

A JOURNEY PAST THE SUN



Group Art Psychotherapy

for

People with Melanoma:

An Investigation using Narrative

and

Immunological and Psychosocial Measures

by

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STATEMENT OF ORIGINALITY

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Signature: *M-Ch. Virago*.....

Date: *May 15th 2008*...

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TABLE OF CONTENTS

ABSTRACT	XII
INTRODUCTION.....	1
BACKGROUND.....	1
THE COMING-INTO-BEING OF THIS PROJECT	9
Early Experience with Cancer Research.....	9
Lessons from Grief.....	11
Art Therapy Training: Lessons from My ‘Patients’	12
CHAPTER 1.	19
BROADENING ‘THE MIND’; THE CONCEPT OF BODYMIND MEDICINE	19
EM’S STORY: THE ARCHAEOLOGY OF THE IMAGE AND BODYMIND REVEALED THROUGH ART PSYCHOTHERAPY	26
THE RITUAL OF THERAPEUTIC IMAGE MAKING AND WHOLE BEING HEALTH/WEALTH.....	30
<i>The Place of the Soul’s Song.....</i>	35
CHAPTER 2	38
INTRODUCTION TO IMMUNOLOGY AND PSYCHONEUROIMMUNOLOGY (PNI).....	38
HISTORICAL PERSPECTIVE AND THEORETICAL MODELS.....	38
A BRIEF DESCRIPTION OF IMMUNE FUNCTION.....	46
<i>Interferon gamma (IFN-γ) Function</i>	54
Literature Supporting Impact of Arousal or Distress on IFN-γ Levels.	56
IMMUNOGLOBULIN ISOTYPE A (IGA) FUNCTION.	57
Literature Supporting Impact of Arousal or Distress on S-IgA levels as Measured in Saliva.....	60
<i>DTH Skin Response</i>	62
Literature Supporting the Impact of Arousal or Distress on DTH Test Response.....	64
PSYCHONEUROIMMUNOLOGY (PNI).....	67
<i>The Emergency Response Mechanism.....</i>	70
Stress, Psychosocial and Psychoncology Research.....	74
A Rationale for the Use of Art Psychotherapy in This Research Context.	77
CHAPTER 3	84
INTRODUCTION TO ART PSYCHOTHERAPY	84
<i>Signposts.....</i>	96
CHAPTER 4	100
METHODOLOGY, OR THE METHOD OF INVESTIGATION	100
THE PHILOSOPHICAL UNDERPINNING OF THE METHOD OF RESEARCH.....	100

SCIENCE AND CULTURE, AND THE CULTURE OF SCIENCE	104
ART PSYCHOTHERAPY AS RESEARCH: WHERE DOES IT FIT?	112
CONNECTION TO FELT EXPERIENCE IN RESEARCH	115
PHENOMENOLOGY	116
HERMENEUTIC PHENOMENOLOGY AND ART PSYCHOTHERAPY	119
MIXED METHODS RESEARCH.....	122
CHAPTER 5	125
QUANTITATIVE METHOD	125
THE STUDY PROTOCOL	125
PARTICIPANTS (SUBJECTS).....	127
<i>Eligibility</i>	127
<i>Recruitment Procedure</i>	127
DATA COLLECTION.....	129
QUESTIONNAIRES	130
1.The Mental Adjustment to Cancer Scale	130
2. The General Coping Strategies' Scale	131
3. The European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire: Core (EORTC.QLQ-C30)	132
4. The Hospital Anxiety and Depression' Scale.....	133
IMMUNOLOGICAL MEASURES.....	134
Salivary samples	134
ELISA for S-IgA	134
ELISA for S-IFN- γ	135
Skin Test, DTH.....	136
DATA ANALYSIS.....	136
CHAPTER 6	138
DESCRIPTION AND DISCUSSION OF QUANTITATIVE RESULTS.....	138
DATA MEASURES	138
DEMOGRAPHIC DATA.....	139
RESULTS OF RECRUITMENT PROCESS	140
<i>Participant Denominators</i>	142
IMMUNOLOGICAL RESULTS	144
<i>Saliva IgA (S-IgA) Results</i>	144
<i>Saliva IFN-γ (S- IFN-γ) Results</i>	156
<i>Comparison of S-IgA and S-IFN-γ Data</i>	168
<i>DTH Test Results</i>	168

PSYCHOSOCIAL RESULTS	170
1. <i>Mental Adjustment to Cancer Scale</i>	170
2. <i>Hospital Anxiety and Depression Scale</i>	171
3. <i>The COPE Questionnaire</i>	172
4. <i>EORTC-QLQ-C30</i>	175
CORRELATION BETWEEN QUESTIONNAIRES	176
DISCUSSION OF QUANTITATIVE RESULTS.	179
IMMUNOLOGICAL RESULTS	179
PSYCHOSOCIAL RESULTS	183
MAC	183
HAD	183
COPE	184
EORTC-QLQ-C30	184
CORRELATIONS BETWEEN QUESTIONNAIRES	184
CHAPTER 7	186
QUALITATIVE DATA:	186
<i>The Story Behind the Numbers; A Journey Past the Sun</i>	186
THE ART PSYCHOTHERAPY PROCESS: CREATION OF QUALITATIVE DATA	186
<i>Transcription</i>	189
<i>The Duration of the Intervention</i>	190
<i>Reshaping the Protocol</i>	190
OTHER MODALITIES USED AND EDUCATIONAL ASPECTS OF THE INTERVENTION	191
<i>Recruitment and Group Structure</i>	192
<i>The Space</i>	192
<i>Shared Meals</i>	193
<i>My Self Care</i>	194
ANALYSIS OF DATA	194
<i>Steps in Analysis</i>	196
i. The intuitive process: reading the transcripts in their entity	196
ii. The analytic process:	196
iii. Crystallisation:	198
iv. Description:	199
<i>The Storylines Identified</i>	199
1. <i>Same/Other</i>	200
2. <i>Emotional/Physical</i>	200
<i>Analysis of Images</i>	201
<i>A Short Description of Session Themes, in Chronological Order</i>	203

