

Spring April 2016

# An Exploration Of Creative Arts Therapies In Pediatric Hospitals

Jacqueline Marie Carlson

*Loyola Marymount University, jcarls11@lion.lmu.edu*

Hilda Mercedes Galan

*Loyola Marymount University, galanhilda@gmail.com*

Follow this and additional works at: <http://digitalcommons.lmu.edu/etd>

---

## Recommended Citation

Carlson, Jacqueline Marie and Galan, Hilda Mercedes, "An Exploration Of Creative Arts Therapies In Pediatric Hospitals" (2016).  
*LMU/LLS Theses and Dissertations*. 293.  
<http://digitalcommons.lmu.edu/etd/293>

This Research Projects is brought to you for free and open access by Digital Commons @ Loyola Marymount University and Loyola Law School. It has been accepted for inclusion in LMU/LLS Theses and Dissertations by an authorized administrator of Digital Commons@Loyola Marymount University and Loyola Law School. For more information, please contact [digitalcommons@lmu.edu](mailto:digitalcommons@lmu.edu).

AN EXPLORATION OF CREATIVE ARTS THERAPIES IN PEDIATRIC HOSPITALS

By

Jacqueline Carlson & Hilda Galan

A research paper presented to the

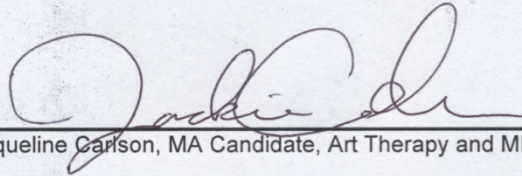
FACULTY OF THE DEPARTMENT OF  
MARITAL AND FAMILY THERAPY  
LOYOLA MARYMOUNT UNIVERSITY

In partial fulfillment of the  
requirements for the degree  
MASTER OF ARTS

May, 2016

Signature Page

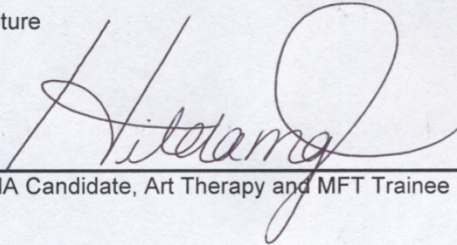
Author's Signature



---

Jacqueline Carlson, MA Candidate, Art Therapy and MFT Trainee

Author's Signature

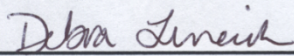


---

Hilda Galan, MA Candidate, Art Therapy and MFT Trainee

Research Project Advisor

Advisor's Signature



---

Debra Linesch, PhD, MFT, ATR-BC

Jacqueline Carlson, MA Candidate, Art Therapy and MFT Trainee

### **Acknowledgements**

The researchers would like to thank our research mentor, Debra Linesch, for her consistent encouragement and assistance with our research project. We would also like to thank Ann Stenglein for reviewing and providing feedback on our writing. Additionally we would like to acknowledge the creative arts therapists at Children's Hospital Los Angeles who were participants in the research process. Without the involvement of these individuals the completion of this research project would not have been possible.

### **Abstract**

This research paper explores the use of creative arts therapies with children and families in a pediatric hospital setting as experienced by the therapists who provide these services. The research investigates art therapy, music therapy and dance/movement therapy at Children's Hospital Los Angeles (CHLA), with an in depth consideration of the role of art therapy services in this setting. The researchers reviewed general literature regarding hospitalization, specifically its effects on children and families, availability and role of psychosocial services and the intensive care units (ICU). Literature discussing creative arts therapies (art therapy, music therapy and dance/movement therapy) was also reviewed, with a focus on art therapy and its role in medical settings with children/families, with pediatric cancer patients and in psychosocial services. Based on information gleaned from the literature review, the researchers crafted an online survey utilized to gather information regarding the experience of providing creative arts therapies in a pediatric hospital setting. The researchers conducted in-depth interviews with three selected survey respondents to further explore these experiences through interview questions and art making. The qualitative data from survey/interview responses, including the art, was reviewed and analyzed by the researchers. Analysis of the data resulted in five prominent themes from the online survey data: being present, family, support, change and identity. Four prominent themes emerged from the interview data: empowerment, culture, being present and identity. The researchers then examined these themes in the context of the general and art therapy literature. The meanings derived from these findings demonstrate the importance of continued and expanded use of creative arts therapies in pediatric hospitals.

**Table of Contents**

Signature Page.....	ii
Acknowledgements.....	iii
Abstract.....	iv
Table of Contents.....	1
List of Figures.....	5
Introduction.....	6
The Study Topic.....	6
Significance of the Study.....	6
Background of the Study Topic.....	8
Literature Review.....	9
General Literature.....	9
Hospitalization.....	9
Children.....	10
Family.....	11
Psychosocial Services.....	13
Intensive Care Unit (ICU) .....	16
Pediatric Intensive Care Unit (PICU) .....	16
Neonatal Intensive Care Unit (NICU) .....	18
Creative Arts Therapies Literature.....	19
Dance/Movement Therapy.....	19
Music Therapy.....	20
Art Therapy.....	21

Clinical Art Therapy.....21

Studio Art Therapy.....22

Medical Art Therapy.....23

    Children.....23

    Family.....27

Art Therapy with Pediatric Cancer Patients.....30

Art Therapy and Psychosocial Care.....32

Conclusion.....34

Research Approach.....35

Methods.....36

    Definition of Terms.....36

        Intensive Care Unit (ICU) .....36

        Pediatric Intensive Care Unit (PICU) .....36

        Neonatal Intensive Care Unit (NICU).....36

    Medical Art Therapy.....36

    Creative Arts Therapies.....37

    Psychosocial Services.....37

    Palliative Care.....37

Design of Study.....38

    Sampling.....38

    Gathering of Data.....38

    Analysis of Data.....39

Results.....40

Presentation of Data.....	40
Survey.....	40
Interview.....	41
Analysis of Data.....	43
Analysis of Survey.....	43
Analysis of Survey Art.....	45
Participant 5.....	45
Participant 6.....	47
Participant 8.....	48
Participant 10.....	49
Analysis of Interviews.....	50
Participant 1.....	51
Participant 5.....	53
Analysis of Art Response.....	55
Participant 7.....	58
Analysis of Art Response.....	60
Findings .....	61
Survey Themes.....	61
Being Present.....	62
Family.....	62
Support.....	63
Change.....	65
Identity.....	66



Interview Themes.....	67
Empowerment.....	67
Culture.....	68
Being Present.....	69
Identity.....	69
Meanings.....	71
Meanings Related to General Literature.....	71
Meanings Related to Art Therapy Literature.....	73
Conclusion.....	76
References.....	79
Appendices.....	84
A. Online Survey Informed Consent Form.....	84
B. Online Survey Questions.....	86
C. Email Sent with Online Survey.....	89
D. Interview Informed Consent Form.....	90
E. Interview Questions.....	92
F. Online Survey Responses.....	94
G. Interview Summary (Dance/Movement Therapist).....	101
H. Interview Summary (Art Therapist).....	106
I. Interview Summary (Music Therapist).....	111

**List of Figures**

<i>Figure 1.</i> Sources of research data.....	42
<i>Figure 2.</i> Survey responses to the question “What themes come up in the work you do?”.....	44
<i>Figure 3.</i> Art response from Participant 5 submitted with online survey.....	46
<i>Figure 4.</i> Art response from Participant 6 submitted with online survey.....	47
<i>Figure 5.</i> Art response from Participant 8 submitted with online survey.....	48
<i>Figure 6.</i> Art response from Participant 10 submitted with online survey.....	50
<i>Figure 7.</i> Art response from Participant 5 created during interview.....	57
<i>Figure 8.</i> Art response from Participant 7 created during interview.....	61

## **Introduction**

### **The Study Topic**

The purpose of this research is to explore the use of creative arts therapies with children and families in a pediatric hospital through the perspective of the therapists who provide the services. Specifically, the research intends to focus on how these therapies impact the children and families in the pediatric intensive care unit (PICU) and the neonatal intensive care unit (NICU). An online survey and interviews with the creative arts therapists who work at Children's Hospital of Los Angeles (CHLA), along with art responses, are used to gather data. The researchers utilize these methods to investigate the clinical experience as observed and lived by the creative arts therapists and provided to children and families at CHLA.

### **Significance of the Study**

This study is warranted due to the lack of literature regarding the use of art therapy, in comparison to the literature about other creative arts therapies, in a pediatric hospital. Therefore this research is beneficial to the field of art therapy because it increases the awareness of the impact of art therapy in these pediatric units. This is also valuable to CHLA for further partnership and research with Loyola Marymount University. The researchers hope to raise understanding within CHLA of the importance of their creative arts therapies program. Both researchers are passionate about the use of art therapy within these specific settings and its benefits to children and families. Researcher Hilda Galan had the opportunity to work at CHLA for her first practicum. While there, she gained experience as an art therapist working with children and families in various units, including the PICU. Researcher Jackie Carlson is currently working with children and families as an art therapist in the school setting and is interested in exploring how art therapy changes when working in the hospital environment. The

researchers anticipate finding that the use of art therapy increases attunement and communication within the family, as well as a sense of normalization for the children and family. They also expect to discover that creative arts therapies repair ruptured attachments within the family system. The findings might be used to increase support and funding of creative arts therapies in these units at CHLA. This research may also provide a greater understanding about the role of creative arts therapies with children and families in pediatric hospital settings, which may lead to further research exploring the children and families' lived experiences.

### **Background of the Study Topic**

The experience of hospitalization causes stress, fear and anxiety for both children and their families. Children may be fearful for a variety of reasons including: “separation from family and friends; being in an unfamiliar environment; receiving investigations and treatments; and loss of self-determination” (Coyne, 2006, p. 328). The child’s family also likely experiences stress due to uncertainty about their child’s condition and whether development will be affected (Tallon, Kendall & Snider, 2015). A common practice in pediatric hospitals is family-centered care (FCC), which is a partnership between the family and health care providers that promotes the child’s recovery and the wellbeing of the family (Kuo, Houtrow, Arango, Kuhlthau, Simmons, & Neff, 2012). The specialized units of the intensive care unit, specifically the pediatric intensive care unit (PICU) and neonatal intensive care unit (NICU), create additional stressors and considerations for treatment since these units provide care to children with life-threatening illnesses or injuries.

Many creative arts therapies, such as art therapy, music therapy and dance/movement therapy, are offered in pediatric hospitals to help children cope with the stressors associated with hospitalization. Art therapy provides many benefits to hospitalized children including “alleviat[ing] trauma, encourag[ing] emotional reparation, and enhanc[ing] mental and physical health in pediatric patients” (Malchiodi, 1999, p. 13). Art expression allows children to communicate nonverbally and gives them control by choosing materials and depicting upcoming procedures they may be worried about (Malchiodi, 1999). The use of art therapy in medical settings has been researched; on the other hand, the impact of art therapy with pediatric hospitalized children understood through the lens of the clinician was minimal.

## **Literature Review**

This literature review explores the work of various authors that discuss creative arts therapies in pediatric hospitals. It begins by discussing the general literature regarding hospitalization, psychosocial services, and the intensive care units (ICU). Then it reviews the creative arts therapies literature, connecting the use of dance/movement, music and art therapy to pediatric hospitals. It discusses the use of medical art therapy in general and then specifically addresses art therapy and psychosocial services and art therapy with cancer patients.

### **General Literature**

This section looks at the general literature regarding hospitalization, specifically how it affects children and their families, the psychosocial services offered in medical settings and lastly, the intensive care units (ICU). The section regarding the ICU further describes the pediatric intensive care unit (PICU) and the neonatal intensive care unit (NICU).

**Hospitalization.** The experience of hospitalization likely evokes a variety of emotions, especially ones of fear and uncertainty. This can certainly be true for children who may be experiencing their first hospitalization and do not fully understand what is happening. Coyne (2006) identifies how it is crucial that due to these circumstances, children are involved in their treatment and care and thoughtfulness are provided to help them understand what is happening. Coyne (2006) points out that children who are ill may be overlooked when it comes to consultation because adults believe they have limited abilities to communicate and understand due to developmental levels. The child's family members also are inevitably impacted by the hospitalization and may struggle to know the best way to support and care for their child.

**Children.** Coyne (2006) and Salmela, Salanterä and Aronen (2010) suggest that hospitalized children and adolescents experience a variety of fears and concerns related to illness. Coyne (2006) notes that hospitalization is likely a new experience for children and involves many changes in family and peer relationships, activities, school attendance and the environment, which inevitably contribute to feelings of stress. Although the new environment of the hospital likely causes anxiety, Coyne (2006) states that children who have been previously hospitalized are not less anxious. Coyne adds that children have a variety of fears regarding hospitalization, which fit into these categories: “separation from family and friends; being in an unfamiliar environment; receiving investigations and treatments; and loss of self-determination” (p. 328). Children also struggle with fears related to procedures and treatments they may endure due to the possibility of “harm, mutilation, pain and possible death” (Coyne, 2006, p. 331). These medical procedures are generally described as intrusive and represent loss for a child, which can include loss of identity. Coyne suggests that children may have apprehension regarding altered body image that comes with medical procedures, reflecting a concern about looking different from other children or having scars or disfigurement from procedures. Another concern regarding hospitalization is independence since children lose the ability to make basic decisions such as waking up and going to sleep, getting food or drinks and using the bathroom. The autonomy children might usually feel by being able to make these decisions is taken away by hospital rules, thus contributing to feelings of powerlessness (Coyne, 2006). The loss of independence likely has a negative impact on a child’s self-esteem. Due to the fears experienced by hospitalized children, it is important for hospital personnel to promote an environment of safety, understanding and preparation for procedures (Coyne, 2006). They must accommodate

the personal preferences of children when possible and encourage them to share what concerns they have so they can be addressed.

Salmela et al. (2010) suggest that due to the stress that accompanies hospitalization, it is important to figure out what might help children cope. Coping strategies are an important consideration because they can help a child deal with the trauma of hospitalization; Lazarus and Folkman describe them as “specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce or minimize stressful events” (as cited in Salmela et al., 2010). Salmela et al. (2010) provide examples of coping strategies, including pleasure, positive imagery, security, confidence, care, understanding the meaning of the situation, participating, asking for help, readjustment and protecting oneself. Children find comfort and are able to cope with hospitalization when they engage in play, use their imagination to think about familiar things, and have toys and their family present (Salmela et al., 2010). Due to the stressful impact of hospitalization, it is important to consider how children can best be supported through the process, especially through the involvement of the family.

**Family.** Salmela et al. (2010) suggest that being near parents and other family members is helpful for children to cope with their fears regarding hospitalization. Tallon, Kendall and Snider (2015) note it is also evident that parents often feel unsupported and may be uncertain about the best way to help their child. Parents feel stressed during the hospitalization of a child for many reasons such as uncertainty about the condition of their ill child and whether the child’s development will be affected. Tallon et al. (2015) add that there is also concern regarding coordination of care for other children, management of work responsibilities and possible financial strain and lack of support from others. Burns-Nader, Hernandez-Reif and Porter (2014)



state that these many stresses contribute to feelings of helplessness and suggest the importance of providing quality care to families of hospitalized children.

Kuo, Houtrow, Arango, Kuhlthau, Simmons, and Neff (2012) and Tallon et al. (2015) agree that family members should take an active role in discussing and making decisions. Kuo et al. (2012) describe a common practice in pediatric hospitals, family-centered care (FCC), which is described as “a partnership approach to health care decision-making between the family and health care provider” (p. 297). Tallon et al. (2015) mention that this approach developed from an increased understanding of attachment theory and how important it is for a child’s development to have their caregivers present during the traumatic experience of hospitalization. Kuo et al. (2012) add that family-centered care highlights the understanding in the medical field that including the rest of the family in the care of a child is important to promote recovery and positively impact the mental health and wellbeing of family members. Kuo et al. (2012) goes on to point out that although there are many different interpretations of what family centered care involves, there is consensus that it includes information sharing, respect and honoring differences, partnership and collaboration, negotiation, and care in the context of family and community. This type of care is most prevalent in pediatric settings since families are often involved in their child’s treatment. Family-centered care considers the needs of all family members, including the child (Kuo et al., 2012). Burns-Nader et al. (2014) suggest that family centered care helps parents feel useful in the care of their children, rather than helpless.

Tallon et al. (2015) mention that a parent’s ability to cope with their child’s hospitalization will be determined partially by their personal characteristics and also by the resources they have access to. Tallon et al. (2015) add that the hospitalization of a child causes great stress on parents, which could lead to anxiety and depression and thus impede a parent’s

ability to properly care for the child and contribute to poor physical and mental health outcomes. A parent's ability to provide appropriate care to their child is crucial to promote the wellbeing of the child. Therefore, the hospital personnel should focus on listening to and valuing the concerns and questions of family members so they can feel supported and confident in their ability to care for their children (Tallon et al., 2015). Burns-Nader et al. (2014) found that mothers who were able to utilize more coping strategies caused their child's anxiety to decrease. Burns-Nader et al. (2014) add that an increase in coping strategies can also lead to greater satisfaction in the overall experience of their child's hospitalization. A hospital can help a family cope by providing them with resources, which may include "giving information to the hospitalized child and family, offering a family break room, supporting the hospitalized child during periods of family absence, and maintaining a parent reference library" (Burns-Nader et al., 2014, p. 16).

