

Emily came to art therapy to complete her mural. She complained of being tired. She told me about her new ideas for the mural. Instead of including words, Emily told me she would continue to work only abstractly.

Emily carefully enhanced the last right section of her mural. She added more shading with oil pastels to create dimension. She then focused on a segment of the right half of the mural. In this segment, Emily painted lines, which she described as 'bamboo'. She then focused on the left section of her mural. She began to add faint washes of a variety of colours. Emily removed herself from

the table and retrieved a wider brush from within the room. She explained that her intention was to paint the left side of the mural without the use of pre-drawn lines, or printed words. Emily then began to rapidly apply paint onto the surface of the paper with long, sweeping strokes. She applied individual colours to the surface and blended them with her brush. Emily used black, white, red and blue to create a chromatic movement of shade from dark to light. She then blurred the dividing line on the paper and attempted to meld the two sections together. Emily completed this effect and presented her artwork.

She described the right section of her mural as the 'positive side'. The right side was 'things to look forward to' and she listed goals of acquiring a 'job, house, car and going to university'. Emily presented the left section of her mural as 'where I came from'. Quietly and briefly, she talked about past difficulties with her family. She disclosed how difficult it was for her to trust her extended family members. She referred to those experiences as 'hard to deal with'. She further reflected on how much more she distrusted *ALL* people in her current situation. She expressed regret at verbalizing this feeling. Abruptly, she changed her conversation to her desire to 'move forward to more positive things'. She discussed the possibility of being able to trust someone, perhaps in the near future.

At this point in the session, I encouraged her to create a mandala and I explained to her the mandala's usefulness as a tool of relieving tension (Malchiodi, 2003b). I presented her with an HB pencil and coloured pencils to be used on 8_"x11", white paper. I drew a circle using a template. I encouraged her to explore the inner and outer portion of the circle, as a reflection of herself. Emily began by creating a 'vine' pattern in the upper-right corner of the paper. She used a singular, fluid line to draw the vine and embellished it with spirals and leaves. Emily then focused on a nature-inspired environment on the bottom-left corner of the paper. This part of her mandala received the most investment. She drew two, crossed shoots of 'bamboo' and focused on adding dimension to them. She created dimension by layering and blending colours, and added notches along the shoots to

make them appear naturalistic. Emily added greenery to the background and carefully placed two butterflies on either side of her drawing. The butterflies consisted of outlining and filling in the wings with a variety of colours.

Emily presented her art piece, but retrieved it back to add a ‘world’ within the circle. She described her artwork as representative of her desire to learn about different people, cultures and languages.

Fig 4 Mandala 8_”x11”

Discussion

The completion of Emily’s mural presents a strong contrast between her experiences of life within the ‘positive side’ as opposed to ‘where I came from’. Although the previous session suggested some indication of abuse, the addition of the section ‘where I came from’ appears to support this in its

gloomy and blurred appearance. Perhaps Emily's representation of her past life experiences may reflect her attempt to dismiss threatening memories or keep them beneath conscious expression (Malchiodi, 2007). Such expression of threatening thoughts may be indicated not only in Emily's colour selection (Malchiodi, 1998), but also in the expressive quality of her brushstrokes, which appear rapid and anxious (Ogdon, 2001).

Emily's lack of subject matter may also indicate her evasiveness in materializing past experiences and may be experienced as mysterious and shadow-like (Malchiodi, 2007). This may be supported by Emily's reluctance to expand on her difficult experiences with her family. Nevertheless, her ability to identify her distrust as well as her motivation to move beyond past experiences may indicate Emily's growth and determination as an individual. Additionally, her inclination to discuss the effect of HIV on her social development may indicate her development of trust within the therapeutic relationship, despite her discomfort in discussing the subject matter.

In directing Emily to create a mandala, I attempted to encourage her to relieve some of the anxiety she displayed while discussing her mural. The creation of mandalas encourages spontaneous imagery that may be useful as a reflection of transformation during emotional struggles (Malchiodi, 2007). Mandalas may be interpreted as a representation of one's psyche and may encourage self-exploration and healing.