<i>The Organisation of the Story Elements</i>	206
<i>Verification of the Stories</i>	207
STORYING	208
THE NARRATIVE	214
<i>The Question of Change and Causality</i>	216
<i>The Intervention Phase; Fellow Travellers</i>	217
<i>The Participants</i>	223
Ned, Alan, Paul, Darren, Ron M, Ron B, Jim, K, Colleen, Rose and S.	223
Alan: aged 60	224
Paul: aged 49	226
Ron B: aged 57	229
Ron M: aged 70	233
Jim: aged 67	237
Darren: aged 56	240
Colleen: aged 48	244
Rose: aged 51	246
Christina: aged 57	249
The images: all 200 or so!	249
<i>The Core Childhood Stories</i>	250
THE THERAPEUTIC 'DOING'	250
DISCUSSION AND CONCLUSION	358
The objective of the study	358
<i>THE OUTCOME OF THE STUDY.</i>	360
<i>MATTERS RELATING TO THE STUDY DESIGN.</i>	361
<i>OBSTACLES TO RECRUITMENT.</i>	362
<i>COMPARISON WITH OTHER STUDIES.</i>	362
The use of questionnaires for evaluation of psychological state	363
<i>QUALITATIVE DATA AND PSYCHOSOCIAL MATTERS.</i>	366
<i>LIMITATION IN THE STUDY.</i>	370
<i>FURTHER RESEARCH AND POTENTIAL APPLICATIONS OF THIS RESEARCH.</i>	372
<i>THE IMPORTANCE OF THE INDIVIDUAL.</i>	373
BIBLIOGRAPHY	375
APPENDICES	

LIST OF FIGURES

Fig1: Immune and nervous systems cross talk.....	22
Figure 2: Basic configurations of immunoglobulins (antibodies)	52
Figure 3: IFN- γ model	54
Figure 4: The dimeric IgA molecule	57
Figure 5: The triangular relationship between the therapeutic protagonists.....	84
Figure 6: The Magical Mesh of the Group Communication.....	91
Figure 7: Mean Post-vs- Mean Pre-session Salivary IgA	146
Figure 7a: ID1 Salivary IgA.....	148
Figure 7b: ID2 Salivary IgA	149
Figure 7c: ID21 Salivary IgA.....	150
Figure 7d: ID 31 Salivary IgA.....	151
Figure 7e: ID 71 Salivary IgA.....	152
Figure 7f: ID 102 Salivary IgA	153
Figure 7g: ID 202 Salivary IgA.....	154
Figure 7h: ID 302 Salivary IgA	155
Figure 8: Group Mean Post vs pre-session salivary IFN- γ	158
Figure 8b: ID2 Salivary IFN- γ	161
Figure 8c: ID ₂₁ Salivary IFN- γ	162
Figure 8d: ID ₃₁ Salivary IFN- γ	163
Figure 8e: ID ₇₁ Salivary IFN- γ	164
Figure 8f: ID ₁₀₂ Salivary IFN- γ	165
Figure 8g: ID ₂₀₂ Salivary IFN- γ	166
Figure 8h: ID ₃₀₂ Salivary IFN- γ	167

LIST OF TABLES

Table 1: Intervention Time Points, Dates and Actions per Session.	129
Table 2: Recruitment Results	140
Table 3: ID numbers and names of completing participants.	142
Table 4: Time Points and Images Made During the Intervention.....	143
Table 6: S-IFN- γ Group Means Post-vs-Pre-Session Over Time Wilcoxon signed-rank test $p < 0.05$	159
Table 7: DTH test, Raw and Mean score	169
Table 8: DTH and IFN- γ Pearson Correlation: Significant at 0.05 (2-tailed)	169
Table 9: Mean scores: Mental Adjustment to Cancer Scale	171
Table 10: Mental Adjustment to Cancer Scale: Wilcoxon signed-ranks test: $p < 0.05$	171
Table 11: Mean Scores: Hospital Anxiety and Depression Scale	172
Table 12: Hospital Anxiety and Depression Scale Wilcoxon signed-ranks test: $p < 0.05$	172
Table 13: Mean Scores: COPE Questionnaire	174
Table 15: Mean Scores: EORTC-QLQ-C30 Quality of Life Scale.....	176
Table 16 EORTC-QLQ-C30 Quality of Life Scale.....	176
Table 17a: Pearson's Correlation chart for Negative correlations between Questionnaires:.....	177
Table 17b Pearson's Correlation chart for Positive correlations between Questionnaires:	178

LIST OF PLATES

Plate 1: The Black Hole.....	13
Plate 2: The Bloody Brick Wall.....	15
Plate 3: The Black Rainbow.....	15
Plate 4: The House of Hell.....	27
Plate 5: Singing the Soul's Song.....	36
Plate 6: The Hermeneutic Circle Becomes the Lemniscates of Infinite Possibility.....	120
Plate 7: Hecate's Call.....	197
Plate 8: First Group Image.....	220
Plate 9: Allan: KFD Aged 5 yrs.....	225
Plate 10: Allan: KFD Present family.....	225
Plate 11: Paul: KFD Aged 5 yrs.....	227
Plate 12: Paul: KFD Present family.....	227
Plate 13: Paul: Favourite Childhood Story: Snow White & the Seven Dwarves.....	228
Plate 14: Ron B:KFD Aged 5 yrs.....	230
Plate 15: Ron B: KFD present family:.....	231
Plate 16: Ron B::Favourite Childhood Story: Little Toot.....	231
Plate 17: Ron M: KFD Aged 5 yrs: <i>Summer holidays "my brother and I were terrified of girls"</i>	235
Plate 18: Ron M: KFD present family: <i>"My wife and I like to travel"</i>	235
Plate 19:Ron M: Favourite Childhood Story: The Three Little Pigs.....	235
Plate 20: Jim: KFD Aged 5 yrs, <i>"My dad went off to war when I was five: we didn't see him for years"</i>	238
Plate 21: Jim: KFD present family: <i>"We're all having a bar-b-que at home"</i>	238
Plate 22: Jim: Favourite Childhood Story.....	239
Plate 23 Darren; KFD Aged 5 yrs. Darren on his rocking horse.....	241
Plate 24 Darren: KFD present family. Darren and his wife and combined families.....	242
Plate 25: Darren: Favourite Childhood Story: Little Red Riding Hood.....	242
Plate 26: Colleen: KFD Aged 5 yrs <i>"Me and my sister playing in the yard"</i>	245
Plate 27: Colleen: KFD present family. All sitting together watching television.....	245
Plate 28: Rose: KFD Aged 5 yrs. <i>"Mum was a very sick lady"</i>	247
Plate 29 a-f: Diagnosis.....	257
a: Colleen.....	257
b: Paul.....	257
c: Darren.....	258
d: Jim.....	258
e: Ron B.....	259
f: Ron M.....	259
Plate 30: a-f, Bliss.....	260
a: Colleen.....	260
b: Paul.....	260
c: Darren.....	261