The hospitalization of a child is likely unexpected and can cause the child and family a considerable amount of stress and trauma. Through a family-centered care treatment modality, which is prevalent in most pediatric hospitals, it is the responsibility of the medical team to provide satisfactory care to families. This can be accomplished by providing various psychosocial services to the children and families in the hospital.

**Psychosocial services.** Psychosocial services are important to facilitate family-centered care and help family members adjust to the hospitalization of a child. What services are available varies depending on the hospital. Kazak (2006) suggests the importance of providing psychosocial care that correlates with a family's intensity of need and risk. By viewing the child within the framework of his or her family, one can see the ways that the family might add to the child's distress and interventions can target this. It can also be helpful to highlight the strengths of a family to promote their resiliency and ability to cope with the situation. Pai, Patino-

Fernandez, McSherry, Beele, Alderfer, Reilly, Hwang, and Kazak (2008) mention that psychosocial risk can be understood as “a constellation of individual, family, social, and economic factors that, when considered collectively, increase the likelihood that an individual or their family members will experience difficulties managing the challenges of cancer and its treatment” (p. 50). Kazak (2006) suggests the use of a system to categorize families based on level of risk and need of psychosocial services, which is referred to as the Pediatric Psychosocial Preventative Health Model (PPPHM). The PPPHM divides families into three levels of risk: universal, targeted, and clinical/treatment.

Kazak (2006) describes the universal level as the largest group that represents children and their families who experience distress, but are resilient and utilize coping skills to adjust. Due to their apparent ability to function and adapt to a stressful situation, they are not likely to receive psychosocial services. Kazak (2006) adds that the next level, targeted, includes families who have preexisting aspects such as poverty, employment difficulties or family conflict and less effective coping skills, which may contribute to continuing challenges. The families in this level generally receive psychosocial services, but they may be inconsistent or limited to what is available in a particular unit. Lastly, Kazak (2006) mentions the families in the clinical/treatment category are at the highest risk for continued suffering from the hospitalization. These families receive psychosocial services, but may be in need of additional services and are generally “the most time and labor intensive to treat and use the greatest number of resources over time” (Kazak, 2006, p. 386). Pai et al. (2008) state the use of these three levels to categorize families is supported by a study that found mothers in the universal and targeted groups showed “less acute stress symptoms, fewer child problems, and less family conflict” (p. 60). It also found that mothers in the universal category showed less anxiety than the others.

These findings suggest that such a system could be used to categorize families and help them receive the necessary support during a hospitalization.

Kazak (2006) mentions that this model has been used as the basis to develop various screening procedures, which are currently being implemented at Children's Hospital of Philadelphia (CHOP) in order to make the process of assessing families and providing services more efficient. Pai et al. (2008) state that one of these, the Psychosocial Assessment Tool (PAT) is used to assess for psychosocial risk in families who have had a child recently diagnosed with cancer. Kazak (2006) points out that in the hospital environment, families generally do not need traditional psychotherapy, but rather "support, assistance with issues related to medical procedures and intrusive medical care, and consideration of short- and long-term health needs for their child and family" (p. 387). Kazak (2006) adds that the providers of psychosocial services include social workers, child life specialists, psychiatrists and psychologists and a child and their family may receive support from any combination of these. Social workers provide families with financial and social resources and possibly therapeutic interventions; child life specialists understand developmental needs of children and help them manage their experience of hospitalization; psychiatrists are involved in cases where a child's behavior makes it difficult to provide medical services; psychologists provide knowledge about a number of different presenting problems (Kazak, 2006).

Depending on the level of risk that a family is experiencing, they receive different levels of psychosocial support in the hospital through the providers mentioned above. Kazak (2006) describes that universal level families receive "general support, education, and access to resources that support and enhance child and family coping" (p. 388). Families in the targeted services level might receive more extensive counseling and support from a social worker or child

life specialist or be considered for a cognitive-behavioral or family therapy intervention (Kazak, 2006, p. 389). Kazak (2006) adds that families who need the most intensive services, those in the clinical/treatment services, are often referred for consultation by a psychologist and likely receive a specific treatment approach to best address their challenges.

Overall, psychosocial services are an important aspect in the pediatric hospital environment in order to promote adjustment to illness and hospitalization. These services can be particularly beneficial to support families with children in the ICU.

**ICU.** The intensive care unit (ICU) is a department of a hospital that provides intensive care medicine. The ICU serves patients with severe life threatening illnesses and/or injuries. Hospitals have ICUs that serve a specific medical specialty such as the pediatric intensive care unit (PICU) and the neonatal intensive care unit (NICU). This section focuses on the pediatric intensive care unit (PICU) and the neonatal intensive care unit (NICU), because Children's Hospital Los Angeles (CHLA) has creative arts therapy services in these units.

**PICU.** This section explores the literature on the PICU in medical settings and how it may be experienced both by children with illness and their families. It is important to understand the context of the PICU before exploring how it is experienced. According to Meyer, DeMaso, and Koocher (1996), the primary mission of the PICU staff is "acute, often life-saving, care" (p. 130). Admissions of PICU patients may be planned or unplanned. The types of PICU patients vary from children diagnosed with serious chronic illness to children recovering from complex surgeries. Meyer et al. (1996) note that for children common responses to being admitted include symptoms of anxiety or depression. Meyer et al. (1996) mention specific patient issues in the PICU, including the possibility that medical conditions or medications could affect a patient's current mental status. For PICU patients, following their medical crisis is a loss of

control, which tends to be the first and ultimate overwhelming stressor for them (Meyer et al., 1996). Children in the PICU may also experience loss of autonomy. For example, Mattsson Arman, Castren, and Forsner (2014) mention the severity of the child's condition may prevent the child's ability to express his or her needs, which results in the parents being more involved. The literature also provides insight into PICU family issues. Meyer et al. (1996) mention that family issues include the uncertainty and worry that comes with having a child in a PICU and that parents may be under great stress and worry. Their concerns involve the survival of their child, possible mental or physical impairments, the type of diagnosis, and the pain experienced by their child (Meyer et al., 1996). Miles and Carter (1982) mention that the abrupt admission, gravity of their condition, and the severity of the treatment or procedures can also be sources of parental anxiety. Miles and Carter (1982) discuss that the outcome of the admission also increases the anxiety level. According to Meyer et al. (1996) "parents often describe the emotional experience of being on [a] roller coaster" (p. 133). The literature on PICU families also addresses the experiences of parents having to surrender control of their child to the hospital clinical providers. Here, "the traditional parental roles of protector, provider, and decision maker are surrendered out of urgent necessity; this leaves some parents feeling lost and frustrated" (Meyer et al., 1996, p. 133). Parents essentially take on a passive role in giving the responsibility of caring for their child to the clinical staff (Mattsson et al., 2014). Parents might also experience an emotional and physical feeling of distance from their child (Mattsson et al., 2014).

Mattsson et al. (2014), emphasize that "caring" in the PICU involves treating the child as a whole person and being responsive to their needs. Mattsson et al. (2014) continue to mention that caring becomes evident when clinicians show sensitivity or awareness to the child's expressions and needs. Caring "intends to build bridges across chaos in the community with the

parents to anchor them in closeness with the child in the present” (Mattsson et al., 2014 p. 340).

Mattson, Forsner, Castrén, and Arman, (2013) argue the importance of the clinical staff, such as nurses, to show care for the patient and their families by giving the patient a sense of being a whole person that is seen and listened to. If care is not provided, patients’ suffering increases (Mattson et al., 2013).

*NICU.* This section explores the literature on the neonatal intensive care units (NICU) in medical settings. The NICU specializes in the care of premature or ill newborn infants who require specialized treatment. The birth of a premature newborn can be a stressful event for parents. According to Stacey, Osborn, and Salkovskis (2015) “the physical environment, the baby’s physical appearance or behavior, staff-parent interactions and alterations in the parental role” contribute to parental stress (p. 137). Stacey et al. (2015) created a study utilizing semi-structured interviews with parents of infants in a NICU to ask about their overall experiences in the unit. The objective of the study was to understand the factors that supported or hindered coping for the parents. The researchers pulled four key themes from the results of the interviews, which include rollercoaster of emotions, baby wellbeing, physical environment, and other people. The parents describe many different emotions that correlate with the unpredictability of the NICU such as “guilt, anxiety, fatigue, joy and apprehension characterizing their experience” (Stacey et al., 2015, p. 138). Although the wellbeing of all infants in the NICU is compromised, parents describe the value in seeing progress in their child to promote their own wellbeing. The interviewees mention the benefit of meeting other parents who help normalize their experience in the NICU and being able to have normal conversations with staff. The parents also describe additional stressors, such as not having choices, not always feeling included or not knowing what is happening with the care of their child.

Parker (2011) mentions that many mothers who have babies in the NICU may experience depressive symptoms, which likely affect their ability to connect with their child. Due to this, it is important to provide them with psychotherapy support (Parker, 2011). Parker (2011) highlights that NICU babies are part of a family that he or she is dependent upon, so the mother's experience should not be under-estimated. The stress of having a baby in the NICU "has the potential of detrimentally impacting the mother's relationship with her infant, therefore appropriate psychological support is imperative in order to minimize the severe long term consequences of this experience" (p. 182). Parker (2013) discovered that mothers saw counseling services as providing consistency and stability that gave them psychological support within a therapeutic relationship.

### **Creative Arts Therapies Literature**

This section begins by exploring the literature to define each of the creative arts therapies; it will review one article from the dance/movement therapy literature and one from the music therapy literature and then delve into the art therapy literature. Due to the vast amount of articles on various creative arts therapies and this literature review's focus on art therapy, only one article will be chosen as reflective of music and dance/movement therapies. All art therapy literature relevant to pediatric populations in a hospital setting will be reviewed.

**Dance/movement therapy.** The website of the American Dance Therapy Association (ADTA) describes dance/movement therapy as "the psychotherapeutic use of movement to further the emotional, cognitive, physical and social integration of the individual" (American Dance Therapy Association, 2016). Plevin and Parteli (2014) discuss the importance of the dance/movement therapist bringing a therapeutic presence into the hospital room in order to



promote a “moving, dancing, playing, holding environment” for the child (p. 230). The hospital environment inevitably impacts the child and family who must adjust to restricted movement and space and likely spend a lot of time sitting and waiting (Plevin & Parteli, 2014). This can be particularly challenging for children who are accustomed to moving and playing on a regular basis. Plevin and Parteli (2014) add that dance/movement therapy engages hospitalized children in movement they would not otherwise participate in while in this setting and can involve “using the bed or the child’s body as a percussive instrument, stamping feet on the floor, swaying arms in the air in time to music, or simply playing ball” (p. 232). A child’s movement conveys a message about their experience of illness, which the dance/movement therapist can understand and translate to hospital personnel in order to improve care. A child can be engaged in movement interventions by the therapist to shift their focus away from illness (Plevin & Parteli, 2014).

**Music therapy.** The American Music Therapy Association (AMTA) defines music therapy “as an established healthcare profession that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages” (as cited in Avers et al., 2007). Avers, Mathur and Kamat (2007) mention the therapeutic potential music therapy has in the pediatric setting. The utilization of music therapy in the hospital setting “can be effective in helping children cope with being in an unfamiliar environment in which many new and scary things may be occurring in their lives” (Avers et al., 2007, p. 576). It provides them with opportunities “to have choices and control in a therapeutic session [which] is integral since a patient’s choices are limited” (as cited in Avers et al. 2007, p. 576). Choices are provided in allowing them to choose between instruments or the song they would like to listen to or play (Aver et al., 2007, p 576). Music therapy allows pediatric patients to “cope with their pain, anxiety, and fear” (Avers et al.,

2007, p. 576). Music therapy can also encompass songwriting, which can be used in supporting families through a grieving process (Avers et al. 2007).

**Art therapy.** Most pediatric hospitals have a creative arts therapy program, which may include art therapy. This section describes the different types of art therapy that are practiced in the field. Since art therapy practices vary depending on the region and facility, it is important to understand how they differ. This section will focus on clinical art therapy and open studio art therapy. Due to the abundant amount of art therapy articles for these two types of practices this section will explore their differences using one article for each, written by the pioneer of that practice.

**Clinical art therapy.** To describe clinical art therapy, it is useful to look at an article which provides a concise description of clinical art therapy as practiced by Landgarten, who helped pioneer this specific type of art therapy and should be viewed as an expert on the topic. Here, Landgarten (1981) begins by describing her family art psychotherapy approach and how it is “dynamically oriented and based on family systems theory” (p. 379). The author then discusses art tasks that are utilized in assessing the family system and helping the therapist understand the family through the art process and content. The art tasks include the family creating an art piece together without talking, which can be done in two separate teams if there are at least four family members, and a single piece of art created with talking. Landgarten provides descriptive case examples of both of these tasks. The author also describes what the art therapist should be noticing while observing the family complete the art tasks, which demonstrates how valuable an art task can be in understanding the family dynamics. Landgarten then discusses the role of the art medium and how the art therapist must consider the goals of

interventions when determining whether to use structured (markers, colored pencils) or unstructured (clay, paint) art materials.

*Studio art therapy.* To describe studio based art therapy, it is useful to look at a summarizing description of a type of studio based art therapy, open studio, as practiced by Pat Allen, who along with two other Chicago area art therapists began to further this concept. It is important to note that in the open studio process the spirituality component is the belief in the existence of a force that may be anything from God, nature, the universe, energy, to creativity. In the open studio process clients make art alongside another person and the therapist. Allen (2011) adds that “by engaging in one’s own art making alongside another person, the therapist models in actuality what faith in a force larger than oneself looks like – the process of risk and openness to the unseen” (p. 183). Allen explains that because of the personal engagement during the open studio process no comments from others about the art or the witness writing are allowed. Allen distinguishes this being a great difference between open studio and traditional art therapy.

The open studio process begins with an intention, which is “a statement, composed by each person for him or herself, directed toward the universe, acknowledging what the participant wishes to receive from engaging in the process of art making” (Allen, 2011, p. 182). The next step that occurs after the intention is the art making, which can be two hours long. Following the art making is the writing about the art, which can be twenty minutes long. Here “participants are encouraged to write as freely as possible, without regard for grammar, syntax, or sense, adding anything that comes to mind, including judgment or self-observations, without censorship” (Allen, 2011, p. 183). After the writing, each person is presented with the opportunity to read their intention, writing, or talk about their artwork. No comments are allowed while others

share. Lastly, the therapist/facilitator may choose to end the time here or if time remains, a chime is rung and a brief meditation or a physical activity is offered.

***Medical art therapy.*** This section explores the use of art therapy in medical settings and how it is experienced both by children with illness and their families. Malchiodi (1999) mentions that art can “alleviate trauma, encourage emotional reparation, and enhance mental and physical health in pediatric patients” (p. 13). Creating art allows hospitalized patients to increase their wellbeing through focusing on something other than their illness. Councill (2012) suggests that art may also provide hope and the opportunity to learn to cope with pain by exploring fears about medical procedures. Malchiodi (1999) describes art therapy as utilizing art expression with individuals who are experiencing physical illness or enduring intense medical treatment. The approach of medical art therapy can be dated as far back as 1945, when Adrian Hill, an artist suffering from tuberculosis, realized that art was helpful for his recovery (Malchiodi, 1999). Councill (2012) adds that medical art therapy can be helpful so children can communicate their perceptions and needs to the treatment team who takes care of them. Both children and families can be impacted by the use of medical art therapy.

***Children.*** The art therapy process provides hospitalized children the opportunity to explore what is happening; it gives them a visual language to communicate their experience to others. Councill (2012) and Prager (1995) mention that art created by children in a hospital setting may show thoughts and emotions about loss of control over surroundings and uncertainty about the possibility of death. Malchiodi (1999) adds that the art process can provide children the opportunity to prepare for a medical procedure by depicting it, which may reduce their anxiety. On the other hand, the art may be about something unrelated to their hospitalization since it gives them the opportunity to think about other things (Malchiodi, 2012; Prager 1995).

Arnett and Malchiodi (2013) discuss how a child's spontaneous drawings in medical settings may provide a wealth of information to help the therapist and other hospital personnel understand what the child is experiencing internally regarding their illness. This understanding can help a child receive the best possible care while experiencing a potentially traumatic hospitalization. Councill (2012) notes that many hospitalized children do not suffer from mental illness; therefore the goals of art therapy in this environment are generally to "uncover strengths, coping mechanisms, and qualities of resilience" (p. 225). Art therapy can be particularly helpful because it brings awareness to a client's strengths. Malchiodi (1999) states that children must cope with many factors while in the hospital such as loss of independence, pain from treatment, altered body image, and a struggle to deal with the trauma of the situation and understand why they got sick. The art therapy process can facilitate exploration of all these challenges, helping children feel empowered in a situation that generally makes them feel helpless.

One common challenge children encounter in hospital settings is the loss of control; in the structured setting of a hospital, there are many rules, which tend to restrict a child's ability to make choices in their daily life. Prager (1995) suggests that art therapy gives children a chance to be in charge, thus allowing them to preserve their autonomy despite a restrictive hospital environment. The art process gives hospitalized children many options including what art materials to use, what imagery to create and who they want to share the art with (Prager, 1995). Malchiodi (1999) adds that the physical, active quality of "making, doing, cutting, arranging, molding, gluing, and constructing" (p. 16) experienced during the art making process may help children feel purposeful and in control. Councill (2012) suggests that creation of a physical, tangible art product shows a child that they are capable of accomplishing something, thus helping them feel that they can actively work to get better rather than feel victimized. Malchiodi

(1999) and Councill (2012) add that art also gives children the opportunity to reveal how they perceive medical procedures, which can give them a sense of mastery over upcoming examinations. The art can reveal perceptions children have about medical tests, which may be inaccurate and contributing to their fears. It can be helpful for the therapist to intervene and assist the child in understand what is happening in their body. Councill (2012) also suggests that children might use medical equipment and alter it into a new art piece, helping them gain control over their environment.