Final Session

This session comprised of discussing the process of termination and a comprehensive review of the art therapy sessions. Emily was encouraged to discuss any concerns she had about her art and our conversations. She was responsive and expressed an interest in integrating art making more frequently into her schedule. Then, I asked Emily to create a gift that she would like to give to herself, as a final reflection of her art therapy experience. I provided materials for the completion of this directive which included 8_"x11", white paper, modelling clay, sculpting tools and a paintbrush. These

materials were novel to Emily but presented her with an opportunity to explore and experiment with new media.

Emily carefully considered the directive and pondered the type of gift she would like to make for herself. She also contemplated the nature of the media and its ability to form dimensional sculpture and relief. This reminded her of her childhood experience using clay, but she also reflected that it was ‘a long time ago’.

Emily began working on her piece by mixing various colours of clay into one ball. She began to push the clay into the paper, flattening and manipulating it to create a relief. She referred to this as her “island.’ She continued to enhance the texture with her fingers and the end of a paintbrush. She did this for some time before moving onto the waves. She mixed blue and green modelling clay and filled the space beneath the island. She used the end of a paintbrush to create choppy waves and indented sections of the clay with her thumbs.

She added a sky, which she referred to as a ‘sunset’. She spent quite some time on this aspect of her artwork, adding and mixing pieces of clay to create the effect of a sky during dusk. Additionally, she included a setting sun. Emily experienced some difficulty cutting out the segment of a circle to fill the space. However, she was able to achieve this on her fourth attempt. She placed the segment onto the sky and melded the clay to blend the sun into the background.

Emily then focused on the creation of a coconut tree. She moulded a trunk with roots and attached individually rolled branches and leaves to the top of the trunk. Emily utilized differing shades of clay to create areas of light and shadow within the tree. The final element of her piece consisted of the addition of a starfish to which she adhered small balls of clay.

Emily stated that her sunset represented relaxation and tranquillity. Emily discussed her desire to ‘get away from all the noise’ which I interpreted as her

internal turmoil as well as, her current environment at the facility. She told me that she wanted some aloneness to think, but she also reflected that she did not wish to experience isolation continuously. She was appreciative of her experience in art therapy and her ability to create personal artwork that symbolized her emotions. She also discussed her desire to continue art making and considered the use of art as a means of personal expression and release.

Fig 5 Gift 8_”x11”

Discussion

Emily’s final piece of artwork is comparable to her free drawing, during the first art therapy session. Although the second art piece was produced as a final reflection many similarities can be observed between Emily’s first and final art pieces.

The overall imagery in both pieces remains constant in their depiction of a sunset. However, Emily's approach to creation of the latter piece appears less pressured than the former. This may be in part, due to the media provided. Perhaps Emily approached the use of modelling clay with a stronger attentiveness, which therein, produced more patience and self-confidence?

The symbols in both pieces are comparable. The creation of a setting sun may signify a space of tranquillity and relaxation for Emily. She references this as an escape from stressful situations. Perhaps Emily utilizes this imagery as an escape, as in the feathers of her Carnival mask. Another recognizable element of Emily's clay piece is the tree. It is also similar to the tree in her free drawing. However, the clay tree appears more grounded. This may indicate the strengthening of Emily's ego-strength and therein, coping skills (Ogdon, 2001).

A noted difference between Emily's free drawing and her final art piece is the inclusion of a starfish on the shore of the island. Characteristically starfish are noted for their ability to regenerate autotomized limbs and continue survival with the loss of greater than 75% of their body mass (Ramsay, Kaiser and Richardson, 2001). Perhaps this is representative of her desire to survive her illness.

Emily's therapy ended at this juncture, because I was returning to the United States to complete my clinical training.

Conclusion

Emily's response to art therapy can be characterized as her continued willingness to discuss her values, goals, desires and responses to her illness. More importantly, she was able to understand that art making could be therapeutic. I therefore encouraged the director of the facility to let Emily continue making art.

I have also come to understand how Emily was able to artistically experiment rather than place emphasis on the production of a refined product. As an art therapist in Trinidad and Tobago, I have observed that patients tend to

engage in artistic experimentation, and utilize this process for healing, more often than attending to the final product.