d: Jim	261
e: Ron B	262
f:Ron M	262
Plate31 a-d: ‘Stress’	267
a:Paul	267
b: Darren	267
c: Ron B	269
d: Ron M	270
Plate32 a-f: Colour Garden 1	275
a: Allan	275
b: Paul	276
c: Darren	277
d: Jim	278
e: Ron B	278
f: Ron M	279
a: Allan	282
b: Colleen.	283
c:Rose	283
d: Paul	284
e: Ron B	284
f:Ron M.	285
g: Darren	285
Plate 34 Jim:.....	286
Plate 35: a-h: Free Image.....	287
Plate 36: a-d: Misery and Joy	299
a: Allan Misery and Joy	299
b1:Paul: Misery	300
b2: Paul: Joy	300
c: Darren: Misery	301
d: Rose: Misery and Joy	301
Plate 37: a-h2; The Under Sea Journey.....	312
Plate 38 a & b: From Darren’s Diary.....	317
Plate 39:a-f: ‘I’m not Talking?’	321
Plate 40 a-f: Pain or Happiness.	323
a: Alan	323
b: Paul	323
c: Ron M	324
d: Ron B.	324
e: Jim:	324
Plate 41: a-f2: Body Outlines.....	325

Plate 42, a-g: A Celebration of ‘Me’	333
a: Allan	333
b: Rose	333
c: Jim	334
d: Paul	334
e1& 2.: Ron B:.....	335
f:Ron M:	335
g: Darren	335
Plate 43,a-h: Mask.....	337
a: Allan	337
b1 Rose: Being naughty.....	340
b2: Rose	341
c: Jim:	342
d: Ron B	343
e: Ron M	343
f: Paul	344
g Darren	344
h: Colleen.	345
Plate 44: Final Group Image	347
Plate 45, a-h. ‘What I’ve Taken from The Group’	349
a: Colleen:.....	349
b: Rose	349
c: Jim:	350
d: Paul:	350
e: Ron M:.....	351
f 1.: Darren:.....	351
f2:	352
g : Ron B.	352
h: Alan:	353

Healing

*I am not a mechanism, an assembly of various
sections,*

*And it is not because the mechanism is working
wrongly, that I am ill.*

I am ill because of wounds to the soul, to the deep

Emotional self

*And wounds to the soul take a long, long time,
only time can help*

And patience, and a certain difficult repentance

*Long, difficult repentance, realisation of life's
mistakes, and the freeing oneself*

*from the endless repetition of the mistakes
which mankind at large has chosen to sanctify.*

D.H. Lawrence¹.

Explanations (stories) can work on one level without reference to any other level. Be that as it may, there are those of us who are integrators. We want to find stories that work on several levels. We seek stories that explain the correlations among levels of explanation. Explanatory pluralism does not mean we must eschew multi-level explanations, but rather that no one level of discourse is inherently superior to another.

Lewis Mehl-Madrona²

ABSTRACT

Psychotherapeutic interventions have been used to support people with cancer for more than half a century, with continuing debate as to whether there is any impact on the disease process itself. Very few of those studies have assessed physiological impact, and although art psychotherapyⁱ has been employed to assess and enhance change in quality of life, reduction in distress and increased treatment compliance amongst adults and children with cancer, in the main these studies have been qualitative. To date few studies have been published reporting the use of **art psychotherapy** in the exploration of the human being from a systems perspective, using both biological and psychosocial means of assessment of efficacy, and at the time of research, none reporting immunological changes. The advantage of art psychotherapy over purely verbal psychotherapy is in the readily accessed unconscious content, and that a relaxed meditative state is entered in making images: it gives the body voice while creating a concrete record of the process. This study, therefore, addresses a gap in both psychoneuroimmunological and psycho-oncology research.

The objective was to assess if engaging in group art psychotherapy would have a positive effect on general quality of life with a reduction of 'stress' and if this would be reflected in immunological, psychosocial, image and narrative data. The specific parameters under investigation were salivary immunoglobulin isotype A (S-IgA), salivary interferon gamma (S-IFN- γ), delayed type hypersensitivity test response, psychosocial questionnaire results, images created during art psychotherapy and the narrative of that group process.

The study utilised a mixed methods approach. The quantitative arm of the study was framed within the positivist paradigm required for the assessment of discrete physiological and psychosocial parameters, while the qualitative arm of the study was framed in the interpretive paradigm suited to the investigation of subjective experience. The dominant philosophy informing the methodology for the qualitative work was hermeneutic phenomenology.

Analysis of salivary immunoglobulin alpha (S-IgA) results indicated that there was a general upwards trend in the group mean post-vs-pre-session levels, positively correlating to sessional

ⁱ The term 'art therapy' is used when quoted from another author; however it is generally interchangeable with the term 'art psychotherapy'.

emotional tone. The salivary interferon gamma (S-IFN- γ) results showed no such increase, although there was a correlation to emotional content in individual sessions and an overall upward trend.

There was an observable lessening of anxiety and improvement in interpersonal dynamics and participants' self report over time, not reflected in the psychosocial questionnaire results.

The study suggested that involvement in art psychotherapy does have a positive impact on immunological function, and has contributed to the understanding of a systems approach to healing, which may broaden understanding of the value of psychological support to people with cancer. This may be extrapolated to other chronic illnesses where immunological function must be optimised. The study has also demonstrated that it is possible to involve art psychotherapy in the scientific dialogue, without losing its integrity.