Since pain involved with medical procedures and treatment usually contributes a great deal of stress to hospitalized children, Councill (2012) shares that art therapy can serve as a “proactive tool for coping with pain that is not fully relieved by medication” (p. 229). Councill (2012) adds that art can be utilized in many ways to express pain, such as creating a scale of pain, showing location of pain within a body outline or drawing symbols or lines to represent pain. Being able to visually depict what is happening in their physical body may make it easier for children to verbally describe their pain and think about ways to cope with it. Councill (2012) further states that children will likely respond positively to the art therapist who brings art materials into the sterile hospital room, rather than needles or pills, as most of the other hospital professionals do. The process of creating artwork can simply be therapeutic to allow children to direct their physical body to focus on something other than their illness. Arnett and Malchiodi (2013) mention that focusing on drawing positive imagery might also help children reduce their fears and thus increase the effectiveness of treatments.

Another challenge due to hospitalization is the struggle for a child to understand the physical changes they experience due to illness and how their body image is altered due to these changes. Malchiodi (1999) mentions that body image, or “how an individual mentally represents

or perceives his or her body” (p. 20), can be significantly threatened or altered through hospitalization. Art therapy allows children to explore their identity and create a new sense of self amidst many changes. Malchiodi (1999) points out that the experience of hospitalization involves “wearing hospital clothes, experiencing unfamiliar surroundings, smells and sights, and fear and confusion about what is happening” (p. 17) which all affect a child’s understanding of his or herself and the world. Since hospitalization most often involves physical defect of some kind, children struggle to integrate their condition into their self-image. Cameron, Juszczak and Wallace (1984) suggest that this struggle may be revealed in their artwork through “omission, exaggeration, or additional body parts” (p. 108). Cameron et al. (1984) also note that invasive procedures that may accompany hospitalization contribute to a child feeling overwhelmed or scared, which is subsequently revealed in the artwork; a child may depict themselves relatively small in comparison to doctors, medical equipment or other surroundings. Due to the frightening nature of hospitalization, children might also project their fears onto animals or other subjects they choose to include in their artwork. Malchiodi (1999) points out that self-image can be explored through creation of a body outline where a child fills in the outline with colors, lines and images to represent the pain they are experiencing. Cameron et al. (1984) add that these outlines can be used for children to better understand their body image, by exploring different parts and their functions, and adjust to issues occurring with their physical selves.

The experience of illness has been described in the literature as traumatic and life altering; therefore the opportunity to use art therapy can help children explore the intense emotions surrounding trauma. Council (2012) notes that many children and families experience some symptoms of trauma and “may feel frightened, helpless, and vulnerable” (p. 232) after diagnosis and while being treated. Council (2012) adds that an illness is likely unexpected,

which also contributes to the traumatic experience of it. Art can be particularly beneficial in the treatment of trauma because it brings patients into the present moment by focusing on the tactile qualities of the various art materials. This is important because hospitalized children may be experiencing posttraumatic symptoms, which could include “reexperiencing, avoidance and arousal symptoms” (Councill, 2012, p. 232); therefore, art reminds them they are in the here and now. The art process can also help the therapist build rapport with children, thus creating a safe environment for the child to feel comfortable sharing their feelings. Creating art can help patients integrate their experiences in a nonverbal manner. Councill (2012) suggests that since traumatic memories are stored in the nonverbal hemisphere of the brain in sensory and emotional details, the nonverbal qualities of the art process can help patients access these memories. Due to the potential trauma of hospitalization, it is likely that children will struggle to understand why they became ill. Many children believe it is punishment for something they have done (Councill, 2012). Malchiodi (1999) adds that the art therapy process can be beneficial to address these concerns and help clients reauthor their narratives about illness.

The literature makes it evident that hospitalized children can improve their wellbeing through the use of art therapy. It is also important to involve the family in such treatment as they may also benefit from this therapeutic modality.

*Family.* Since the family is inevitably affected by and involved in a pediatric patients’ treatment and recovery, it is important for the family unit to be incorporated into medical art therapy. Councill (2012) and Malchiodi and Goldring (2013) suggest the traumatic impact of childhood illness on both the child and his or her family. Councill (2012) adds that children are able to cope better with illness if their parents are actively involved and receive information about their child’s treatment. Therefore, when integrating art therapy into a hospital setting, it is



important for the therapist to support not only the child, but also the family. Malchiodi (1999) points out that this may take the form of learning about the child's perceptions of family interactions and the support he or she receives from family members. Council (2012), Martin (2013) and Malchiodi (1999) agree that involving the caregivers in mental health treatment is important to make sure they are aware of what is happening with their child.

Martin (2013) states that the family is greatly impacted by the hospitalization of a child and might experience stress, guilt, isolation and worry. Council (2012) asserts that medical illness requires all family members to adapt and may even involve a temporary move to receive specialized care, which increases stress. Martin (2013) supports this idea and suggests the need to treat the whole family unit by mentioning that parents of pediatric patients have higher levels of posttraumatic stress symptoms than their children. On the other hand, Prager (1995) suggests working just with the children to allow them the opportunity to be expressive and meet other children, unless it becomes apparent that "the parents are impeding the overall wellbeing of the patient" (p. 33).

When a child is ill, the rest of the family experiences a great deal of stress and can benefit from art therapy to address these concerns. Martin (2013) emphasizes that parents might feel isolated and stressed, and as though they are losing part of their identity to care for their child. They may also worry about whether the child will get better. Siblings of an ill child also struggle with difficult emotions. Martin (2013) adds they may feel isolated and not cared for by their parents or they might feel fearful that they caused the illness. Since parents do not have as much time to dedicate to the siblings who are healthy, siblings might keep their emotions inside to avoid adding more stress to what their parents are dealing with. Malchiodi (1999) notes that family art therapy can help improve communication between family members about what is

happening. The child can draw his or her pain and the primary caregiver can draw how they perceive their child's pain. This can be important in bonding and gaining understanding about what the child is experiencing. Malchiodi (1999) points out that art therapy with the rest of the family can also provide an understanding of how culture and religion may affect the child's understanding of why they are ill and how they can cope with it.

Martin (2013) mentions a distinction between family art therapy and medical art therapy. Family art therapy "encourages communication and provides a visual record of family patterns and dynamics" (p. 306). Since family art therapy involves all members of the family, it is likely that this will not be possible in the hospital setting; therefore, the therapist must adapt these practices to fit within the hospital setting. Most often, art therapy sessions in the hospital will include the patient and one other family member if possible. Martin (2013) asserts the benefits of these families participating in art therapy, which may include the patient seeing how concerned the family is, the patient sharing his or her experience of the hospitalization, and the patient's siblings expressing their emotions and increasing their understanding of the situation.

Medical art therapy with families is the adaptation of family art therapy to accommodate the hospital environment and the reality of the complexity of pediatric hospitalization, which creates challenges to involve all family members in treatment. Martin (2013) describes the focus of this approach as evaluating the family, working with siblings, helping families express feelings and trauma stories, addressing family separations, and addressing grief and loss. Many different art interventions might be helpful to explore the emotions of a family. Martin (2013) mentions that one in particular is mask making, since this process allows the patient, siblings and parents to "express identity, feelings, and perceptions of each other and the hospitalized individual" (p. 308). It is important to consider the impact of illness on a child's siblings and

provide understanding of the treatment to reduce the fear that siblings may experience. All members of the family may potentially experience trauma if the child is being hospitalized due to an injury; therefore, having them draw about what happened can help them integrate the experience. Martin (2013) emphasizes that the family will inevitably deal with grief and loss during their child's hospitalization, either from preparation for the possibility of their child's death, the death of their child, or grief from past losses. Art can help family members create images of strength, faith and hope to help them cope with the uncertainty of hospitalization. Martin (2013) notes that scrapbooking can be a beneficial way for families to document the event of a child being in the hospital by taking photos and writing about what is happening. This can serve as a tangible reminder of an impactful event in a child's life. Supporting the family is an important consideration when a child is hospitalized, and art therapy can serve as a means to encourage expression and improve wellbeing. Art therapy promotes the ideal of family-centered care in pediatric hospitals because it encourages the involvement of parents and siblings in the care of the child.

*Art therapy with pediatric cancer patients.* This section explores the use of art therapy with pediatric cancer patients. According to Councill (1999) children with cancer may enter long term medical care, which exposes them to foreign sounds, smells, sights, language, and medical procedures. Children with cancer face many challenges such as psychosocial and physical impacts of cancer because of the illness itself or certain medications (Councill, 1999). Councill (1999) mentions the child's knowledge or questions about death or dying being a psychosocial impact of cancer. Physical impacts of cancer may include hair loss, rapid weight gain or loss, decrease or increase of appetite, mood disturbances, and lability (Councill, 1999).

Another physical impact to consider is how children with cancer may experience their sense of taste altered during or after their period of chemotherapy (Councill, 1999).

Malchiodi and Goldring (2013), Councill (1993), and Councill (1999) suggest that art therapy addresses the child's emotional and developmental needs under extreme stress in dealing with cancer. Councill (1993) suggests that art therapy may be used to reduce symptoms of depression and anxiety, raise a patient's sense of control and autonomy, and provide communication with their family and medical team. Councill (1999) also demonstrates the use of art therapy to support children while they are receiving treatment. "Creating art offers the comfort of touch, the freedom of nonverbal expression, reduction of stress, and the opportunity to exercise a measure of control" (Councill, 1999, p. 75). Goals of art therapy with this population may include communicating emotional expression, encouraging symbolic representation of physical states, expressing expectations of treatment outcomes, developing personal imagery, encouraging interaction between other patients, including opportunities for mutual support, and building a sense of competence and control (Councill, 1999).

Councill (1999) expresses the importance of art-based assessments and interventions and advocates for the use of these tools to help patients work through internal conflicts and their physical illness. The art can become "a window not only to the patient's feelings about his or her illness, but also to cognitive and developmental maturity, coping styles, and personality" (Councill, 1999, p. 79). Malchiodi and Goldring (2013) mention that art therapy approaches are respectively adapted to the needs of pediatric oncology patients. Malchiodi and Goldring (2013) add that art therapists provide interventions designed to connect the psychosocial impact of medical illness, to strengthen adaptive coping skills, and to aid patients and families in

developing resiliency and posttraumatic growth. Malchiodi and Goldring (2013) state that patients' capacities and capabilities can also be evaluated through art therapy.

Councill (1993) describes how art therapy may be valuable in the beginning and middle phases of treatment and during moments of relapse or palliative care. The beginning phase of a child's cancer treatment affects their views on their body image and their identity. The child "may try internally based coping strategies which results in possible depression, withdrawal, self-blame, and alienation" (Councill, 1993). Councill (1993) suggests, "a supportive, client-centered, and at times nonverbal approach can help the patient both express troubling feelings and regain some sense of bodily integrity and self-worth" (p. 80). During the middle phase of treatment, intervention is intended to support the child through the long-term stress of their cancer treatment (Councill, 1993). Council (1993) notes that art therapy provides a valuable channel for reflection of feelings about losses and self within a supportive therapeutic space. Council (1993) and Malchiodi and Goldring (2013) also support the use of art therapy during moments of relapse or palliative care. Council (1993) suggests "the power of art to give expression to profound existential themes and the relationship with the art therapist can be a strong support to the patient when words are too difficult either to say or to hear" (p. 85). Malchiodi and Goldring (2013) note that a contribution of art therapy with this population is "the possibility of helping young people emerge from their illness as emotionally whole and healthy as possible" (Councill, 1999, p. 91).

*Art therapy and psychosocial care.* Art therapy is an important psychosocial service that pediatric hospitals provide along with others that promote healthy adjustment for children who are hospitalized and their families. Malchiodi and Goldring (2013) mention that psychosocial care focuses on the individual needs of each child due to illness and hospitalization; the goal is to

“support and enhance children’s growth and recovery by addressing emotional, cognitive and social needs of individuals” (p. 49). Malchiodi and Goldring (2013) point out that the process of providing psychosocial care begins with an evaluation of various aspects of a child, including development, affect, interpersonal relationships, previous stress or trauma, coping skills, self-efficacy and self-concept.

Art therapists and child life specialists work closely to assist with psychosocial needs and both are knowledgeable about the emotional and developmental needs of children. Rode (1995) describes the goal of both creative arts therapies and child life programming as “protect[ing] and enhanc[ing] the emotional, social, cognitive, creative, and imaginal integrity of children undergoing the stress of illness and hospitalization” (p. 106). Both art therapy and child life programming utilize play to engage a child’s imagination despite serious illness. Rode (1995) states the role of a child life specialist is to “use play to provide developmentally appropriate, normalizing, and educational experiences to children during hospitalization and illness” (p. 104). Rode (1995) adds that the role of the art therapist involves engaging the imagination of children suffering from physical illness through art making. The art can serve as an intermediary between a child’s inner feelings regarding hospitalization and the world they live in. When end of life issues are addressed, art therapy will focus more on the rest of the family, especially siblings. Malchiodi and Goldring (2013) note that at this time it is also beneficial to help children prepare for death by making art as a tangible object by which he or she can be remembered by others.

Psychosocial care involves various specialists, including art therapists, who provide services in order to reduce potential stress and increase coping of children and adolescents with physical illness. These services are beneficial to promote use of healthy coping skills and adjustment to illness and hospitalization.

**Conclusion**

The purpose of this literature review was to explore the creative arts therapies in pediatric hospitals. To do so, it first looked at the general literature regarding hospitalization, psychosocial services and the special departments of the intensive care unit, the PICU and the NICU. The literature about hospitalization discusses the stressors that children and families undergo when a child is hospitalized, whereas that on the PICU and NICU mentions the specialized challenges that come with having a child in these hospital units. The information about psychosocial services discusses the ways in which children and families are able to receive support in pediatric hospitals. This information naturally informs the creative arts therapy section of the literature review since various modalities are utilized to help children cope with the stresses of hospitalization. Art, music and dance/movement therapy each provide a unique lens through which to help children and their families process the experience of hospitalization. There is a great deal of information regarding medical art therapy and how the pediatric hospital setting informs the process. Art therapy gives children a sense of autonomy by choosing materials and depicting medical procedures they may be nervous about. Overall the general literature is ample, while the creative arts therapy literature is limited. Literature regarding art therapy in a pediatric hospital setting as understood by the creative arts therapists who provide the services was minimal, suggesting the need for further research on this topic.

### **Research Approach**

This research project utilizes a qualitative research approach, specifically an online survey emailed to participants and in-depth interviews of creative arts therapists at CHLA. Both the survey and the interviews ask the therapists to engage in art making as a way for the researchers to understand and examine the therapists' experiences. The researchers chose to explore the topic via qualitative methods because of the unique experiences that are captured best through personal, verbal and nonverbal accounts (art making) of the therapists. A qualitative method allows for themes to emerge from the data and to maintain the "meaning that the participants hold about the problem or issue" (Creswell, 2014). These aspects are essential to gather the richest data that informs an understanding of the creative arts therapists' experiences. The researchers utilize three collection methods including surveys, qualitative interviews and qualitative visual materials (art responses) (Creswell, 2014). Parker (2011) adds that utilizing an interview method with mothers in the NICU to learn about their experiences receiving supportive counseling services was beneficial to "provid[e] descriptive accounts of the mothers' experiences and [allow] new themes to emerge" (p. 184). The inclusion of art making as a source of data both in the survey and the interviews will help guide the research question by allowing themes to emerge. Kapitan (2010) suggests that the artwork that participants create will need to be interpreted "to illuminate for others the meanings and understandings contained in the experience" (p. 170).



## Methods

### Definition of Terms

**ICU.** The Intensive Care Unit (ICU) is “a unit in the hospital where seriously ill patients are cared for by specially trained staff” (“What is the ICU,” 2014). The ICU includes staff such as “doctors, nurses, respiratory therapists, clinical nurse specialists, pharmacists, physical therapists, nurse practitioners, physician assistants, dietitians, social workers, and chaplains” (“What is the ICU,” 2014). Here people can recover from very serious illnesses, accidents, or operations.

**PICU.** The Pediatric Intensive Care Unit (PICU) is “the section of the hospital that provides sick children with the highest level of medical care” (“When Your Child's,” 2015). The PICU “also allows medical staff to provide therapies that might not be available in other parts of the hospital,” such as more serious therapies, which “include ventilators (breathing machines) and certain medicines that can be given only under close medical supervision” (“When Your Child's,” 2015).

**NICU.** According to Stanford Children’s Care “newborn babies who need intensive medical attention are often admitted into a special area of the hospital called the Neonatal Intensive Care Unit (NICU)” (“The Neonatal Intensive,” 2015). The NICU integrates “advanced technology and trained health care professionals to provide specialized care for the tiniest patients” who may be premature, have low weight, or have medical conditions (The Neonatal Intensive,” 2015)

**Medical Art Therapy.** According to the Art Therapy Association, art therapy "provides therapeutic, healing benefits for patients in hospitals and other medical settings, and is used with greater frequency to significantly reduce a broad spectrum of symptoms related to pain, anxiety,

and discomfort" ("American Art Therapy," 2011). It also "helps individuals cope with complex health-related issues, lifestyle transition, grief, expression and communication, and more" ("American Art Therapy," 2011).