Artistic self-expression was especially relevant to her opening herself up to speaking about her illness. She was able to openly verbalize her sadness about her stigmatisation. Emily utilized the art process in a healing manner that focused on future endeavours, regeneration and sometimes a bit of escapism. Responding emphatically, how can escaping not be understood as playfulness? Thus the therapeutic process provided her with a means of prevailing past difficult struggles with the uncertainty of the future.

Emily was able to use the process of art making to explore her feelings about identity, lessen her social isolation as well as to express positive aspirations for her future (Kaimal and Gerber (2007). She also seemed to become less guarded and more engaged in the process as the therapeutic alliance strengthened (2002).

I felt that Emily would have benefitted from longer term art therapy; however, the short term nature of her experience in art therapy was enabling for her. On the basis of my observations and my experience with her and other clients, I think that giving teenagers with HIV/AIDS the opportunity to engage in art making in an art therapy setting, even if it is short term, allows them to express difficult personal experiences that they may otherwise not communicate. Oftentimes, medical treatment is given priority for persons living with HIV/AIDS. While, medical treatment cannot be denied as essential to the survival of these persons, I feel that it is important to consider their holistic wellbeing. I hope that my work with Emily may highlight the importance of providing therapeutic services for persons living with HIV/AIDS in Trinidad and Tobago.

Bibliography

Aggleton, P., Parker, R. and Maluwa, M., (2003) *Stigma, Discrimination and HIV/AIDS in Latin America and the Caribbean.* Washington, DC: Inter-American Development Bank.

Ainsworth, M. D., (1969) Object Relations, Dependency, and attachment: A Theoretical Review of the Infant-Mother Relationship. *Child Development,* 40, pp.969-1025.

American Psychiatric Association, (2000) *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington, DC: American Psychiatric Publishing Inc.

Atkinson, J. H. and Grant, I., (1994) Natural History of Neuropsychiatric Manifestations of HIV Disease. *Psychiatric Clinics of North America, 17(1)*, pp.17-33.

Battistini, M., 2005. *Symbols and Allegories in Art.* Los Angeles, CA: Getty Publications.

Bourguignon, F. and Chakravarty, S. R., (2002) Multi-dimensional poverty orderings. [pdf] Département et Laboratoire D'Économie Théorique et Appliquée. Available at: http://www.delta.ens.fr/abstracts/wp200222.pdf

Burns, R. C., (1987) *Kinetic House-Tree-Person Drawings: K-H-T-P: An Interpretative Manual.* New York, NY: Brunner-Routledge.

Goudsmit, J., (1997) *Viral Sex: The Nature of AIDS.* New York: Oxford University Press.

Gupta, G.R., (2002) Vulnerability and Resilience: Gender and HIV/AIDS in Latin America and the Caribbean. [online] International Centre for Research on Women. Available at: http://www.genderandaids.org/

Hallman, K., (2004) Socioeconomic Disadvantage and Unsafe Sexual Behaviours Among Young Women and Men in South Africa. [online] The Population Council, Inc. Available at: http://www.popcouncil.org/

Hammer, E. F., (1958) *The Clinical Application of Projective Drawings.* Oxford, England: Charles C. Thomas.

Hrenko, K. D., (2005) Remembering Camp Dreamcatcher: Art Therapy with Children Whose Lives Have Been Touched by HIV/AIDS, *Art Therapy: Journal of the American Art Therapy Association, 22(1),* pp.39-43.

Havlir, D. and Richman, D., 1996. Viral Dynamics of HIV: Implications for Drug Development and Therapeutic Strategies. *Annals of Internal Medicine, 124(11)*, pp.984-994.

Kaimal, G. and Gerber, N., (2007) Impressions over time: Community progressive murals in an outpatient HIV/AIDS clinic. *The Arts in Psychotherapy, 34, pp.*151-162.

Klorer, P. G., (2003) Sexually Abused Children: Group Approaches. In C. A. Malchiodi, ed. 2003. *Handbook of Art Therapy*. New York: The Guilford Press, pp.339-350.