INTRODUCTION

Background

“.....an increase in B and T lymphocytes could be an important prelude to a participant’s abilities to engage cellular or humoral response to cancer.....optimal immune function is a necessary ingredient in the fight against cancer. Psychosocial interventions may be able to provide the setting in which immunosuppressed participants can boost their immune functions and possibly improve prognosis.” Glas et al.³

*“.... psychosocial interventions are much less likely to involve simple cause-effect relationships, and more likely to involve more complex and difficult to measure causal **processes** and dynamic relationships among variables, including synergy, positive and negative feedback loops, cascading events, curvilinear relationships and multiple contributing factors, all of which pose daunting measurement and design challenges.”*
Temoshok.⁴

In April 2006 the online edition of A Cancer Journal for Clinicians⁵ listed nine modifiable risk factors responsible for more than a third of the cancer deaths world wide, amongst which were alcohol and tobacco consumption (the biggest contributor to mortality) unsafe sex, air pollution, diet and obesity. ‘Stress’, however, was not listed, even though it is a well known contributor to all of the listed factors; indeed the toxicity of many pollutants is increased when ‘stress’ is an added feature^{6,7}. Perhaps the researchers reporting in this journal don’t recognise ‘stress’ as being modifiable or they consider it a ubiquitous ‘given’ in today’s world.

Nonetheless, for at least the last six decades researchers have been investigating the correlation between ‘stress’, personality and/or psychosocial factors, immunity and cancer in various permutations, and it is now recognised that those who use ‘Avoidance’ strategies have both poorer psychosocial function and physical outcomes in illness than do those who use ‘Engagement’ strategies^{8,9}. Further, in studies of ‘exceptional patients’ (those who survive beyond that which is clinically expected) repression is the single strongest predictor

of the onset of cancer, and that **any** expression of affect is, according to Katz and Epstein¹⁰, an important prognosticator of survival. It is also recognised that humour enhances coping, reduces overall stress and assists in ‘re-framing’¹¹: it also greatly facilitates interpersonal connection, thus reducing feelings of isolation

Glas and colleagues have made an interesting proposition, which I think has received little attention to date, in that psychosocial intervention effectiveness may depend upon cancer type, defined by the histology of the cancer cells: whether Type I (responsive to hormone treatments, but not drug or immune therapy/stimulation) and Type II (which responds well to immunostimulation and drug therapy). Melanoma, they point out, is a classic Type II cancer. The suggestion also points to the possibility of ‘tailoring’ psychosocial interventions to specific cancers, rather than the concept of psychotherapeutic modalities being trialled as effective or not.

Temoshok¹² points out that “*congruence matters*”, speaking about the incongruity of affect and physiological response amongst those she describes as Type C personalities, however, as Glas et al. suggest, there may be other issues of congruity to address. Temoshok¹³ has been researching the connection between psychosocial factors, personality types and HIV/AIDS and cutaneous malignant melanoma since the early 1980’s, and in 2004 made the point that our way of researching these aspects of personal ecology must change.

Since antiquity there has been both an observed and intuitive understanding of a relationship between personality types (for example the melancholic, sanguine and phlegmatic personality types known since at least Galen’s time) and also the impact of shock, isolation, despair¹⁴ and long term distress on health. In the twentieth century this understanding was subjected to scientific scrutiny which continues with gatehring interest into this century.

In 1956 leShan¹⁵ and his team published their propositions regarding what has become known as the ‘cancer prone personality’^{16,17,18}, followed in 1972 by the seminal work of Solomon and Amkraut, when they proposed that there was a definite connection between emotions, stress and immunity¹⁹, and in 1977 Achterberg, Matthews-Simonton and Simonton²⁰ described the personality factors which they found were prognostic of survival

beyond clinical expectation, at the same time as Bartrop et al²¹ identified the impact of bereavement on lymphocyte function.

In 1979 Achterberg²² and her team had extended the earlier work of the Simonton's²³ on visualisation, to investigate individual correlates between emotional state and immunological function amongst cancer patients. Brown et al²⁴ established that patients who perceived the treatment as being important to a cure of disease, who were actively involved with an understanding of their disease process and did not use avoidance as a coping strategy survived longer, results reiterated by Osborne et al²⁵.

Eysenck²⁶ went further with the personality theory to propose that there was a particular personality trait which predisposed to breast cancer, that of the 'good woman', which he seems since to have abandoned, in favour of a multifactorial approach, including genetic predisposition²⁷. Temoshok²⁸, on the other hand has defined a similar constellation of traits, the Type C personality; those who have blunted anger response, are unable to say 'no' or defend themselves appropriately, as of relevance to melanoma and HIV Infection, in particular. Greer and Watson²⁹ identified a sense of hopelessness and helplessness, deep despair and lack of interest in one's life as also contributory to the 'cancer prone personality'. As a counterbalance, Lazarus³⁰ points out, that resilience is a predictor of resistance to the negative consequences of 'stress'. Amongst the traits associated with resilience are: constructive thinking, hardiness, learned resourcefulness, optimism, self efficacy and a sense of coherence. These traits are learned.

Osborne et al also assessed immunological function, but found no correlation between immunological function and survival. While there is still debate as to the survival value of psychological support for oncology patients, it would seem that there is almost unanimous agreement regarding the positive effect on psychosocial state. Assisting people to change how they cope in the everyday world has been the *raison d'être* of psychotherapy in all its forms for almost a century, and there is no reason to believe that this does not apply to those whose illness manifests in the physical component of the BodyMind.

It is now a little over half a century since this ground breaking research, but only recently has it gained appropriate recognition in the field of general medicine. Two areas which seem to

have been a fertile ground for these kernels of change to grow have been stress medicine and psycho-oncology; the former arising from the very lucrative sports industry and the steadily increasing unremitting psychological pressure under which the general population in the West functions and the latter from a tremendous change in attitude to end of life care; palliative medicine.

In a paper in the European Journal of Cancer, in March of 2005 Baum³¹ and his collaborators go further and recognise that the study of breast cancer, and in all probability any cancer, necessitates a multi-layered approach, in essence the approach taken to investigate complex systems relying on the mathematics of chaos.

In 1989 a paper was published which has caused debate ever since. David Spiegel³² and his team were startled when they found that there was an apparent increase in survival of an average of 18 months amongst the women with metastatic breast cancer, who took part in their 12 month psychotherapeutic intervention. The research has been challenged, declared flawed and a host of other projects have failed to replicate their results, most notably a large study in Canada by Goodwin et al.³³. On the other hand there are several studies which have supported Spiegel's findings^{34,35,36}. A review of the statistics of Spiegel's study by Fox³⁷ suggested that the study group had in fact not survived longer, when compared to national and regional population norms. The difference in survival was found in the control arm which was found to be shorter than the population norm, perhaps explaining the non-replicability of the study.