**Creative Arts Therapies.** According to the National Coalition of Creative Arts Therapies Associations (NCCATA), creative arts therapies involve creative arts therapists using "intentional applications of the arts and creative processes to ameliorate disability and illness and optimize health and wellness" ("About NCCATA," 2015). In creative arts therapies, "treatment outcomes include improving communication and expression and increasing physical, emotional, cognitive and/or social functioning" ("About NCCATA," 2015).

**Psychosocial Services.** American Cancer Society provides a useful definition of psychosocial services by defining it as psychosocial support. According to the American Cancer Society, "psychosocial support can include mental health counseling, education, spiritual support, group support, and many other such services" ("Helping Children When," 2012). It mentions that these services are provided by mental health professionals, "such as psychologists, social workers, counselors, specialized nurses, clergy, pastoral counselors, and others" ("Helping Children When," 2012).

**Palliative care.** "The word 'palliative' means to 'relieve symptoms'. Palliative care at Children's Hospital Los Angeles offers physical, emotional, physical and spiritual support to children and teens with life threatening illnesses, and their families" ("Comfort and Palliative Care", n.d.)

## **Design of Study**

**Sampling.** The researchers emailed a survey to current and recent creative arts therapists who have worked and interned at CHLA to gather data about their experiences of providing services in this setting. The names and emails of these therapists were obtained from the manager of the Expressive Arts and Therapies Department at CHLA. On this survey, subjects indicated whether they were willing to be individually interviewed to further discuss their experiences at CHLA, which is how the researchers gathered the subjects to be interviewed. All participants were adults, over the age of 18, and included males and females. The researchers sent the online survey to thirteen creative arts therapists and interviewed three of these therapists.

**Gathering of data.** The subjects were contacted via email by researchers Jackie Carlson and Hilda Galan to answer a Qualtrics survey including an informed consent, about ten questions and the opportunity to create an art response to include with the survey. The subjects were informed that responses to the survey would be utilized for a Masters level research project investigating the use of creative arts therapies at CHLA. Participants were informed that their participation was voluntary and they could chose to be individually interviewed to further discuss their experiences in person with the researchers. From the survey respondents who indicated they would be willing to participate in an interview, the researchers chose three based on diversity in creative arts therapy modality (art therapy, music therapy, dance/movement therapy) and amount of experience at CHLA (those with the most years of experience). The researchers then contacted these three creative arts therapists via email to schedule a day and time for an in person interview at CHLA. The semi-structured interviews conducted by the two researchers were audio recorded and lasted approximately 60 minutes.

**Analysis of data.** The researchers utilized the information gathered through the surveys and interviews to compare and contrast information, collect emergent themes, and to assess the interviewees' thoughts, opinions, and feelings. The researchers intended to focus the research on receiving creative arts therapies services in a PICU or NICU setting in a pediatric hospital. However, the data provided by the participants in the survey did not focus on this topic. Therefore, the researchers guided the interview questions to further explore the topics that were mentioned in the survey data, rather than focusing on the PICU and NICU. The researchers began the data analysis process by reading and discussing participant responses to survey questions and selecting the most relevant questions that would meaningfully address this research project. These selected questions were then reviewed in-depth along with the art responses from the survey and the researchers identified emergent themes from the survey questions and survey artwork as a whole. The researchers then reviewed responses to the interview questions and interview art responses to identify themes within these.

## Results

### Presentation of Data

**Survey.** The researchers gathered data from research participants via an online survey and interviews (via telephone and in person at Children's Hospital Los Angeles). These methods of data collection provided research participants the opportunity to create art as an additional way to express their experiences. The researchers gathered participants for the online survey from the director of the Expressive Arts and Therapies Department at Children's Hospital Los Angeles, who provided the researchers with a list of thirteen names and email addresses of current and recent employees/interns in music therapy, dance/movement therapy and art therapy. The researchers created an online survey via Qualtrics that included an informed consent form, questions regarding theoretical orientation and experiences working at CHLA, as well as the option to further discuss their experiences in an in-person interview (a copy of the informed consent and online survey questions can be found in Appendix A and Appendix B of this paper). One of the online survey questions prompted the research participants to create a piece of art about their responses to the survey questions that could be uploaded as a JPEG image and submitted with their typed online survey response. A follow-up survey question also provided an opportunity to those who created an art piece to write a statement about the art. The online survey was emailed to participants on January 19th, 2016, with a description that can be found in Appendix C of this paper. The researchers sent a follow-up email on January 26th, 2016, reminding research participants to complete the online survey. The researchers received a total of ten complete survey responses, four of which included an art response, and one partial response. All ten completed online surveys indicated that the respondent would like to participate in a follow-up interview to further discuss their experiences.

**Interview.** From the online survey responses, the researchers selected three research participants to interview. The researchers chose the three interview participants based on years of experience at CHLA (those with the most years of experience) and variety in creative arts therapy modality (dance/movement therapist, art therapist and music therapist). The three interview participants were contacted via email to schedule a time to complete a one-hour in-person interview at CHLA. One interview participant (the dance/movement therapist) works limited hours at CHLA, which did not coincide with the researchers' in-person availability, and therefore the researchers offered a phone interview to this participant. The phone interview was conducted on February 15th, 2016 and the in-person interviews were conducted with both researchers present on two separate days (February 19th, 2016 & February 26th, 2016). All interview participants signed an informed consent form (Appendix D). The interviews lasted forty-five to sixty minutes and the researchers used the same list of interview questions for each participant, only modifying questions to state the specific creative arts therapy modality used by each participant (art therapy, music therapy, dance/movement therapy), which can be found in Appendix E of this paper. The researchers recorded all three interviews and the three participants were made aware of this as part of the informed consent process. The participants were also asked to create a piece of art as part of the interview process. The two participants in the in-person interviews created art responses with the researchers present and the participant in the telephone interview was asked to complete an art response within two weeks of the interview and email an image of it to the researchers. The prompt for the art piece was: "Create an art piece about your identity as a creative arts therapist." The art therapist and music therapist created art responses and the dance/movement therapist chose not to create an art response. The researchers provided a variety of art supplies for the in-person interviews at CHLA, including

collage images, color pastels, colored pencils, colored tissue paper, googly eyes, markers, mix media paper (two sizes: 9 x 12 in and 5.5 x 8.5 in), model magic clay, scissors, small wooden shapes (circles, diamonds, and squares) sharpie markers, watercolor paint, and writing tools (a pen and pencil).

The following chart, Figure 1, identifies the sources of data gathered from the ten research participants. Due to the length of online survey responses and interviews, the full data is not presented here. The researchers provide summaries of selected survey questions and the interview responses in the next sections of this paper. A table with full responses to selected survey questions can be found in Appendix F. The full interview summaries can be found in Appendix G for the dance/movement therapist, Appendix H for the art therapist and Appendix I for the music therapist.

Sources of Data				
	Online Survey	Art Response 1	Interview	Art Response 2
Participant 1	x		x	
Participant 2	x			
Participant 3	x			
Participant 4	x			
Participant 5	x	x	x	x
Participant 6	x	x		
Participant 7	x		x	x
Participant 8	x	x		
Participant 9	x			
Participant 10	x	x		

Figure 1. Sources of research data

### **Analysis of Data**

In the process of data analysis the researchers used various methods to analyze the four sets of qualitative data: online survey responses, art created as part of the online survey, in-person interview responses and art created as part of the in-person interview. The researchers began the process of data analysis by reading the data (survey responses, summaries of the in-person interviews) and looking at the art responses from the surveys and in-person interviews and writing about it. One piece of art from the in-person interviews was also brought into a research analysis workshop and the researchers and group members formed ideas about it.

**Analysis of survey.** The online survey was completed by a total of ten past and current employees/interns in the Expressive Arts and Therapies Department at CHLA. The research participants included nine females and one male, with length of time working or interning at CHLA varying from four months to eight years. The creative arts therapies modalities utilized by the research participants include five music therapists, four art therapists and one dance/movement therapist. The researchers chose to select and analyze particular questions from the online survey that seemed most relevant to their research project.

The survey question “Which theory helps you best understand the work you do?” included multiple-choice options of: cognitive behavioral, family systems, attachment, psychodynamic or other (participants were able to write in an answer here). The most frequent response was family systems, with three respondents (or 30%) answering with this option. The next most frequent responses to this question were cognitive behavioral, other: humanistic and other: eclectic or combination, all with two respondents (or 20%). One respondent chose attachment and no respondents chose psychodynamic. The responses to this online survey question suggest the importance of considering the family system when providing creative arts



therapy services in a hospital setting. Another survey question that informs this research project asked participants “Describe how this theory informs or is informed by your clinical experiences at CHLA” with no word limit. Various themes that emerged from this question include: being present (in the here and now), connection (intrapersonal, interpersonal, within the family system), coping, meeting patients where they’re at, medical condition, needs, quality of care, reality of situation (life and death), role of the therapist (facilitator, relational), support, the body, and wholeness. These themes seem to reflect the nature of the situation patients and their families at CHLA are dealing with, as explored through the work with creative arts therapists.

The online survey also asked research participants to discuss “What themes come up in the work you do?” The ten research participants identified a total of fifty-four themes that come up in their work and these themes are summarized in Figure 8 below.

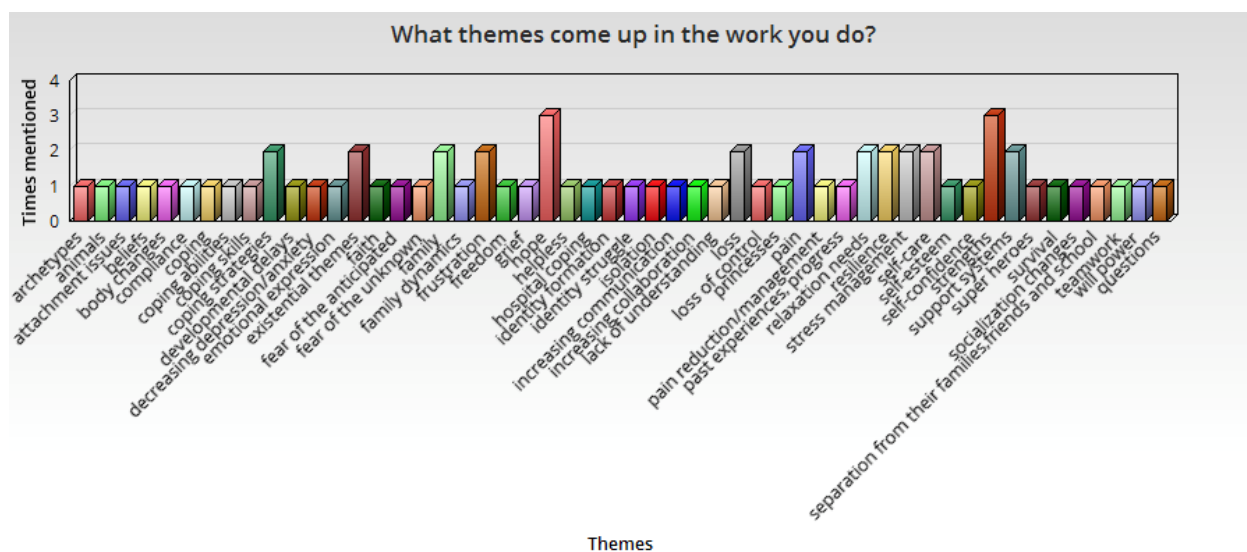


Figure 8. Survey responses to the question “What themes come up in the work you do?”

The online survey participants were asked, “How has working at CHLA changed the way you think about or approach the creative arts therapy modality you use?” The researchers note

the following themes that came from participant responses: therapist role in the hospital setting, being in the here and now and therapist identity.

*Analysis of survey art.* The art created by four survey respondents was another set of data gathered to obtain information about the experience of being a creative arts therapist at CHLA. The prompt for creation of this art piece was “As art therapy students we understand the value of nonverbal and creative expression. We invite you to reflect and create a piece of art on your responses to the survey questions, take a picture and upload it (as a JPEG file) below.” Research participants who chose to create an art piece had the opportunity to “write a statement about the art piece you created.” The researchers only briefly discuss the themes of these art pieces, as they were not present when the art was created, so there was not a context of conversation to inform the themes gathered from the art.

*Participant 5.* The art response of Participant 5, Figure 3 below, includes imagery representative of the clinician’s identity in the hospital (her badge, pen, mood rating scale, contact information, emergency procedures, pager and lanyard). This central image perhaps suggests the clinician’s role as holding the space for patients to express their experience. Lines swirl off of this central image, to a smaller image of arrows showing movement, multiple directions and possible uncertainty, which may reflect a patient’s experience of being in the hospital. A pair of hands could represent the role of a creative arts therapist as someone who is nurturing and open, which helps them connect with patients. An image of three family members in one bubble and a faceless patient in an adjacent bubble is suggestive of the isolation and disconnection families experience when a child is hospitalized. It could also reflect a child’s sense of losing his or her identity when conforming to the hospital environment. Another image

of two hearts, one with stitches and one with muscles, may suggest the medical aspect of working in a hospital, but also the idea of empowering patients through the creative process.



Figure 3. Art response from Participant 5 submitted with online survey

*Participant 6.* The art response of Participant 6, Figure 4 below, includes a family of butterflies surrounded by music. The scale of the butterflies with one large one in the center and four smaller ones surrounding it, suggests a focus on the patient and the role of the rest of the family members as supporting this patient. The butterflies are the logo colors of CHLA (red, yellow, green, blue), suggesting the concept of identity. The butterflies also elicit concepts of change, growth, metamorphosis, fragility, transition, cycles and nurturing/support (cocoon). The surrounding lines suggest movement and the music notes are reflective of the creative arts therapist's identity as well as the power of music to support, contain and hold patients.



*Figure 4.* Art response from Participant 6 submitted with online survey

*Participant 8.* The survey art response of Participant 8, Figure 5 below, is a photograph of various art media, which suggests the centrality of variety and choice in the creative arts therapies that occur in a pediatric hospital setting. The image also evokes thoughts of identity of the creative arts therapist and the containment provided by the therapist and the art materials. The layers and dimensions in this image suggest the depth of the creative process as well as the layered experience patients have while in the hospital (new environment, separation from family, loss of identity).



*Figure 5.* Art response from Participant 8 submitted with online survey

*Participant 10.* The art response of Participant 10, Figure 6 below, is an image of a burnt out candle, reflecting the reality of life and death that comes up in the hospital. The burnt out candle can also suggest the intensity of creative arts therapy work with this population and the possibility for creative arts therapists to feel worn down emotionally and physically. The compass reflects the concept of lack of control and also uncertainty about the journey. This is especially true in a hospital setting and the reality of not knowing whether patients will survive. The image also suggests the concept of trusting in a higher power or faith when presented with such uncertainty. Flowers and roots reflect ideas of growth and being supported and nourished in order to grow/change; this is reflective of the family supporting the patient while in the hospital. The many layers and overlapping images suggest connection within the process of creative arts therapy, both between the therapist and patient/family and between the patient/family and the creative process. Large open hands suggest the role of the creative arts therapist as supporting and remaining open to the patient's needs. A red tear and a line through the image of a bird may represent the physical and emotional pain experienced by patients in the hospital. The blue surrounding the burnt out candle suggests sadness about the experience of hospitalization and the possibility of death.



*Figure 6.* Art response from Participant 10 submitted with online survey

*Analysis of interviews.* The sources of data include three interviews conducted by the researchers with an art therapist, music therapist and dance/movement therapist who work at CHLA. Due to the length of the interviews and incoherent parts, the researchers chose to include summaries of the interviews, rather than transcripts. Full summaries of participant responses to

all interview questions can be found in Appendix G (dance/movement therapist), Appendix H (art therapist) and Appendix I (music therapist).