Knörr, J. and Meier, B., (2000) *Women and Migration: Anthropological Perspectives.* Frankfurt and New York: Campus & St. Martin's Press.

Malchiodi, C. A., (1998) *Understanding Children's Drawings.* New York: The Guildford Press.

Malchiodi, C. A., (2003a) Psychoanalytical, Analytic, and Object Relations Approaches. In C. A. Malchiodi, ed. *Handbook of Art Therapy*. New York: The Guilford Press, pp.41-57.

Malchiodi, C. A., (2003b) Using Art Therapy with Medical Support Groups. In C. A. Malchiodi, ed. *Handbook of Art Therapy.* New York: The Guilford Press, pp.351-361.

Malchiodi, C. A., (2007) *The Art Therapy Sourcebook.* New York: McGraw Hill.

Ogdon, D. P., (2001) *Psychodiagnostics and Personality Assessment: A Handbook.* Los Angeles, CA: Western Psychological Services.

Parker, R. G., Easton, D. and Klein, C. H., (2000) Structural barriers and facilitators in HIV prevention: a review of international research [Structural Factors in HIV Prevention]. *AIDS, 14(1)*, pp.22-32.

Pederson, C., Lindhardt, B., Jensen, B., Lauritzen, E., Gerstoft, J., Dickmeiss, E., et al., (1989) Clinical course of primary HIV infection: consequences for subsequent course of infection. *British Medical Journal, 299*, pp.154-157.

Peterson, J. and Files, L., (1989) The Marriage of Art Therapy and Psychodrama. In H. Wadeson, J. Durkin and D Perach, *e*ds. *Advances in Art Therapy*. Canada: John Wiley & Sons. Inc, pp. 317-335.

Ramsay, K., Kaiser, M. J. and Richardson, C. A., 2001. Invest in arms: Behavioural and energetic implications of multiple autotomy in starfish (Asterias rubens). *Behavioural Ecology and Sociobiology, 50(4),* pp.360-365.

Rao, D., Nainis, N., Lisa Williams, L., Langner, D., Eisin, A. and Paice, J., (2009) Art therapy for relief of symptoms associated with HIV/AIDS. *AIDS Care*, 21(1), pp. 64-69. doi: 10.1080/09540120802068795

Rintamaki, L. S., Davis, T. C., Skripkaukas, S., Bennett, C. L. and Wolf, M. S., (2006) Social Stigma Concerns and HIV Medication Adherence. *AIDS Patient Care and STDs, 20(5*), pp.359-368.

Sacktor, N. C., Wong, M., Nakasujja, N., Skolasky, R. L., Richard, L., Selnes, O. A., et al., 2005. The International HIV Dementia Scale: a new rapid screening test for HIV dementia [Basic Science]. *AIDS, 19(13)*, pp.1367-1374.

Spira, R., Lepage, P., Msellati, P., Van de Perre, P., Leroy, V., Simonon, A., et al., (1999) Natural History of Human Immunodeficiency Virus Type 1 Infection in Children: A Five-Year Prospective Study in Rwanda. *Pediatrics, 104(5)*, e56.

UNGASS (United Nations General Assembly Special Session), (2008) *UNGASS Country Progress Report Trinidad and Tobago.* [pdf] National AIDS Coordinating Committee. Available at: http://data.unaids.org/pub/Report/2008/trinidad_and_tobago_2008_country_progress_report_en.pdf

Wood, M. J. M., (2002) Researching art therapy with people suffering from AIDS related dementia. *The Arts in Psychotherapy, 29*, pp.207-219.

Ms. Sarah Soo Hon MA is a 2009 graduate of Long Island University with a MA in Clinical Art Therapy. She is a member of AATA, as well as the Vice President of the Caribbean Art Therapy Association. Sarah has been working with psychiatric inpatients and also works with HIV/AIDS patients. She has additional training in HIV counselling and ARV treatment.

Dr. Christine Kerr, ATR-BC, LCAT, CGP, is the Director of Clinical Arts Therapies at Long Island University. She is the author of Family Art Therapy (2008), Routledge; and numerous articles on the clinical application of art therapy with diverse populations.