The study undertaken by Fawzy et al, which informed this present project³⁸, has consistently reported a survival advantage, as a result of their intervention, up to 10 years later³⁹. The study utilised a six week structured psychiatric intervention, which appears to have been mostly psycho-educative, addressing issues such as coping strategies, relaxation and diet. Fawzy et al. reported statistically significant increases at 6 weeks post intervention in CD57 T-cells, and at 6 months post intervention this also included CD16 and CD56 T-cells, as well as natural killer cell activity (NKCA), with concomitant decrease in negative affect and increase in positive coping strategies and general quality of life. At 5 to 6 year follow-up the trend to longer survival and recurrence free time, in comparison to the control group was established, with retention of affective changes and general quality of life improvement. In

addition, factors predictive of survival were found in the Breslow depth of the original melanoma, age at diagnosis and affective state, the latter factor also being identified in Australia by Brown, Butow, Culjak, Coates and Dunn⁴⁰. Older onset age, with a tumour on the trunk, a Breslow depth greater than 1.5mm and being male, were all prognostic of lowered survival.

The advantage of using the Fawzy et al. and Brown et al. studies as a benchmark was that the study populations in all are the same; people with a diagnosis of cutaneous malignant melanoma, treated with simple surgical excision. Different markers of immunological activity (in the case of the Brown et al. study, none) and psychosocial questionnaires, however, were used. There are additional differences in the study reported in this thesis to these studies. While the intervention in my study was a psychosocial intervention, it was not structured, ran longer (6 months) and was an intervention which engages both cognitive activity **and** creative expressive activity (art psychotherapy), and in using the qualitative data, also gave the participants a voice.

In his analysis of the Spiegel study Fox made an astute observation, suggesting that there may well have been **‘an-as-yet-unidentified-difference’** between Spiegel’s treatment and control groups, a difference which might well have been masked by the population size of the Goodwin study (ten times larger than Spiegel’s). This difference was nonetheless important. Cunningham et al⁴¹, have revisited the notion of the ‘as-yet-unidentified differences’, and like the Simontons almost forty years ago, and Le Shan ten years prior to that, are investigating **‘individual differences’** to gain an understanding of unexpected survival. Unlike his predecessors, and like this study, Cunningham is not using a randomised controlled study design; rather, he has recognised the necessity for a qualitative study in order to identify qualitative differences between people and the differences of existential issues and how they are confronted, before embarking on any further quantitative study. This recognition of the importance of individual difference is something which, to date, has been lacking in many of the studies investigating stress, personality factors and disease in any shape.

The experience of the illness has rarely been discussed, although it has been recognised that the linchpin on which ‘stress’ hangs is **appraisal mediated by coping strategies**⁴². The inclusion of the narrative and images in my study, may well prove a further source of

information regarding the ‘as-yet-unidentified-differences’, **as coping strategies are reported as they change in direct connection to the appraisal process as it occurs.**

Lazarus, a psychologist who has worked in this field for more than half a century, remarked⁴³: *“I note, parenthetically, that psychology has for long been ambivalent about individual differences, opting for the view that its scientific task is to note invariances and develop general laws. Variations in such laws are apt to be considered errors in measurement, though they must be understood if reasonably accurate prediction is to be possible.”* In assessing invariances, as Cunningham⁴⁴ noticed, the exceptional is not seen. In fact the reliance on the randomised controlled trial construct militates against this very understanding. As Lazarus points out; statistical analysis seeks the norm, and regards the variant as ‘noise’. Yet it is in this noise that the song of the soul may be heard.

Individual differences in immunological results, coping strategies and response to the intervention were most certainly apparent over the time of my project, and would seem to concur with Cunningham’s exploratory findings, and those of Katz and Epstein⁴⁵, Kemeny and Laudenslager⁴⁶ and Davidson⁴⁷ reinforcing the much earlier work of Lazarus et al⁴⁸.

Davidson has reported on the importance of individual differences in affective style, their neural structuring and immunological correlates, which are evident as early as an infant’s first year of life. It may seem on the face of it that differences laid down so early are a set factor in the individual’s life, until it is also recognised, as Davidson points out, that neural structures are plastic, that is, contrary to previous belief, these structures are amenable to change, and one way in which this can be affected is through psychotherapy or direct learning. As with Lazarus, he identifies **resilience** as a crucial factor in recovery from the impact of negatively stressful events. There is a learned component to resilience.

Katz and Epstein and Cunningham all suggest that changes in coping strategies, particularly those related to the so called ‘cancer prone personality’, can ameliorate distress and disease, pointing out that these changes are consistent among people who survive beyond clinical expectation: they are the invariants amongst the variants. The positive changes revolve around engaging a capacity for resilience by learning constructive thinking and resourcefulness and allowing oneself to enjoy true optimism and full engagement with life with a sense of self efficacy and coherence.

A further observation made by Katz and Epstein, and which I observed amongst the people with whom I worked in the UK, is that around two years preceding a cancer diagnosis a period was experienced of what people so diagnosed perceived as significant distress.

Neither Spiegel, in that early research, nor Goodwin, however, described individual differences, reported on preceding stressors or assessed immunological function as a facet of reduction of the ‘stress’ which they were aiming to ameliorate. Their reports focused only on statistically relevant psychological change; and used different ways to assess that change, which means that comparisons of psychological outcomes are difficult.

The difference of measurement tools is a confounding factor in this area of research. Undoubtedly study designs will change, according to budget constraints and in order to progress, however true comparisons are problematic if different tools are used.