*Participant 1.* A telephone interview was scheduled and conducted with a dance/movement therapist on February 15th, 2016 using the guiding interview questions found in Appendix E. A summary of this participant's response to each interview question can also be found in Appendix G, but due to the length of the interview the researchers provide an overall summary in this section of the research paper. This creative arts therapist discusses the rigidity that patients experience while in the hospital and how dance/movement therapy can help them move their bodies to work through the pain. She also describes the importance of seeing the child as a whole person, not their illness, and tailoring goals depending on the needs of the specific patient. At one point the clinician states, "my work is really about seeing each child as they are." She further describes that in her role as a clinician it is important to connect with patients by mirroring their movements. The dance/movement therapist goes on to share that her work is about helping patients communicate and express emotions, managing pain and meeting them where they are (helping them see that they can move certain parts of their body even if they can't move other parts). She discusses challenges that come up in the work she does, which mainly surround misunderstandings of what dance/movement therapy involves. This challenge is managed through describing the process to children as hanging out and moving together. The creative arts therapist describes dance/movement therapy in a different manner to hospital clinicians and staff. She shares that it is the therapeutic use of movement to further the emotional, physical, cognitive and social aspects of a child, and help them to integrate. The dance/movement therapist adds, "illness is in our body, so what better way to work through it." She goes on to point out that dance/movement therapy can be many different things such as



blinking their eyes, using sheets/gloves or simply envisioning movement in parts of their body that they cannot physically move. The importance of patients maintaining autonomy is touched upon when the creative arts therapist describes how children will sometimes say “no” to seeing her because they want to have control. The dance/movement therapist discussed the connection of dance/movement to culture in regards to how passionate a family is about dance and also how it is important to consider physical space and what is appropriate distance/closeness to patients. She also touches upon the opportunity for this creative arts therapy modality to decrease the barrier of language since “you are connecting through movement and you create your own language.” This participant describes her use of attachment theory in the work she does, mentioning that it is sometimes about helping the mother/child relationship and many times about helping children learn to regulate the chaos and rigidity they likely experience due to the hospitalization. By helping children develop skills to self-regulate, they increase their ability to be flexible within the hospital environment, thus helping them adapt to procedures and new things happening around them, which may help them get better sooner. She further describes the role of attachment theory in her work and how dance/movement therapy helps children learn to soothe themselves. The dance/movement therapist can observe movement and assess whether a child has difficulty connecting with others or is well adapted based on his or her movement and where there seem to be restrictions in the body. By moving and feeling good in one moment, children’s bodies can become aware that despite pain, they still have the ability to feel good. In her work at CHLA, this participant helps children be present with where they are and focus on how they can move/dance to feel good in just one moment. The creative arts therapist notes that dance/movement therapy helps children bring awareness and be present with their whole bodies, not just the part that is ill. This process helps children “become aware of their control, potential

[and] capabilities” which may help them become healthier. This clinician mentions that she often does not work with the family, but notes the value in this approach since “kids don’t live in a vacuum” and it helps “support the parent child relationship”. She adds that family work can help her reinforce that it is acceptable for children to express negative or challenging feelings in the therapeutic space in order to encourage their expression and communicate that it is safe and healthy to do so. She further mentions the importance of self-regulation as a crucial aspect in helping children integrate their negative experiences and get better by stating “if our body is in a state of isolation or pain or discomfort, [it] can’t start to heal”. The process of integration starts on a physical level and promotes further recovery and healing on an emotional level because “we feel better when our bodies feel good.” She adds that as a creative arts therapist in a hospital setting she takes into consideration that interruptions happen frequently and that medical needs must take priority. She also states that the work is mostly short-term treatment, which reinforces the need to “stay true to where they are in that moment.” As mentioned previously, the dance/movement therapist chose not to create an art response.

*Participant 5.* An in-person interview was scheduled and conducted with an art therapist on February 19, 2016 using the guiding interview questions found in Appendix E. A summary of the participant’s response to each interview question can be found in Appendix H, but due to the length of the interview the researchers provide an overall summary in this section of the research paper. This creative arts therapist first provides a brief background history of her identity when she began working at CHLA. She mentions “my identity as an art therapist would get to be centralized again. Instead of being an MFT intern I’d be an art therapist first.” This creative arts therapist discusses how she uses art therapy with the various units (PICU, NICU, rehabilitation, bone marrow transplant (BMT), hemodialysis, CTICU (cardiothoracic intensive

care unit), cardiovascular acute) and populations (patients, parents, and families) of CHLA. Specifically, she mentions that the NICU is where she feels she makes the most impact at CHLA. She notes that “the babies are really helpless and its medical intervention that help them the most . . . and the parents get forgotten quite a bit . . . so all the focus is on this little tiny baby, so I feel like providing art therapy for the parents makes it so they can be here longer and they don’t burn out, and they can be there more for their child, and they can bond with their child more.” She also addresses the challenges she encounters, such as possible resistance to art therapy in working with adults, specifically the parents, but how using her personality, honesty, and welcoming approach allows them to engage. She has also found a way to introduce art therapy to the patients by having an elevator speech prepared, “Sometimes it’s hard to talk about what’s happening in the hospital. Sometimes it’s easier to draw about it. Art therapy is another way for you to express yourself.”

In the interview, this creative arts therapist addresses the cultural diversity of the patients at CHLA and how she accommodates various cultural components. She mentions how “every room you walk in is a completely different system and a cultural value system and being a white female, my experience of me is different than their experience of themselves and their families. So I really have to come in at a very humble place . . . and to just meet them where they are.” During sessions where she does not speak the same language as the child and family she realizes that “it’s difficult, but the art is the medium which cuts through all the language barriers. So, I can walk in and show my supplies and do kind of like a \*gesture made here\* body movement.” It also seems that her role as a creative arts therapist is not lost in these situations as evidenced by her mentioning that “holding the space is very, very important” and “I’m still an active observer and still very much in the process even if we’re not speaking the same language.” This

creative art therapist uses an eclectic theory approach in her work at CHLA. In describing her use of this theory, she mentions she likes using narrative theory, humanistic, existential and cognitive-behavioral therapy (only rarely). She then discusses how these theories address the needs of the family. In further discussing this, she touches upon her role as a therapist, “I can’t control what happened before I got here or what’s gonna happen after I leave the room, but where the marker hits the paper, that’s where I can exist with them. In her use of eclectic theory she mentions that she often questions, “Who is this child as a whole person? Who is this family as a piece of this child? How do I assist or fit into this?”

This creative arts therapist sees the many ways art therapy engages the patients she sees. She sees art therapy as providing patients an opportunity for self-expression and a choice in a setting in which they are unable to make their own choices. She notes “the art meets them where they are.” When asked how art therapy contributes to change or healing in the patients/families that she sees, she mentions that their mental wellbeing and feelings about themselves definitely contribute to how quickly they get better. The idea of transformation is talked about as she discusses how a session can be “an hour where they were able to transform their pain into something different and that impacts the rest of their day. So that means they’re less likely to push their pain medicine button because they’re not feeling that pain while they’re doing the art and the art has relieved them in some way and has created more of an ease for them.”

*Analysis of art response.* The art response Participant 5 created during the interview, Figure 7 below, is an image with six collage images. During the interview process this participant describes her identity as human being and an art therapist, her role as an art therapist, the process that patients or families go through while being at CHLA, and the power of art therapy in a pediatric hospital. The researchers notice several themes evident in the artwork. The

participant's choice to use a large image at the center of the paper may suggest the idea of centrality. In relation to centrality, this image may also suggest identity of the participant (her role, physical attributes, and use of self). Like the silhouette image, the participant also has short hair. The nature scenery present within this image may represent the idea of the freedom, clearness and perspective that the creative art therapist may provide that patients might not have, due to hospitalization and stressors that come with that (stress, isolation, worries, fears, etc). The image of the wolf disguised as a sheep may represent the notion of the underestimation of art therapy (or even creative arts therapies) and for art therapists having to be tactful in introducing their modality to patients, family, or other hospital clinicians and staff. The participant's choice to use an image of colorful keys may suggest the idea of art therapy being: individualized for each patient, providing a unique experience, providing resources, and unlocking emotions and thoughts in ways that other modalities are not able to. The image of the cookie with color sprinkles may be representative of the participant's personality. It may also be representative of art therapy being approachable, providing nurture, and providing a safe holding environment for the patient or families. The bite taken out of the cookie may represent the idea of patients testing out art therapy. However, the researchers also see this bite of the cookie being representative of the therapist giving a lot and possibly becoming consumed or worn out over time.

The researchers notice that labeling or titling was present with every image chosen by the participant. The researchers note highlighting around the images and movement seems present in the use of line work to highlight around images. The researchers understand the highlighting in relation to how art therapy meets patients or families where their needs are and can "highlight" their strengths when needed. The researchers notice that the colors of the building blocks are those of the CHLA logo – red, blue, green, and yellow. Whether this was done consciously or

not, it can represent the way art therapy has become clinical to be appropriate for the population. The researchers also notice through the artwork and conversation with this participant that connection, support and creation are evident themes. All images share a connection and address the idea of supporting the patient and families. Also, five out of six images in this artwork have a circular shape, perhaps suggesting a sense of wholeness. All six images speak to the identity of art therapy in the pediatric hospital and they each potentially illustrate how powerful art therapy is in this setting. This participant mentions how art therapists can “get to this really deep content that other people can’t get to. At times it feels, not deceptive, but I think we are being underestimated and really we’re much more powerful.”



Figure 7. Art response from Participant 5 created during interview

*Participant 7.* An in-person interview was scheduled and conducted with a music therapist from CHLA on February 26th, 2016 using the guiding interview questions found in Appendix E. A summary of the participant's response to each interview question can also be found in Appendix I, but due to the length of the interview the researchers provide an overall summary in this section of the research paper. The music therapist begins by describing her connection to working with this population and she mentions enjoying the intensity of the work and "meet[ing] the immediate needs to make it easier for them to be there". She enjoys working with the families of patients to help the parents feel empowered. The music therapist touches upon the value of working in the ICUs and how challenging that work is because families are under so much stress, but how it can bring a "positive impact and bring light when it's really needed." She goes on to describe how music therapy is always different and she never knows what to expect, suggesting the importance of being present with patients and families. This participant also mentions challenges that arise in the work she does such as maintaining confidentiality and a safe space when patients do not have individual rooms and being flexible with interruptions that happen during session. She goes on to discuss how she describes music therapy to patients and families, which she does by meeting them where they are and being a therapist in the moment. This means she listens and observes how they react to her initial description, which is "my name is \_\_\_\_\_, I'm a music therapist here at the hospital and I wanted to come in today for a visit if now is a good time," and modifies what she says next to accommodate their reaction. Her description of music therapy mentions that it "is something that builds off of music being a really powerful tool in our lives" and can help patients cope with what their going through and decrease pain. The music therapist might ask a child what has been the most challenging part of being in the hospital and then mention how music therapy can

specifically help with that. She describes it differently to other hospital staff, including that it is a service they can order for patients, highlighting how it can be adjunctive to the work they are doing and giving specific examples. This participant touches upon culture by mentioning it is happening all the time and how it is important for her to be curious about what makes them who they are and also what is special to the family, including what music they connect with. The music therapist also discusses the role of culture in the context of hospital culture and how families must adapt to this and how she can function in supporting and advocating for what is important to them. She goes on to discuss the importance of understanding how to help families and how her own role as a mother informs this. She mentions the need to work with families because we are all part of a system, even if we do not want to be. The music therapist stays in the present moment with the family and specifically when working with mothers, notes the importance of conveying that “there are a lot of other factors you and I can’t change, but what you’re doing right now is working.” This is an empowering moment for the clinician to help a mother see that she is doing something beneficial for the child. She adds that this connects to attachment theory as well because reinforcing what the mother does positively will increase how often she does it and therefore increases the connection between her and the child. She also uses cognitive-behavioral therapy because it gives patients practical skills to utilize and can help them feel empowered to know that they have the ability to change. The music therapist mentions that when working with families it can be difficult to figure out how to involve family members (whether to give them a break or engage them) and provide education that music therapy is not about performance. In discussing how music therapy contributes to healing, she describes the importance of staying in the moment and focusing on what they can do right now to help the



patient feel a little better. She adds how the work is about empowering the patient and their family.

*Analysis of art response.* The art response participant 7 created during the interview, Figure 8 below, evokes her identity as a mother and how this impacts her focus on working with the families of patients with whom she provides music therapy. This image also suggests being happy in a moment and how the music therapist values staying in the present moment to meet patients and families where they are and helping them feel better in the moment. The image of what appears to be a mother and daughter embracing also brings forth ideas of connection and the use of music therapy to connect patients with the therapist, their family, their identity and music. The centrality of the image may reflect the central role of the creative arts therapist in the therapeutic space and also the centrality of this participant's role as a mother in informing her work as a music therapist. These concepts seem to be highlighted by the warm colors surrounding the central image. The colors (yellow, orange, pink, purple) suggest warmth and containment, possibly suggestive of the role of music therapy in supporting the healing of patients. During the interview the music therapist describes her art response. She mentions that the image stuck out to her because it connects to who she is as a person, a mother, and her desire for the families she works with to feel this connection and feel empowered as a family. She adds that "there's this light around that and I want to help that shine as much as I can." The music therapist wants the patients/families to connect with who they are as a person and a family outside of this illness. She shares that while creating the art piece, she felt the concept of empowerment.



*Figure 8.* Art response from Participant 7 created during interview

## **Findings**

In this section, the researchers begin by naming prominent themes that emerged from the online survey data, including the written responses and the artwork. These themes are further discussed through connections to specific words and imagery from the online survey responses. The researchers will then complete this process with themes from the interview data.

**Survey themes.** The researchers note five themes from the online survey data, which include being present, family, support, change and identity. These themes are explored separately in the next sections.

***Being present.*** The theme of being present or in the here and now came up in the online survey data and artwork. This idea is evident in participant responses to “How has working as CHLA changed the way you think about or approach the creative arts therapy modality you use?” Participant 4 notes “being at CHLA really emphasized the importance of being present...and truly meeting the patient where they are at that given moment.” The survey question “Which theory helps you best understand the work you do” and the follow-up question “Describe how this theory informs or is informed by your clinical experiences at CHLA”, evokes responses from two participants who use eclectic or combination theory to meet the client where they are. Participant 5 mentions “I found that being in the “here and now” is a huge benefit for me...We don’t have control over what has happened to the patient to lead them to this point, nor can we control the outcome of their medical treatment. But I can create therapeutic space, and give them an outlet to explore whatever they need to.”

The art response of participant 8 (Figure 5, p. 50) especially suggests the theme of being present; this creative arts therapist took an image at CHLA of the art materials used in sessions, bringing the viewer into his present reality. The use of a photograph also evokes ideas of using a lens to focus on a particular moment in time.

***Family.*** The researchers note the theme of family throughout the survey results and art responses. This is evident in participant responses to the question “Which of the following theories helps you best understand the work you do?” with family systems as the response with the greatest percentage. This suggests the importance of incorporating the family in a patient’s treatment. Participant 3 notes that “I found I was most effective as a therapist by actively involving family in sessions...and utilizing family strengths for the purposes of supporting and coping throughout the patient’s hospitalization.” Participant 6 adds that “encouraging

communication, increasing positive interactions and engaging in new experiences together can help families grow together...and help with the health and care of the child”. When asked specifically what themes come up in the work they do, the participants mentioned family, family dynamics and separation of their families. When asked how working at CHLA changed the way that clinicians approach their work, Participant 3 notes that she “now believe[s] that it is vital to include the family as much as possible whenever you are working with children.” Participant 4 discusses how important the family is in a child’s life; whether the family is present or absent this will inevitably affect the child.

The theme of family is also present in the survey art responses. The art response from participant 5 (Figure 3, p. 48) depicts a patient and the rest of their family in separate bubbles, suggesting the isolation and disconnection experienced by families as a result of hospitalization. Figure 4 (p. 49), completed by participant 6, also evokes the concept of family. This participant describes her artwork as “a family of CHLA butterflies surrounded by music.” The scale of the butterflies is important to note in regards to family dynamics within the hospital environment; when a child is hospitalized, the family’s attention turns to the child, which is suggested in the large scale of the central butterfly. The role of other family members shifts to support the patient, suggestive in the smaller scale and placement of the other butterflies surrounding the large one. The theme of family also comes up in the art of participant 10 (Figure 6, p. 52), who notes that the red flowers at the base of the candle represent the patient’s family. This participant adds that the green roots underneath these flowers reflect the family’s “need to be “well rooted” in their support system or faith – to better help their child through their hospital experience.”

**Support.** The survey respondents’ answers also reflect the theme of support. This theme is understood as the support patients receive from their families, the creative arts therapists and

themselves. The question “What themes come up in the work you do?” evoked a variety of responses that relate to the theme of support. Respondents note the following themes that connect to support: coping, coping abilities, coping skills, coping strategies, family, family dynamics, hospital coping, support systems and teamwork. Other themes respondents mention relate to lack of support, including helpless and separation from their families, friends and school. In response to the survey question “Describe how this theory informs or is informed by your clinical experiences at CHLA,” Participant 4 discusses the importance of the support patients receive from creative arts therapists. “The therapeutic relationship plays such a big role at CHLA that you’re really able to support and challenge families to identify coping strategies that do or don’t work for them. You’re able to encourage them to be autonomous in decision making, but facilitating it in a way that they’re supported throughout the therapy.”

The theme of support is suggested in the artwork of Participant 5 (Figure 3, p. 48) who includes an image of open hands to represent “being open to whatever happens, being approachable, and perceptive.” The hands suggest the support offered to patients by creative arts therapists at CHLA. The art response from participant 6 (Figure 4, p. 49) also represents the concept of support because the central butterfly is surrounded by other butterflies and music notes; the butterflies represent support of family members, and music notes suggest support and nurturing offered by the creative process of music therapy. The image created by participant 8 (Figure 5, p. 50) shows support because the art materials represent a modality of support and healing that is offered to patients at CHLA. The artwork created by participant 10 (Figure 6, p. 52) alludes to the theme of support with an image of open hands, representing the therapist being supportive and open to the patient’s needs.

*Change.* The researchers notice examples of the theme, change, in the participants' survey responses and art responses. In response to the survey question "What themes come up in the work you do?" participants note body changes, progress and socialization changes. These ideas suggest the changes that patients experience due to hospitalization and changes they experience due to receiving creative arts therapy services. The question "How has working at CHLA changed the way you think about or approach the creative arts therapy modality you use?" evoked participant responses regarding the role of the creative arts therapist in the hospital setting and how they must change their role to specifically address concerns of this setting and population.

The theme of change is suggested in the art response of participant 5 (Figure 3, p. 48) that includes a heart with stitches and a heart with muscles, representing the physical changes patients undergo while in the hospital. This image also includes swirling arrows that suggest change or movement in regards to physical and emotional aspects of patients as well as the emotions that accompany change (uncertainty, worry). Change is suggested in the art response created by participant 6 (Figure 4, p. 49) who depicts butterflies. This imagery is reflective of the process of change, metamorphosis, growth and transition. The transition from a caterpillar to a cocoon to a butterfly is a subtle, slow process, but the result is a drastic change. This process might be connected to creative arts therapies since it helps patients achieve small changes that contribute to a larger impact on the patient and family over time. The art response of participant 10 (Figure 6, p. 52) suggests this theme in the imagery of flowers/roots that allude to growth and change that results if a flower, or a patient, receives adequate support and resources. The burnt out candle may reflect the reality of life and death, which represents a great change to grapple with for both the patient and family.