With regard to the questionnaires in general use there may be an over emphasis of the ‘case’, rather than a recognition that a degree of anxiety ‘goes with the territory’ of a clinical consultation of almost any kind, let alone one in which a diagnosis of a malignancy is the crux of the consultation⁴⁹. The dis-ease need not reach the extent of pathological anxiety or depression in order for it to be subjectively distressing to the ‘patient’ and family, or indeed, have a negative immunological impact⁵⁰. *“There are many realities, rather than a single one and deviance is not necessarily pathological.”*⁵¹

Tacón⁵² also points out that the issues of attachment/loss, is to be seriously considered in the development of affective styles, and that *“the inclusion of a developmental biopsychosocial perspective is offered because the traditional organic psychosomatic dichotomy has become obsolete by recent advances in psychoneuroimmunology and behavioural medicine. Health is contextually dependent...”* Furthermore it is important to keep in the forefront of the researcher’s mind that, while it is convenient and offers an **apparent** point of reference to take measurements at set times, psychological state (no less than health), is both a process⁵³, and context bound.^{54,55} There is now increasing recognition of the understanding that coping, in particular, is not a static function and may vary tremendously depending on the **context** and **duration**⁵⁶ of a physically or emotionally taxing experience^{57,58}, further discussed in Chapters 1 and 2.

Butow⁵⁹ states that results reflect benefit “as it is defined by researchers and clinicians whose measures and questionnaires patients are asked to complete.” Holmes⁶⁰ goes on to say that “definition and measurement at a static point may not capture the unique experience of **individuals**”ⁱⁱ.

These comments voice the concern regarding the use of instruments embedded in a positivist paradigm, while purporting to establish something which is in essence subjective, relational, context bound⁶¹ and interpretivist. It would suggest that another way of assessing this fluid state is required. As Butow pointed out, and Strong et al.⁶² also recognised, what ill people want is “*someone who cares*”: a sense of care may be conveyed in conversation, and through conversation an evaluation of **psychological state** is possible.

Kosslyn et al⁶³ make the statement that “*Individual differences show how biological mechanisms are called into play during psychological events and how these interact.....Without question, studying individual differences can clarify what previously had been muddy waters*”. They go on to say that “*...visualizing an aversive object can cause skin conductance increases like those found when one actually views the object....and memories of images are crucial for the interpretation of perceptual input...key facts about the link between psychological events and the immune system, (for example) dispositional differences in the effects of stress on the immune system, rely in part on the presence of social support.*”

From my perception there was a subtlety missed in the ‘personality as prognosticator of cancer’ propositions, which has caused a great deal of distress, and subsequent antipathy, particularly in the 1980’s and early 1990’s when it resulted in a ‘blame the victim’ stance, rather than an understanding of the deepseatedness of coping strategies which may have **led to** the behaviours that were identified as related to cancer. We are indeed what we think. Most of what we think, however, goes on beneath the surface, subconsciously, and that is the subtle but important factor missed by the proponents of the personality theory and the vast industry of ‘positive affirmations’ that followed. It is, however, recognised by Tacón in her work on attachment. This subtle difference may also point to one of the factors, which has been overlooked in the short duration interventions which failed to replicate Spiegel’s 1989 work⁶⁴ with a 12 month intervention. It takes time and patience to unearth and then change these modes of behaviour. It is also important to remember that we are **individuals** who are part of an environment which influences our bodyminds as much as does our thinking.

ⁱⁱ My emphasis.

As Cunningham⁶⁵ wrote more than a decade ago “*The diagnosis and treatment of cancer typically heralds a series of frightening events over which the patient has little control. Many studies, in both animal and humans, have shown that a sense of helplessness or lack of control may have profoundly negative effects on behaviour, mood and physiology*”.

Psychotherapy is central to altering such behaviours and mood and presumably also the accompanying physiological correlates. Art psychotherapy is a form of psychotherapy particularly suited to such periods of fear, anxiety and perceived lack of control, in that the person need not talk directly of these fears, but can rather approach them tangentially, through the metaphore of the images she makes. In the process of this ‘metaphore making’ she can also become absorbed almost in an ‘altered state of consciousness, and the soothing exercise of creating something over which there is control, the individual’s creative expression.

The Coming-into-Being of this Project.

Early Experience with Cancer Research

My initial contact with cancer research, as a young nurse, was with the children on a medical ward; children with leukaemia (both acute lymphoblastic and acute myeloid leukaemias) and involved in the early trials of Vincristinⁱⁱⁱ. Two children left indelible marks in my memory: one little girl was running around playing chasings around the ward with the other children, when her nose started to bleed. Within minutes she collapsed as she began haemorrhaging from every orifice of her body; the curtains were quickly drawn around her bed and half an hour later she was dead. The other children were hurried to the other end of the ward, where I was to keep them ‘occupied’. No-body spoke of her death.

The second was a little boy of five who was battling for every breath as a raging fever claimed his life in the final phase of acute lymphoblastic leukaemia. He knew, in a non-intellectual sense, that he was dying; he had asked me to look after his teddy if he ‘went away’, and also if it was a long way to heaven. He wanted to know if he could he catch a

ⁱⁱⁱ Vincristin, an alkaloid found in the Madagascar periwinkle, is a drug used in the treatment of haematological cancers.

plane, “*like my Poppy*”^{xi} to get there. We nurses were told not to speak of anything ‘emotional’ with him but only ‘happy’ things, were admonished to remain ‘professional’ and distant. His parents knew that he was dying, but were counselled to remain ‘positive’ with the child, lest they rob him of hope, at the same time as being told that there was ‘nothing more’ that could be done for him. There was an aching gap between the child and his parents as he died. We’ve come a long way since then, and it is acknowledged that even very small children have the right to appropriate emotional support when dealing with life threatening illness, as do their parents and families, and those who care for them. Art psychotherapy has been recognised as one of the media, *par excellence*^{66 67} through which to deliver such support.

After I left paediatric nursing I worked in the new Electron Microscopy Unit at the University of Sydney and was a laboratory technician processing photographic plates. One of the projects on which I worked was research into melanoma. At Queensland University, in the early 1970’s, I worked in the Department of Veterinary Science, again as a laboratory technician, and again on a cancer project, this time Mareck’s disease, an avian variation of lymphoma, triggered by a virus. I became aware of the immunological/stress involvement in cancer as chickens low on the ‘pecking order’ succumbed to the viral infection and died quicker than dominant chickens. McEwen and Seeman⁶⁸, in an article discussing the mediators of ‘stress’ remark that hierarchical struggles amongst animals (two and four legged) are amongst the most damaging in the long term.

Back in Sydney in the mid 1970’s, and at Sydney Hospital working in haematology, I assisted in bone marrow aspirations. Again, the patients suffered from acute lymphoblastic leukaemia, although they were adults and taking part in bone marrow transplant research. After a stint at the Eye Bank collecting and processing corneas I left laboratory work behind to learn about counselling drug addicts, enrolled in psychology and married a psychiatrist.

Involvement with cancer was no longer a facet of my life, I thought, as I was busy raising a brood of children and co-counselling with my husband. We attended training workshops with Stan Grof and became aware of the transpersonal movement and a profound shift in the study of consciousness. Stan had begun research in Czechoslovakia in the late 1960’s into

^{iv} The child’s grandfather had gone away on a holiday by plane, and had subsequently died.

perceptions of reality after LSD^v ingestion. He recognised, within the reported altered states of consciousness of his research participants, a commonly experienced phenomenon: a feeling of ‘universality’ or ‘one-ness’, where people experienced a feeling of being at one with the ‘divine’, and a sense of boundarilessness. When he moved to Esalen, California, in the 1970’s Groff⁶⁹, realised that a particular breathing technique that he had devised, ‘Holotropic breathing’ akin to controlled hyperventilation, resulted in the same types of experience. A couple of years later my husband’s younger son died as a result of complications from a regimen of drugs for what had been supposed, erroneously, to be a rare neurological disorder. Our youngest daughter was born three weeks later.

It was suspected that she had an intra-laryngeal tumour. Thankfully, she had what is called a ‘floppy larynx’ and a heart problem associated with a genetic disorder, Noonan’s Syndrome, instead.

We attended intensive workshops with Elizabeth Kübler-Ross, individually and together, to learn about, and attend to our grief. Through her I learned about the power of image making, in particular, the unconscious content, which was brought to the level of consciousness in the metaphor of imagery, as well as the process of well supported and dignified, conscious death. I had no idea that the latter was to be a guiding beacon for both of us.

Six months following the workshops, cancer came back into my life, and this time walked close by my side, when my husband was diagnosed with inoperable bowel cancer. A year later he was dead. During that year he often used the techniques of picture making learned at Elizabeth Kübler-Ross’ workshop.

Lessons from Grief

I recognised that there was both something I needed to learn about grief and the dying process, and something that I apparently had to offer, and joined a palliative care support training group. With the reality of having to support my four children I decided to explore

^v LSD: lysergic acid diethylamide: a hallucinogenic drug, used in the 1960’s and 1970’s in the study of consciousness, also used as a medication in psychiatry until the mid 1980’s when it fell out of favour: an illicit ‘recreational’ drug.

my artistic abilities and enrolled in Visual Art at University of Newcastle (the then College of Advanced Education), as well as a course in naturopathy in order that I would be able to create an income at home, because our younger two children were only 3 and 4 years old at the time. Shortly afterwards I began to explore my inner process with a Jungian therapist who had trained with Kübler-Ross. I couldn't balance the three processes as well as parenting, so dropped naturopathy and failed my second year of visual arts, moved to Sydney to train in Waldorf education^{vi} and then heard of the first conference of the Australian Art Therapy Association.

I attended the conference and my passion was fired!

I could see the relevance of what I had recognised as the recurring theme in my work life and understood what I had to offer. This required, however, that I go either to Perth where the first Australian post graduate course in art therapy had recently been set up, or to the UK to train. In the UK art therapy training was very well established. I applied to, and was accepted by, Sheffield University, and so the two younger children and I moved to Sheffield where we lived while I trained and eventually set up a pilot project as a part of a higher degree research project. The children had the wonderful opportunity of attending an ethnically diverse primary school close to the University.

Art Therapy Training: Lessons from My 'Patients'

Unlike my classmates, I requested a *practicum*^{vii} placement in the local oncology hospital because I wanted to take what I had learned from Kübler-Ross, and my husband's and step-son's processes, and see whether it could be applied in a hospital setting. I had an idea that if people were engaged in visualisation, as the Simonton's⁷⁰ suggested, and then enabled to externalise the visualisation through art therapy, the force of the visualisation would be potentiated, in a sense, made more focused, particularised and therefore more powerful; I had a hunch that the act of externalising that which had remained 'secret' and unscrutinised; sharing it with a trusted 'other', would unlock a source of previously unrecognised power or energy. With the image created by the patient sharing, as a third participant in an exchange, it

^{vi} Waldorf education was devised by Rudolf Steiner at the end of the 19th century.

^{vii} *Practicum*: The supervised, practical component of training, in a designated clinical placement.

would be possible to clarify any potentially negative or paradoxical content in the imagery, hopefully thereby transforming it to maximise the individual's innate capacity of attaining 'wholeness'. An excellent example to illustrate this point is that of Barbara, who was suffering from non-Hodgkin's lymphoma when she was referred for art therapy sessions.



Plate 1: The Black Hole

When I'd asked her to describe her cancer, she referred to it as a black hole, sucking all goodness into it, however, as she made an image of what she had described, she started with a small, intense black circle, **out** of which spiralled elegant lines of pure rainbow colours. Through the subsequent discussion, she explored what her cancer had **given** her, the **colour** that she had **gained** from it in her life and eventually her relationship to her father and her God, and how that was all at odds with her desire to live and give to her community as a lay preacher.

Unfortunately for my plans, while there were patients willing to engage in art psychotherapy, during my *practicum*, none of them had ever heard of visualisation, and I learned one of the most important lessons about the art psychotherapy process; I **followed and accompanied** the 'patients', **learning to listen intently to cues** for paradoxes (such as that described

above), or points of tension which would be clarified by the making of an externalised image, always trusting in their organic process of self healing.

What transpired was exciting stuff. Each one of the patients with whom I worked identified a major life event within a halo of between two and five years preceding their diagnosis, **and which they identified as being of significance to the onset of their cancer.** The identification occurred **only** through the image making and exploration of those images, suggesting that it is not simply the creative process in itself which is of importance, as is often suggested, particularly in British art psychotherapy. Another thing that was often revealed was an apparently unconscious ‘knowing’ of their disease process; something that I had learned about in workshops with Elizabeth Kübler-Ross, and one of her students, Greg Furth.