*Identity.* The researchers note examples of the theme identity in the participants' survey responses, which comes up in the context of patient identity as well as creative arts therapist identity. In response to the survey question "How has working at CHLA changed the way you think about or approach the creative arts therapy modality you use?" participants note that working at CHLA provides opportunities to look at relationships and advocate for their work, impacts their approach as a therapist, helps them become more flexible, increases their awareness, informs the theories they use, or revives their identity. Participant 5 mentions that she "enjoy[s] having such a unique role at the hospital . . . our team can provide assistance in a way that no other professionals can at the hospital". Responses to the question, "What themes come up in the work you do?" include identity formation, identity struggle, self-esteem and self-confidence.

The theme of identity is also evident in the artwork of online survey respondents. Participant 5 (Figure 3, p. 48) utilizes an image of her CHLA employee badge and other important items (pen, mood rating scale, contact info, emergency procedures, pager, lanyard). The centrality of these items in the image suggests the importance of her identity as an art therapist to the work she does with patients. The theme of identity is also noted in her artwork that depicts two different hearts (one with muscles and one with stitches); this suggests the altering of a patient's identity based on the medical procedures they undergo in the hospital. Lastly, this theme continues to be present in the image of the family and child with no facial features. This omission could reflect the loss of identity that children feel when they become a patient at the hospital and must conform to the hospital's identity (wearing certain clothes, being hooked up to medical equipment). The art response of Participant 6 (Figure 4, p. 49) depicts butterflies, which may be thought of as a fragile insect, alluding to the fragility of patients as

they adapt and integrate their experience of hospitalization into their identity. This also connects to how they likely feel physically weak due to the illness they are dealing with and how this represents a shift in identity from their normal physical capabilities. The colors of the butterflies are the colors of the CHLA butterfly logo, which suggests the connection this creative arts therapist feels towards the hospital. The music notes in this image connect to the theme of identity in regards to identity as a music therapist. The art response created by participant 8 (Figure 5, p. 50) alludes to the theme of identity as a creative arts therapist since it is an image of art materials used by art therapists at CHLA.

**Interview themes.** The researchers note four themes in the interview data, including empowerment, culture, being present and identity.

**Empowerment.** The theme of empowerment came up in the in-person interviews. When it was discussed in the in-person interviews, the participants addressed other topics connected to empowerment, self-expression, regulation, having choices, autonomy, and integration. Participant 1 mentions that by helping children develop skills to self-regulate, they increase their ability to be flexible within the hospital environment, helping them adapt to procedures and new things happening around them, which can help them get better sooner. The importance of patients maintaining autonomy is touched upon when she describes how children exert their control by sometimes saying “no” to seeing her. Participant 5 discusses that she sees art therapy as providing patients choice in a setting in which they are unable to make their own choices and an opportunity for self-expression. This even seems present in her art response through the use of the Legos and the keys used to unlock emotions. Participant 7 mentions how she enjoys working with the families of patients to help the parents feel empowered. She also notices that music therapy allows the patients to learn coping skills to help them feel empowered and comply



with treatment. During the art response part of the interview, she shares that while creating the art piece, she felt the concept of empowerment. The researchers also note this theme in her artwork, where the child and mother are made central and perhaps empowered by the support the music therapist provides all around them.

**Culture.** The theme of culture also emerged from the in-person interviews. This idea was evident when the three research participants were asked questions about the cultural diversity of their patients at CHLA, the factors that influence their theoretical lens, and how their theories inform the work they do. The research participants talked about family systems, hospital culture, and value systems when answering the above questions. Participant 1 notes that as a creative arts therapist in the hospital setting she takes into consideration that interruptions happen frequently and that medical needs must take priority. Participant 5 addresses the cultural diversity of the patients at CHLA and how she accommodates various cultural components. She mentions how “every room you walk in is a completely different system and a cultural value system and being a white female, my experience of me is different than their experience of themselves and their families.” The notion of culture is also present throughout her artwork. The participant’s choice in using an image of colorful keys may suggest the idea of art therapy being: individualized for each patient, providing a unique experience, providing resources, and unlocking emotions and thoughts in ways that other modalities are not able to. The image of the cookie may be representative of art therapy being approachable, providing nurture, and providing a safe holding environment for the patient and families of various cultures. Participant 7 touches upon culture by mentioning it is happening all the time and how it is important for her to be curious about what makes them who they are and also what is special to the family, including what music they connect with. The music therapist also discusses the role of culture in the context of hospital

culture and how families must adapt to this and how she can function in supporting and advocating for what is important to them. She goes on to discuss the importance of understanding how to help families and how her own role as a mother informs this. She mentions the need to work with families because we are all part of a system, even if we do not want to be. Perhaps this is evident in her art response as she chose to put an image of a child and mother in the center and drawing around it, which could be illustrative of parts forming a complex whole that also contains a cultural component.

***Being present.*** The theme of being present or in the moment came up in the in-person interviews. This idea was evident when the three research participants were asked questions about the cultural diversity of their patients at CHLA, the factors that influence their theoretical lens, how their theories inform the work they do, how they see their creative arts modality engage the patients they see, and how they see their creative arts modality contribute to change or healing. The three research participants discussed the importance of meeting their patients where they are in terms of their diagnosis, progress, and whether it is short-term or long-term treatment. They also touched upon the role of the therapist and how their role informs how they adapt their modality to what the family or patient needs. They also talked about how interruptions occur in a session and this results in them being flexible and providing quality of care. The art response of Participant 7 depicts this theme. Her artwork suggests being happy in a moment and how she values staying in the present moment as a music therapist to meet patients and families where they are and help them feel better in the moment.

***Identity.*** The theme of identity (of the therapist or the patient) came up in the in-person interviews. This idea was mentioned in the responses of most of the interview questions. Participant 1 describes the importance of seeing the child as a whole person, not their illness, and

tailoring goals depending on the needs of the specific patient. At one point the clinician states, “my work is really about seeing each child as they are”. She further describes that in her role as a clinician it is important to connect with patients by mirroring their movements. Participant 5 mentions in her interview the need to meet patient and families where they are. During sessions where she does not speak the same language as the child and family she realizes that it is difficult, but that her role as a creative arts therapist is not lost in these situations as evidenced by her mentioning that “holding the space is very, very important” and “I’m still an active observer and still very much in the process even if we’re not speaking the same language.” The theme of identity continues to be present in her art response. This participant touches upon this by utilizing a large image in the center of the paper, which may suggest her identity (her role, physical attributes, and use of self). Like the silhouette image, the participant also has short hair. The nature scenery present within this image may represent the idea of the freedom, clearness and perspective that the creative art therapist may provide that patients might not have, due to hospitalization and stressors that come with that (stress, isolation, worries, fears, etc). Participant 7 begins by describing her connection to working with this population and she mentions she enjoys the intensity of the work and “meet[ing] the immediate needs to make it easier for them to be there”. The art response of Participant 7 evokes the theme of identity as well. The art response participant 7 created during the interview, Figure 8, evokes her identity as a mother and how this impacts her focus on working with the families of patients with whom she provides music therapy. This image also suggests being happy in a moment and how the music therapist values staying in the present moment to meet patients and families where they are and helping them feel better in the moment, which is something this participant seems to value and is integrated into her identity as a music therapist.

## Meanings

The process of data analysis gave the researchers a more informed understanding of the experience of providing creative arts therapies to children and families in a pediatric hospital through the lens of the creative arts therapists who provide these services. In this section, the researchers connect the findings from this research project to the literature reviewed earlier in this paper.

**Meanings related to general literature.** The findings derived from the data analysis process inform the researchers' increased understanding of the general literature regarding pediatric hospitalization. Overall the data gathered in this research project highlights the importance of the following themes, which were also present in the general literature. The survey themes include being present, family, support, change and identity. The interview themes include empowerment, culture, being present, and identity. The researchers notice two overlapping themes between the surveys and interviews: being present and identity. These overlapping themes focus the meanings section and are connected to the general literature.

The general literature reviewed by the researchers mostly focuses on the themes of providing quality care to families of hospitalized children, understanding how the hospitalization of a child causes great stress on them and their parents, and how coping strategies are beneficial. Within these themes, the researchers note connections to the concept of being present. The literature and research data highlight the use of coping skills to help children regulate their experiences in the present moment. The importance of coping strategies is apparent with Salmela et al. (2010), who suggest that due to the stress that accompanies hospitalization, it is important to figure out what might help children cope. Coping strategies are an important consideration because they can help a child deal with the trauma of hospitalization. The research

data notes that each creative arts therapy modality uniquely facilitates appropriate coping strategies for the patient and how it connects to them being in the hospital (strengths, diagnosis, and length of treatment). Burns-Nader, Hernandez-Reif and Porter (2014) state that the stresses of hospitalization contribute to feelings of helplessness and suggest the importance of providing quality care to families of hospitalized children. Mattsson et al. (2014) mention that caring becomes evident when clinicians show sensitivity or awareness to the child's expressions and needs in the present moment. Caring "intends to build bridges across chaos in the community with the parents to anchor them in closeness with the child in the present" (Mattsson et al., 2014 p. 340). The researchers found that this theme was also prominent in regards to the creative arts therapists' identity. The data from this research project illuminates the importance of being present for the creative arts therapists who work at CHLA. Many of them note how being present or in the here and now is important in order to meet the patient and family where they are and be supportive to whatever the needs are in that moment. Also, various creative arts therapists touch upon how their lived experiences at CHLA have changed the way they think about or approach the creative arts therapies modalities they use to meet the needs of the patient. They are mindful of adapting their therapeutic interventions to address the individual and unique needs of each patient and family they provide therapeutic services to. This thoughtful consideration provides patients wholeness of self and quality of care during their hospitalization, which may contribute to an increase in their self-esteem.

The researchers also note the theme of identity in the general literature. It discusses the loss of independence that children face from being in a hospital environment and not being able to make choices autonomously (Coyne, 2006). This loss of independence impacts a child's self-esteem and sense of identity. Coyne (2006) also mentions medical procedures, which can alter

body image, thus affecting the child's identity. Coyne (2006) further notes the importance of involving children in their treatment and helping them understand what is happening; this is a process that can help a child integrate their experiences in the hospital into their identity. This idea is reflected in the research data as many participants discuss seeing the child as a whole person and using the creative arts therapies to help children explore their experiences in the hospital. The concept of loss of independence and identity is also noted in the responses of research participants who mention that some children will say no to receiving creative arts therapies to assert a degree of control and independence in an environment where they otherwise cannot. Identity is also mentioned in the general literature in regards to the family. Tallon et al. (2015) highlight that the hospitalization of a child causes great stress on parents, which could lead to anxiety and depression and thus impede a parent's ability to properly care for the child and contribute to poor physical and mental health outcomes. Research participants suggest the connection of family identity by suggesting a shift in the family dynamics to care for the child who is hospitalized.

The general literature demonstrates significant connections with the research data gathered in this research project. The researchers note that the themes of identity and being present overlap and are interconnected with each other. Research participants consistently mention the need to be present and open to modify their interventions and approaches to meet the patient and family where they are and facilitate an exploration of current struggles. This awareness of being in the present moment suggests a positive impact on the patient's identity, as they are able to address and integrate their experiences of hospitalization into their sense of self.

**Meanings related to art therapy literature.** The findings derived from the data analysis process inform the researchers' increased understanding of the art therapy literature regarding

pediatric hospitalization. Overall the data gathered in this research project suggests the importance of the creative process, including the process of art making, as a means for children to cope with the experience of being hospitalized. The themes that emerged in the data analysis process connect back to the art therapy literature. The survey themes include being present, family, support, change and identity. The interview themes include empowerment, culture, being present, and identity. The researchers notice two overlapping themes between the surveys and interviews: being present and identity. These overlapping themes focus the meanings section and are connected to the art therapy literature.

The art therapy literature reviewed by the researchers mostly focuses on the theme of being present in regards to the child's experience and how art making can bring awareness to the present moment (Councill, 2012). Malchiodi (1999) also notes that the art process can provide children the opportunity to prepare for a medical procedure by depicting it, thus reducing their anxiety in the here and now. The researchers found that this theme was also prominent in regards to the creative arts therapists' identity. The data from this research project illuminates the importance of being present for the creative arts therapists who work at CHLA. Many of them note how being present or in the here and now is important in order to meet the patient and family where they are and be supportive to whatever the needs are in that moment. Some of the creative arts therapists mention they use an eclectic theoretical lens when providing therapeutic interventions in order to address what the client is currently experiencing. Although they do not have control over what has happened to a child and what the prognosis of their treatment is, the creative arts therapists are able to create a space for the child to explore what they need to in that moment using art, dance or music.

The research data suggests that identity is understood not only in relation to the patient and their family, but also to the therapist. The literature review explores in great depth how the patient and family experience being in a pediatric hospital (Cameron, et al., 1984; Council, 2012; Malchiodi, 1999; Malchiodi & Goldring, 2013; Martin, 2013; Prager, 1995; Rode, 1995). Malchiodi (1999) states that children must cope with many factors while in the hospital, such as loss of independence, pain from treatment, altered body image and a struggle to deal with the trauma of the situation and understand why they got sick. All of these factors inevitably affect the child's identity, which can be explored and addressed through creative arts therapies. Council (2012), Martin (2013) and Malchiodi (1999) agree that involving the caregivers in mental health treatment is important to make sure they are aware of what is happening with their child. Therefore, the literature and research data suggest the importance of incorporating family into the child's treatment as the family is part of the child's identity and is affected by the hospitalization. The literature does not address the creative arts therapists' experience in this setting. Various creative arts therapists touch upon how their lived experiences at CHLA have changed the way they think about or approach the creative arts therapies modalities they use to meet the needs of the patient. They are mindful of adapting their therapeutic interventions to address the individual and unique needs of each patient and family they engage in therapeutic services. This thoughtful consideration provides patients wholeness of self and quality of care during their hospitalization, which may contribute to an increase in self-esteem. The act of moving, creating and engaging helps patients feel purposeful and allows for feelings of accomplishment, which also positively impact their identity. Prager mentions that art therapy gives children a chance to be in charge, thus allowing them to preserve their autonomy despite a restrictive hospital environment. Malchiodi (1999) adds that the physical, active quality of



“making, doing, cutting, arranging, molding, gluing, and constructing” (p. 16) experienced during the art making process may help children feel in control. Each creative arts therapy modality uniquely facilitates conversation about what identity is for the patient and how it connects to them being in the hospital (strengths, diagnosis, and length of treatment). In conclusion, the researchers note that the identities of the patients and the identities of the clinicians inform each other.

### **Conclusion**

Overall, the research created an understanding of the lived experiences of the creative arts therapy clinicians. The researchers felt it was beneficial to look at the experiences of the creative arts therapists. The literature review informed the survey questions and the survey responses influenced the interview questions. Research participants were asked to create an art response in the surveys and interviews to further demonstrate their experiences of providing creative arts therapy services in a pediatric hospital setting. The research highlighted how each modality has its own uniqueness and all contribute in different ways to helping the patient in their hospital experience. The researchers note certain limitations of the research study. Due to time and only two researchers, no more than three creative arts therapists could be interviewed. This limitation influenced the decision to choose one clinician from each modality. The researchers originally intended to explore in depth these modalities in the PICU and NICU only, but this intent was modified after survey responses focused more on other pertinent issues regarding working in the pediatric hospital setting. Another limitation of the study was that the interview with the dance/movement therapist was conducted over the phone and researchers did not obtain an art response from this participant.

Despite these limitations, this research study was meaningful and greatly contributed to the current research discussing art therapy in pediatric hospitals. The researchers felt it was empowering to note overlapping themes in the data with the literature review. The research highlighted important facets of hospitalization that the creative arts therapies can address. Another strength of this research project was the utilization of a qualitative research approach. The use of surveys, interviews and art responses supported the intent to gather the richest data on the lived experiences of the creative arts therapists who provide the services.

The researchers note that it was helpful that both of them had different personal experiences with the pediatric hospital population. This gave multiple lenses to see and understand the research process (literature review, survey/interview questions). Researcher Jackie Carlson found that the research facilitated a greater understanding of art therapy in a pediatric hospital setting. She also found that it was empowering to contribute to the current art therapy research. This experience also increases this researcher's interest in this population and how art therapy can be beneficial in this setting. She was inspired by the work of the creative arts therapists at CHLA, who provide meaningful therapeutic services despite interruptions and unpredictability. Researcher Hilda Galan relived her experience as a prior CHLA art therapy trainee through the explored lived experiences. She continues to gain a profound perspective on the impact creative arts therapists have in working with patients and families. It affirmed her passion for working with this particular population and co-facilitating with music and dance/movement therapists in the future. She is inspired to continue being an advocate for creative arts therapies and hopes for further LMU research with CHLA.

In conclusion, this research project contributes in a meaningful way to a greater understanding of the process of creative arts therapies in a pediatric hospital setting. Further

research is warranted to expand upon the information gathered in this research project.

Specifically, the researchers hope that future research addresses the lived experiences of the children and families who receive these services.

## References

About NCCATA. (n.d.). Retrieved December, 2015, from NCCATA website:

<http://www.nccata.org/#!/aboutnccata/czsv>

Allen, P. (2001). Art making as spiritual path: The open studio process as a way to practice art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp. 178-188). New York, NY: Routledge.

*American art therapy association: Art therapy supporting patient care in medical settings:*

*Toolkit.* (2011). Retrieved December, 2015, from

<http://www.arttherapy.org/upload/medicalsettingstoolkit.pdf>

American dance therapy association. (2016). Retrieved November, 2015, from

<https://adta.org/>.

Arnett, M.C. & Malchiodi, C.A. (2013). Understanding children's drawings in medical settings. In C.A. Malchiodi (Ed.), *Art therapy and health care* (pp. 33-47). New York: Guilford Press.

Avers, L., Mathur, A., & Kamat, D. (2007). Music therapy in pediatrics. *Clinical Pediatrics*, 46(7), 575-579. doi:10.1177/0009922806294846

Burns-Nader, S., Hernandez-Reif, M., & Porter, M. (2014). The relationship between mothers' coping patterns and children's anxiety about their hospitalization as reflected in drawings. *Journal of Child Health Care*, 18(1), 6-18.

Cameron, C. O., Juszczak, L., & Wallace, N. (1984). Using creative arts to help children cope with altered body image. *Children's Health Care*, 12(3), 108-112.

doi:10.1207/s15326888chc1203\_1

Comfort and palliative care FAQs (n.d.). In *Comfort and palliative care - Holistic symptom*

*management*. Retrieved from <http://www.chla.org/comfort-and-palliative-care-holistic-symptom-management>

Councill, T. (2012). Medical art therapy with children. In C.A. Malchiodi (Ed.), *Handbook of art therapy* (pp. 222-240). New York: Guilford Press.

Councill, T. (1993). Art therapy with pediatric cancer patients: Helping normal children cope with abnormal circumstances. *Journal of the American Art Therapy Association, 10*(2), 78-87. doi: 10.1080/07421656.1993.10758986.

Councill, T. (1999). Art therapy with pediatric cancer patients. In C. Malchiodi (Author), *Medical Art Therapy with Children* (pp. 75-93). London, England: Jessica Kingsley Publishers.

Coyne, I. (2006). Children's experiences of hospitalization. *Journal of Child Health Care, 10*(4), 326-336.

Creswell, J.W. (2014). *Research design*. Thousand Oaks: SAGE Publications, Inc.

Helping children when a family member has cancer: understanding psychosocial support services. (21012, August 9). Retrieved December, 2015, from American Cancer Society website:  
<http://www.cancer.org/treatment/childrenandcancer/helpingchildrenwhenafamilymemberhascancer/understandingpsychosocialsupportservices/understanding-psychosocial-support-services-intro>

Kazak, A. E. (2006). Pediatric Psychosocial Preventative Health Model (PPPHM): Research, practice, and collaboration in pediatric family systems medicine. *Families, Systems & Health, 24*(4), 381-395.

Kuo, D., Houtrow, A., Arango, P., Kuhlthau, K., Simmons, J., & Neff, J. (2012).

Family-centered care: Current applications and future directions in pediatric health care.

- Maternal and Child Health Journal*, 16, 297-305.
- Landgarten, H. (1981). Family Art Psychotherapy. *International Journal of Family Psychiatry*, 2(3-4), 379-395.
- Malchiodi, C. A. (1999). Introduction to medical art therapy with children. In C. Malchiodi (Ed.), *Medical Art Therapy with Children* (pp. 13-32). London, England: Jessica Kingsley.
- Malchiodi, C.A. & Goldring, E. (2013). Art therapy and child life: An integrated approach to psychosocial care with pediatric oncology patients. In C.A. Malchiodi (Ed.), *Art therapy and health care* (pp. 48-60). New York: Guilford Press.
- Martin, E.S. (2013). Bringing the family into medical art therapy. In C.A. Malchiodi (Ed.), *Art therapy and health care* (pp.304-315). New York: Guilford Press.
- Mattsson, J., Arman, M., Castren, M. & Forsner, M. (2014). Meaning of caring in pediatric intensive care unit from the perspective of parents: A qualitative study. *Journal of Child Health Care*, 18(4), 336-345.
- Mattsson, J., Forsner, M., Castrén, M., & Arman, M. (2013). Caring for children in pediatric intensive care units: An observation study focusing on nurses' concerns. *Nursing Ethics*, 20(5), 528-538. doi:10.1177/0969733012466000
- Meyer, E., DeMaso, D. & Koocher, G. (1996). Mental health consultation in the pediatric intensive care unit. *Professional Psychology: Research and Practice*, 27(2), 130-136.
- Miles, M. S., & Carter, M. C. (1982). Sources of parental stress in pediatric intensive care units. *Children's Health Care*, 11(2), 65-69. doi:10.1207/s15326888chc1102\_4
- Pai, A.L.H., Patino-Fernandez, A.M., McSherry, M., Beele, D., Alderfer, M.A., Reilly, A.T., Hwang, W.T., & Kazak, A. (2008). The Psychosocial Assessment Tool (PAT2.0): Psychometric properties of a screener for psychosocial distress in families of children

- newly diagnosed with cancer. *Journal of Pediatric Psychology*, 33(1), 50-62.
- Parker, L. (2011). Mothers' experience of receiving counselling/psychotherapy on a neonatal intensive care unit (NICU). *Journal of Neonatal Nursing*, 17(5), 182-189.  
doi:10.1016/j.jnn.2010.12.001
- Plevin, M. & Parteli, L. (2014). Time out of time: Dance/movement therapy on the onco-hematology unit of a pediatric hospital. *Dance Therapy*, 36, 229-246.  
doi: 10.1007/s10465-014-9185-2.
- Prager, A. (1995). Pediatric art therapy: Strategies and applications. *Art Therapy*, 12(1), 32-38.
- Rode, D. (1995). Building bridges within the culture of pediatric medicine: The interface of art therapy and child life programming. *Art Therapy*, 12(2), 104-110.
- Salmela, M., Salanterä, S. & Aronen, E.T. (2010). Coping with hospital-related fears: Experiences of pre-school-aged children. *Journal of Advanced Nursing*, 1222-1231.
- Stacey, S., Osborn, M. & Salkovskis, P. (2015). Life is a rollercoaster...what helps parents cope with the neonatal intensive care unit (NICU)? *Journal of Neonatal Nursing*, 21, 136-141.
- Tallon, M., Kendall, G., & Snider, P. (2015). Rethinking family-centered care for the child and family in hospital. *Journal of Clinical Nursing*, 24, 1426-1435.
- The Neonatal Intensive Care Unit (NICU). (n.d.). Retrieved December, 2015, from Stanford Children's Health. website: <http://www.stanfordchildrens.org/en/topic/default?id=the-neonatal-intensive-care-unit-nicu-90-P02389>
- What is the ICU (Intensive Care Unit)? (2014). In *Learning about your health*.  
Retrieved from [http://www.cpmc.org/learning/documents/icu-ws.html#What is the ICU \(Intensive Care Unit\)?](http://www.cpmc.org/learning/documents/icu-ws.html#What is the ICU (Intensive Care Unit)?)
- When your child's in the pediatric intensive care unit. (n.d.). Retrieved December, 2015, from

Kids Health from Nemours website: <http://kidshealth.org/en/parents/picu.html>



**Appendix A: Online Survey Informed Consent Form****LOYOLA MARYMOUNT UNIVERSITY****Informed Consent Form (Survey)**

Date of Preparation: 12/1/2015

**Loyola Marymount University****An Exploration of Creative Arts Therapies in Pediatric Hospitals**

- 1) I hereby authorize Jackie Carlson and Hilda Galan, M.A. Candidates to include me in the following research study: An Exploration of Creative Arts Therapies in Pediatric Hospitals.
- 2) I have been asked to participate on a research project, which is designed to explore the impact of creative arts therapies with children and families in a pediatric hospital setting and will last for a maximum of 30 minutes (15 minutes to answer the survey questions and 15 minutes to do a short art prompt).
- 3) It has been explained to me that the reason for my inclusion in this project is that I am a Creative Arts Therapist at CHLA.
- 4) I understand that if I am a subject, I will discuss the creative arts therapy work that I do at CHLA. The investigator(s) will ask me questions, encourage me to participate in an art task, take notes and audio record the interview. These procedures have been explained to me by Jackie Carlson and Hilda Galan, M.A. candidates.
- 5) I understand that the study described above may involve the following risks and/or discomforts: embarrassment, nervousness and invasion of privacy.
- 6) I also understand that the possible benefits of the study are to share my insight and experiences related to working with children and families in a pediatric hospital.
- 7) I understand that Debra Linesch, who can be reached at (310) 338-7674 will answer any questions I may have at any time concerning details of the procedures performed as part of this study.
- 8) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.
- 9) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to (e.g., my future medical care at LMU.)
- 10) I understand that circumstances may arise which might cause the investigator to terminate my participation before the completion of the study.
- 11) I understand that no information that identifies me will be released without my separate consent except as specifically required by law.

12) I understand that I have the right to refuse to answer any question that I may not wish to answer.

13) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Hardy, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 (310) 258-5465, [david.hardy@lmu.edu](mailto:david.hardy@lmu.edu).

14) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the "Subject's Bill of Rights".

Subject's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

### Appendix B: Online Survey Questions

1. Thank you for your participation in this survey. The purpose of this survey is to gather information about the experiences of creative arts therapists at Children's Hospital of Los Angeles (CHLA) for a research project being conducted by two current master's level art therapy students (Jackie Carlson & Hilda Galan) at Loyola Marymount University. The survey will take about 25-30 minutes to complete. Please contact Debra Linesch, our research mentor, at Debra.Linesch@lmu.edu or (310) 338-7674 with any questions or concerns. Thank you for your participation!

2. Please review the following informed consent and indicate your approval of terms below. (See copy of informed consent Appendix B).

3. Do you agree to the terms of the informed consent?

Yes

No

4. Please fill in the following information.

Name (Last, First) \_\_\_\_\_

Gender \_\_\_\_\_

Position at CHLA \_\_\_\_\_

How long have you worked at CHLA? \_\_\_\_\_

5. What modality of creative arts therapy do you use?

Art Therapy

Music Therapy

Dance/Movement Therapy

Other \_\_\_\_\_

6. What departments at CHLA have you worked in as a creative art therapist?

PICU

NICU

Rehabilitation

Bone Marrow Transplant

Other \_\_\_\_\_

Other \_\_\_\_\_

7. What conditions are the patients in these units dealing with?

Developmental delays (physical, cognitive)

Co-occurring mental health diagnosis

Physical impairments

Trauma

Brain Injury

Life threatening illness

Other psychosocial stressors (low SES, etc.)

Other \_\_\_\_\_

Other \_\_\_\_\_

8. How did you become interested in this work?

9. Which of the following theories helps you best understand the work you do?

Cognitive Behavioral

Family Systems

Attachment

Psychodynamic

Other \_\_\_\_\_

10. Please describe how this theory informs or is informed by your clinical experiences at CHLA.

11. What themes come up in the work you do?

12. What do you enjoy most about the work you do?

13. What are the greatest challenges about the work you do?

14. How has working at Children's Hospital of Los Angeles changed the way you think about or approach the creative arts therapy modality you use?

15. As art therapy students we understand the value of nonverbal and creative expression. We invite you to reflect and create a piece of art on your responses to the survey questions, take a picture & upload it (as a JPEG file) below.

16. You may use the space below to write a statement about the art piece you created. Please write n/a in the space if you do not wish to do so.

17. Would you be willing to further discuss your experiences in an interview?

Yes

No

18. Please indicate which day/time options (check all that apply) you would be available for a one hour interview at CHLA. If none of these options work, please check none of the above and we will contact you to schedule an appointment. Thank you!

- Friday, February 19th-9am
- Friday, February 19th-10am
- Friday, February 19th-11am
- Friday, February 19th-12pm
- Friday, February 19th-1pm
- Friday, February 19th-2pm
- Friday, February 19th-3pm
- Friday, February 19th-4pm
- Sunday, February 21st-1pm
- Sunday, February 21st-2pm
- Sunday, February 21st-3pm
- Sunday, February 21st-4pm
- Tuesday, February 23rd-9am
- Tuesday, February 23rd-10am
- None of the above

**Appendix C: Email Sent with Online Survey**

Hello,

We would like to introduce ourselves, Hilda Galan & Jackie Carlson, as art therapy/marital and family therapy graduate students at Loyola Marymount University. Our research project is partnering with Children's Hospital of Los Angeles to explore the experiences of the creative arts therapists who work here. You are being contacted to complete our survey as a creative arts therapist at CHLA.

The survey will take about 25-30 minutes to complete and can be found via the following link:

[http://mylmu.co1.qualtrics.com/SE/?SID=SV\\_1B9PK1uQNjLsVLL](http://mylmu.co1.qualtrics.com/SE/?SID=SV_1B9PK1uQNjLsVLL)

The survey includes an opportunity to create art in response to the questions and provides a drop in link to include a picture of it while taking the survey.

Your response to the survey is greatly appreciated! The promptness of your response to this survey, by Wednesday, January 27th, will help us in gathering data for our research project and to schedule interviews for further data collection.

Please contact Debra Linesch, our research mentor, at [Debra.Linesch@lmu.edu](mailto:Debra.Linesch@lmu.edu) or (310) 338-7674 with any questions or concerns. Thank you for your participation!

Hilda Galan & Jackie Carlson

**Appendix D: Interview Informed Consent Form**

**LOYOLA MARYMOUNT UNIVERSITY**

**Informed Consent Form (Interview)**

Date of Preparation: 12/1/2015

**Loyola Marymount University**

**An Exploration of Creative Arts Therapies in Pediatric Hospitals**

- 1) I hereby authorize Jackie Carlson and Hilda Galan, M.A. Candidates to include me in the following research study: An Exploration of Creative Arts Therapies in Pediatric Hospitals.
- 2) I have been asked to participate on a research project, which is designed to explore the impact of creative arts therapies with children and families in a pediatric hospital setting and which will last for approximately 60 minutes.
- 3) It has been explained to me that the reason for my inclusion in this project is that I am a Creative Arts Therapist at CHLA.
- 4) I understand that if I am a participant, I will discuss the creative arts therapies work that I do at CHLA and engage in art making. The investigator(s) will ask me questions about my experiences working with children and families at CHLA. These procedures have been explained to me by Jackie Carlson and Hilda Galan, M.A. candidates.
- 5) I understand that I will be audiotaped in the process of these research procedures. It has been explained to me that these tapes will be used for teaching and/or research purposes only and that my identity will not be disclosed. I have been assured that the tapes will be destroyed after their use in this research project is completed. I understand that I have the right to review the tapes made as part of the study to determine whether they should be edited or erased in whole or in part.
- 6) I understand that the study described above may involve the following risks and/or discomforts: embarrassment, nervousness and invasion of privacy.
- 7) I also understand that the possible benefits of the study are to share my insight and experiences related to working with children and families in a pediatric hospital.
- 8) I understand that Debra Linesch who can be reached at (310) 338-7674 will answer any questions I may have at any time concerning details of the procedures performed as part of this study.
- 9) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.

10) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to (e.g., my future medical care at LMU.)

11) I understand that circumstances may arise which might cause the investigator to terminate my participation before the completion of the study.

12) I understand that no information that identifies me will be released without my separate consent except as specifically required by law.

13) I understand that I have the right to refuse to answer any question that I may not wish to answer.

14) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Hardy, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 (310) 258-5465, [david.hardy@lmu.edu](mailto:david.hardy@lmu.edu).

15) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the "Subject's Bill of Rights".

Subject's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



### **Appendix E: Interview Questions**

1) Could you describe your decision to work in a pediatric hospital setting?

#### **Units at CHLA**

2) Which unit (PICU, NICU, Rehabilitation, Bone Marrow Transplant, etc.) do you feel most passionate about working in?

3) Which unit (PICU, NICU, Rehabilitation, Bone Marrow Transplant, etc.) do you feel you make the most change in?

4) Describe what it's like to do Art (Music, Dance/Movement) Therapy in each of these units.

5) What are some of the challenges of doing Art (Music, Dance/Movement) Therapy in these units?

#### **Description of Art (Music, Dance/Movement) Therapy**

6) Considering how you come into a patient's space who may not have experience with Art (Music, Dance/Movement) Therapy, how do you introduce it to the patient and/or their family?

7) How do you introduce Art (Music, Dance/Movement) Therapy to the hospital staff and clinicians?

8) Have you ever co-facilitated with another creative arts therapist? (How was that experience? Challenges? Strengths?)

#### **Populations in the Pediatric Hospital**

9) Considering the cultural diversity of the patients at CHLA, how do you modify your practice of Art (Music, Dance/Movement) Therapy to accommodate various cultural components (language, attitudes/beliefs about dance, low SES)?

10) What factors (e.g. your educational program, the units you work in, working with children & families) influence the theoretical lens (e.g. family systems, cognitive behavioral, psychodynamic)?

11) How does this theory inform your work/in what ways do the principles of this theory operate in the psychotherapeutic process?

12) How often do you work with the families of your patients? (Benefits? Challenges?)

13) In what ways do you see that Art (Music, Dance/Movement) therapy engages the patients you see?

14) How do you see that Art (Music, Dance/Movement) therapy contributes to change or healing in the patients/families that you see?

**Art Response**

15) Create an art piece about your identity as a creative arts therapist.