After my graduation I set up a pilot project, with the help of Professor Eric Wilkes of the Trent Palliative Care Centre, one of the pioneers in palliative care in the UK, to further research this amongst surgical oncology patients, and to test whether engaging in art psychotherapy had a positive impact on their disease process. The same pattern emerged. Unfortunately however, the project was abandoned after three months as the funding had been diverted to another project. I formed the participants into a group and worked with them for a further three months, unpaid, as I felt strongly that to engage people in a project in which they had agreed to participate for **twelve** months, and then terminate it without adequate explanation after such a short period, was unethical. The following two images state more strongly than I could in words, how two of the participants felt about the termination of the project. The first was made by a young woman whose mother had also been enrolled in a clinical trial, which had been ‘canned’ too. She had died of her breast cancer. Rachel, however, worked on her feelings of abandonment and anger, eventually marrying, having two children and becoming a teacher. The second was made by Di, who had recovered from surgery for her ovarian cancer, and saw the cancellation of the art psychotherapy project as a brick wall which removed the colour from her rainbow of hope. Di had experienced abuse both as a child, and then by the system on which she relied for care. She died 56 weeks after the termination of the group (there are 56 dividing marks on the blocking wall, through which the ‘pac men’ cannot chew).



Plate 2: The Bloody Brick Wall



Plate 3: The Black Rainbow

The surgeon was shocked at the impact of the cancellation of the project, when he saw her painting, but was powerless to change the allocation of funds required for the project to continue.

Without the funding I wasn't able to stay in the UK. I had been granted a student's visa, and I was reliant on the funding for the University fees and our livelihood, so I cancelled my enrolment, and we returned to Australia.

I set up a private practice in the Hunter Valley in NSW, working mainly with issues surrounding grief, psychological, physical and sexual abuse and children with attention deficit disorder (ADD), concurrently making several applications to continue my research, but the time was not ripe. Art psychotherapy was still in its infancy here in Australia, and only minimally recognised, even in the mental health setting.

In 1998 I lost my hearing as the result of a medical accident, and closed my practice. I 'went bush' to come to terms with the loss of a vital component of my existence, drew, painted and renovated a house. A friend in Sociology eventually teased me out of my self-imposed exile, when she suggested that I apply to the University of Newcastle to undertake research.

The then head of Fine Art (now The Conservatorium School of Drama, Fine Art and Music), Professor Anne Graham had the foresight to recognise the potential for art psychotherapy in BodyMind health and accepted my application. I constructed a protocol to explore the use of image making as a mnemonic in healing. Eventually I was introduced to Assoc. Prof Afaf Girgis, who had gained her own PhD researching the immunology and stress interface amongst university students. I showed her the mnemonic protocol, and another, which by sheer serendipity I had found while printing out the former. It was one of the proposals that I had created to examine the connections between immunological function, psychosocial function and cancer, shortly after my return from the UK ten years previously. She found it interesting and took me on as a research student. I was finally able to continue the research I had commenced in the UK.

I proposed that by involving participants in art psychotherapy their capacity for coping in the world would be improved as a result of the deep exploratory process fostered by art psychotherapy, and that this process would also unlock much destructive tension, leading to an improvement in both psychosocial and immunological function. The study population in the UK had been heterogeneous, but such a group presented difficulties from the immunological perspective. We decided, after a study of the literature, particularly the research of Fawzy et al.⁷¹, and consultation with various clinicians, that the best population of potential participants would be those with non-metastatic malignant cutaneous melanoma, which is a significant health issue, particularly in coastal Australia. This disease is treated initially with simple surgical excision, therefore eliminating a major source of

‘contamination’ of immunological results; chemotherapy and radiotherapy. We chose to assess fluctuations in immunoglobulin isotype alpha (IgA) and interferon gamma (IFN- γ), collected and isolated from whole saliva as a non-invasive test and a series of delayed hypersensitivity tests, to assess reactivity to an injected antigen, as measures of immunological ‘memory’. This was to be coupled with a battery of four psychosocial questionnaires to establish direction of shift over time in psychosocial strategies.

The project, which had been in gestation for a decade, came to maturity at the University of Newcastle.

The process, however, was far from smooth.

There were several supervisory changes, a long period without adequate supervision, and it finally reached fruition in the Faculty of Health under the excellent supervision of Dr. Margaret Dunkley, Conjoint Associate Professor in the School of Biomedical Sciences, my final primary supervisor. Margaret provided quantitative supervision and Professor Michael Hazelton, Head of School, School of Nursing and Midwifery supervised the qualitative arm of the study. He was enlisted a week after I’d fallen and broken my arm, moments following a phone call during which I had been told that no supervisor could be found to enable me to complete the write-up of my thesis.

I have experienced the duration of my enrolment as a research student as a profoundly deep process of personal ‘initiation’. During the time of this project I walked the path of death with nine people; one a friend of many years managing to come back a dramatically changed man for the encounter, and the closest three being my grandmother, who I nursed at the same time as I was recruiting participants, my son, who attempted suicide as I began writing up the results, and finally my sister, who was diagnosed with breast cancer within weeks of completing the draft of all but the discussion. I drove to Brisbane with a boot full of papers, books and my computer, and wrote while caring for and being with her through recovery from surgery and subsequent radiotherapy: death and transformation on many fronts.

I have been homeless for short times and yet have presented papers at two international conferences, all the while dealing with porphyria^{viii} and still accommodating to a severely restricted hearing capacity.

I have learned more about my strengths and the ‘meant-ness’ about this project than I could ever have envisaged. Each time I was ready to ‘chuck it in’, something was presented to remind me that this was not an actual option; like the connections with both my last supervisors, and a fortuitous ‘windfall’ of funds, unexpectedly sourced from the School budget, which enabled me to travel to Venice to present the findings at the International Psycho-oncology Conference in 2006, a book of van Manen’s and paper of Lewis Mehl-Madrona’s which crossed my desk at a crucial phase of my writing, restoring my passion for phenomenological analysis, and lastly a godsend in the form of a modest grant-in-aid.

This project then, came into being, almost, it seems, in spite of my intended plans, although it most certainly is consistent with a thread which has woven through my whole work history; the experiences and research associated with cancer, supported by the weft of bodymind and consciousness studies and flecked with spangles of creative expression.

^{viii} A genetic, metabolic disorder where porphyrins are not metabolised, Acute Intermittent Porphyria (AIP) is characterised by intense abdominal and low back pain, multiple chemical sensitivity, confusion, anxiety and depression.