**Appendix F: Online Survey Responses**

<b>Participant</b>	<b>Gender</b>	<b>Years at CHLA</b>	<b>Therapy Modality</b>	<b>Which theory helps you best understand the work you do?</b>
Participant 1	Female	7 years	Dance	Attachment
Participant 2	Female	4 months	Music	Humanistic
Participant 3	Female	6 months	Music	Family Systems
Participant 4	Female	6 months	Music	Cognitive Behavioral
Participant 5	Female		Art	Eclectic: Humanistic, existential, narrative, family dynamics and sometimes cognitive behavioral
Participant 6	Female	1.3 years	Music	Family Systems
Participant 7	Female	8 years	Music	Family Systems
Participant 8	Male	5 months	Art	Cognitive Behavioral
Participant 9	Female	5 months	Art	Humanistic
Participant 10	Female	1.5 years	Art	Combination

<b>Participant</b>	<b>Describe how this theory informs or is informed by your clinical experiences at CHLA.</b>
Participant 1	By understanding early development, brain changes and the mind body connection I can best address symptoms. Since illness occurs in the body what better way to address patient needs then by working with movement as a way to transform, cope and experience challenges and triumphs while at the hospital.
Participant 2	We are very present and person based and focus on qualities that make us very human: values, personal ideas, self-fulfillment. This approach fits very well in this setting because being human is something we can all relate to (especially during tough and fragile times), and through that connection we can help heal.
Participant 3	I found that I was most effective as a therapist by actively involving

	the family in sessions, striving to understand family dynamics, and utilizing family strengths for the purposes of supporting and coping throughout the patient's hospitalization.
Participant 4	Being hospitalized can bring forth many confounding thoughts and emotions for both patients and their families. Being that at CHLA we continue to work with the same families sometimes over multiple hospitalizations, you are more able to identify and work more in depth with patients and their families on those thoughts and emotions. The therapeutic relationship plays such a big role at CHLA that you're really able to support and challenge families to identify coping strategies that do or don't work for them. You're able to encourage them to be autonomous in decision making, but facilitating it in a way that they're supported throughout the therapy.
Participant 5	I've found that I can't hold on to just one theory, because each patient/family presents me with a new situation. I have to blend my approach to meet their therapeutic needs. But overall, I found that being in the "here and now" is a huge benefit from me. We don't have control over what has happened to the patient to lead them to this point; nor can we control the outcome of their medical treatment. But I can create therapeutic space, and give them an outlet to explore whatever they need to.
Participant 6	This theory helps with my clinical experiences at CHLA because I believe that everyone is affected by the relationships around you and tuning into those relationships while in the hospital is important because there could be a lot of stress and tension from strained relationships. Looking at these relationships, encouraging communication, increasing positive interactions, and engaging in new experiences together can help families grow together in the hospital and help with the health and care of the child.
Participant 7	If I could select CBT, Family Systems and Attachment theory, I would have. I truly blend these three styles along with some post modern approaches (solution-focused and narrative therapy) at times. I take a more eclectic approach to my work with patients and families at CHLA because the needs of various families are very diverse. The medical diagnosis always affects the entire family system, therefore having a systems lens always helps inform my work in a more holistic approach.
Participant 8	Clarifies the complexity of behavior, thoughts. Identifies concrete interventions and logical goals that proves to be less threatening

	and more solution focused for the patients.
Participant 9	You never know what you're going to see when you walk into the room, so you have just meet the patient where they need to be at the very moment.
Participant 10	Although I usually implement Cognitive Therapy in my clinical work, I tend to also incorporate other theories such as family systems and attachment theories. In addition, I also do a lot of existential work with the patients and families due to some of the patients having a life threatening illness and don't always survive. However, what I find more important than selecting a specific theory is the ability to see the child as a holistic unit, integrating body, mind and spirit awareness in the work that I do.

<b>Participant</b>	<b>What themes come up in the work you do?</b>
Participant 1	Pain, loss, body changes, loss of control, compliance, coping and relaxation needs, developmental delays, and socialization changes.
Participant 2	self-care, coping skills, strengths, family
Participant 3	Coping strategies, support systems, decreasing depression/anxiety, emotional expression, pain reduction/management
Participant 4	Family, coping abilities and strategies, loss, fear of the anticipated, fear of the unknown, lack of understanding, faith, hope, past experiences, frustration, strengths, and will power.
Participant 5	A lot of Existential themes come up. As well as, superheroes, animals, princesses (a whole array of archetypes). Most of the time themes of survival, resilience, and teamwork come through in the art process and the narratives.
Participant 6	Family dynamics and how it affects the patients hospital coping, patients/families looking at their strengths and progress, freedom, hope, relaxation/stress management
Participant 7	Grief/loss, identity formation/struggle, self-esteem/self-confidence, stress management, self-care
Participant 8	Hope. Resilience. Pain. Existential.

Participant 9	Depression
Participant 10	The themes that I tend to see in my work are: Patients feeling isolated and separated from their friends, families, and school; patients asking themselves "why me?;" some families state their belief that something "bad had to happen" for the family to unite; the ongoing need for self-care: especially in the mother's of the patients; increasing parental support system, communication and collaboration; attachment issues/self-care (helping parents get some rest without having to feel guilty for doing so); frustration due to not always understanding medical diagnosis and/or procedures; parents feeling helpless in terms of not being able to help their child.

<b>Participant</b>	<b>How has working at CHLA changed the way you think about or approach the creative arts therapy modality you use?</b>
Participant 1	The hospital has strengthened my ability for short term treatment. Having the expertise to quickly assess and work with any medical issue, trauma or emotional experience presented to me. The hospital gives me endless opportunities to advocate and talk about my work. I have seen wonderful progress and always an outlet for these patients, which continue to give me the confidence to know that DMT truly works.
Participant 2	I come from a very behavioral background used a lot of CBT approaches in the past however I now understand the benefits and capabilities of being more humanistic and existential.
Participant 3	Working at CHLA has deeply impacted my approach to working with children because I have seen how effective it is to involve the family in the therapeutic process. I now believe that it is vital to include the family as much as possible whenever you are working with children.
Participant 4	Previous to CHLA, my background was rooted in a primarily patient-centered model. After working at CHLA, I have become so much more aware of the effects of a child being hospitalized on both the patient and their family. Whether it be a family's presence or absence, it's such an important factor in a child's life. There were also times where I worked more exclusively with a patient's parents based on the patients condition. Being at CHLA really emphasized the importance of being present in my session because you never

	know what you're going to get. Assessing a patient each time that you have a session and being able to pull from different creative arts therapy modalities can help you in being more adaptable and truly meeting the patient where they are at that given moment.
Participant 5	Being at the hospital revived my identity as an Art Therapist, and gave me renewed faith in the work that I am doing. It helped me see the power of art making and creation. I also, enjoy having such a unique role at the hospital. Our team can provide assistance in a way that no other professionals can at the hospital.
Participant 6	Working at CHLA changed the way I approach music therapy through opening my eyes to the idea of the family systems theory and really seeing the way patients and families are affected by being in the hospital. It helped me ground my thoughts and connect it to the approach by working with the patients/families.
Participant 7	It has helped me be much more flexible in my practice. I have been able to let go of expectations and really come to peace with the fact that the therapy process can look so different depending on the situation and there is no "one way" to provide services.
Participant 8	Increased my awareness in the use of art as a tool and means of accessing thoughts and feelings. Ironically the increased clarity has contributed to my comfort with the unknown.
Participant 9	It has made me become more humanistic/existential oriented and grateful for being involved in patients' lives at times of most need.
Participant 10	Ever since I have started working at CHLA, I have learned, and am continuously learning, how to work with a lot of frequent disruptions.

<b>Participant</b>	<b>You may use the space below to right a statement about the art piece you created.</b>
Participant 1	n/a
Participant 2	n/a
Participant 3	n/a
Participant 4	n/a

Participant 5	<p>The art piece all starts with a color copy of my badge and the things that I carry around with me on a daily basis. Which include: my badge, pen, mood rating scale, contact info, emergency procedures, my pager, and it is all held together on my Disney lanyard. From my badge swirls off different aspects of the work I do. At the top right is a representation of a recent patient I worked with who got a heart transplant. You see the image of a heart with muscles (a stronger newer heart) replacing the one with stitches. At the bottom right, is the depiction of a typical family (mom, dad, daughter) being separate from their child in the hospital. The family and the patient are each in their own bubbles. This denotes the isolation that parents and patients feel when they are in the hospital and separated from each other. The left side has more to do with what I provide as an Art Therapist. The upper left has a pair of open hands. This represents being open to whatever happens, being approachable, and perceptive. The bottom left is a picture of multiple arrows. This represents movement, activity and connection. There are many systems working at the same time, but there is always movement.</p>
Participant 6	A family of CHLA butterflies surrounded by music.
Participant 7	n/a
Participant 8	<p>The confluence of intention, supply and opportunity may or may not result in an effective intervention. Ideal materials and selection of directives may be just as effective by chance.</p>
Participant 9	n/a
Participant 10	<p>This art piece, the process, represents how I see my work at CHLA. I selected this title because I view everything as a process. When a patient enters CHLA, time only will tell what medical interventions are prescribed. Furthermore, a patient's prognosis to health also depends on how the medication and the medical interventions are working. The central image, a pink candle, is representative of the patient and the caregivers involved in the patients care. I selected pink because it reminds me of a child's innocence as well as the passion/care the medical staff and Art Therapists (as well as other Expressive Therapists harbor for the patient and the families. The golden line, coming from the candle, represents the patients personal process (life or their transition, aka death). The red tear to the left of the candle represents the physical pain patients tend to go through. The red flowers on the base of the candle, represents</p>



the patient's support system, aka, their family. The green roots are symbolic of the caregivers need to be "well rooted" in their support system or faith - to better help their child through their hospital experience. The rosary represents the faith patients and families so often talk about. The black bird represents the "higher power" that is behind everything and everyone. The blue flame is symbolic of the tears that are shed by the patient and their families while residing in the hospital. The yellow and white circles within the blue flame represent the glimpses of wisdom and peace that often is found within the process of hospitalization. The compass is a consistent reminder that we are not in control of things and that outcomes can change at any time. Lastly, I framed the piece with a blue ribbon so as to embody the physical "containment" that the hospital represents as well as my containment needed to help me gain insight and sense into the work I do, honoring the patient's process, the family's process, my process and "THE" process.

**Appendix G: Interview Summary (Dance/Movement Therapist)**

Phone Interview

February 15th, 2016

1) Because I had wanted to bring the Andrea Rizzo foundation (dance/movement therapy at children's hospital)...they provide grants for dance/movement therapy at pediatric hospitals & schools . . . didn't have anything in California, wanted to bring something to LA. Went door to door looking at what hospital to bring the program to. Interesting because I was meeting with Dan Siegel (attachment) we were talking about free will. Favorite book as a child was "Death be not proud" (boy with cancer)...about making every moment count. Something brought me to this work.

2) My grant is for hemo-oncology, so that's mostly who I work with, but I don't say no to anyone. I think there is a benefit across the board to using dance/movement therapy. You see children, you don't see the illness or the cancer (you may see fragileness and IV poles) but you do see rigidity due to being in the hospital. See them express feelings, move, work through pain...work on a spectrum from movement to emotional aspects.

3) Depending on any given week, I see many different children with different illnesses. Depending on the population there is a different goal. Across the board work on expressing feelings. The BMT unit is about getting them engaged, moving and socializing. The hemo-oncology is more about pain management. Different things happening across the board.

4) My work is really about seeing each child as they are. DMT is about movement and the body; how we experience life is through movement and there is nothing wrong you can do. It's really about having them feel empowered. How they interact with doctors, family, me is significant. If they have their fists clenched, that's communication. Ultimately help them feel more relaxed, calm, excited. Help them bring awareness to what they are feeling in their body. "Hey this is what your body looks like", how can we change that. I think across the board, patients may feel like they can't move because it looks different than it did outside the hospital. I am there to acknowledge that maybe they can't move both arms, but they can move one of them. Or maybe they can't move fast, but they can move slowly. As they move they will be more flexible/strengthen muscles, but ultimately it's about them communicating. What's so exciting is that they start talking; their movements remind them about experiences they've had. They can express themes, different stories come up...stories are a parallel process for something they are experiencing. I do a lot of pain management work. Many try to divert away from pain, but I've found a significant response to when I help the patients look at their pain (what shape is it, what does it remind them of); the pain is often an emotional pain...it's compounded by a lot of different things they are going through. By the end of the session they feel calm, relaxed, happy; they give me those adjectives. You can tell I like what I'm talking about.

5) The number one challenge is unfortunately that everyone doesn't understand it...oh we can't dance or the patient is in so much pain that they can't dance. Stigma around the name, which makes me have to explain it. But once they hear my description they understand. CHLA is good about giving referrals and respecting sessions (support). Not necessarily difficult, but eye opening. Helping children become aware of their senses...just hear the beeping (how many other sounds can you hear) just feel pain (what else can you feel). Challenge of coming up with ideas and being creative, alternative ways for children to feel success; I like the challenge.

6) Mostly the same thing; the only other thing I might say is "hey I want to hang out with you" lets see how were going to move today. When I sit with a patient then I will say we have our bodies and we can move with them. Many times patients and parents will say no to things cause they think it's too much for them or they don't feel well. The patient would happily say no to have that control. Just getting in the door & getting to know them a little bit, connect with a show/game. So sometimes I don't have to describe a lot until I get to know them a little bit. DMT can be playing with a toy, eating together, rocking a baby to sleep; it doesn't have to look like something in particular, which is a benefit to the therapy.

7) It's the therapeutic use of movement to further the emotional, physical, cognitive of child, social aspect, helping them to integrate. Illness is in our body, so what better way to work through it. I let them know that I do guided imagery, sensory work, can be a place for the child to have control (mirroring what the child does...so much of what happens in the hospital is not in their control). I have to be humble, showing them that even little things are significant. At minimum I can say that I am giving the child something different to do. I was working with a mom & child (lots of anxiety & pain)...doctors were saying it was really difficult to connect with the child. Just playing a simple game of having mom rock fast and then stop and then go. The child was laughing so much! It was to teach the child that things would happen and they would stop; so she can tolerate when someone comes into the room.

8) I haven't at CHLA due to limited hours. I have over the past and interns have and it's a great benefit. I come from a background where we got training with art therapists; it's wonderful to go from movement to drawing/journaling. Picture cards sometimes...different images of water or connection (people touching), children can move with it. Movement is not a necessity in dance therapy, but can help facilitate the sessions. I use music on Pandora radio (kids like pop or Disney). With babies I make up songs all the time...music is so important for the brain.

9) Certain cultures dance resonates stronger in terms of community and family. I also look at it in terms of physical space; certain cultures need more body space than others. The great thing about my work is that I'm reading what the patient is doing and how they and the family react (mirroring them). Across the board, families at CHLA are open to it. From excitement that their child gets something different to they really see it as this is working. Some of the larger families

is fun because everyone will get involved. My goal: I love traveling to other countries and working with other populations. To me, dance/movement therapy is so flexible with language; you don't have to say anything and can just start moving with the child. You are connecting through movement and you create your own language. As you keep moving with them, they will increase talking/gesturing even if you don't speak their language. So it doesn't hinder me from seeing a patient. We have translation at hospital; sometimes I want to translate who I am what my goal is. Then I would use the translator and empower them if they have any questions.

10) Well I'm also a clinical psychologist so my foundation in work is attachment theory; looking at the work of Bowlby and the mother relationship. The population at the hospital...not always working with parent/child, but what brings up the attachment work is thinking about how we integrate someone to help them self-regulate. At the hospital, always seeing chaos or rigidity in the children and so in my work I'm looking at how can I help them integrate. If they can self-regulate then they can take in what's happening around them, have relationships, get healthier again to deal with procedures/surgeries. So the dance/movement therapy is constantly doing that for them; give bodies a way to regulate in order to integrate their experiences and to be more flexible/adaptable in this environment.

11) I think I can't do therapy without attachment theory. Self-regulation-take in their environment and remain in a regulated state/balanced state to be flexible/adaptable. I've found and am working on writing it up, we have different theories of dance/movement therapy where we look at developmental movement. By looking at the way they move, I can identify areas of restriction. When a child is in a very rigid state they might move in a vertical way (sitting up, asserting themselves) and need help moving horizontally, side to side to soothe themselves, look at how they soothe, help them learn how to soothe. Also, if they're having difficulty connecting with new people, they need to have a foundation of soothing and then I help them move to asserting themselves and to developing relationships. The movement is significant; without them having to tell me their whole story I can see where there is a restriction. I can see a difference between a child that has difficulty with attachment or relationships or trauma compared to a child who is more well-adapted. Depending on our time I can help them be present with where they are and ultimately give them the possibility of moving in a different direction and expanding their experience. Connection to attachment...children learn through creativity. "Worrying is a waste of our imagination". So often there is worry about what's gonna happen to me. Use creativity to work on relationships (therapist, family) and new ways of relating to others. They learn that they can be their worst self and their best self and still be accepted. They can use their imagination to work through problems in a creative way...not solving illness, but how to move hands in a different way, etc.. All that plays into attachment. Neuroscience-mirror neurons, possibility of having experience of their body being in a state of comfort even for this moment, this feels right, my body will keep this memory...different experience in hospital than they were. Neuroplasticity-learning new things, new ways to adapt

12) I often don't work with the families. There are wonderful benefits when the parents are there; obviously kids don't live in a vacuum, therefore things can be worked on even when you (therapist) aren't there. It can be wonderful to support the parent child relationship; get parents a chance to see their child as a child...they tell stories. Give parents ideas of what to do in the room all day. Parents have a lot on their plate; often during the session it's a good time for them to take a break...I work with them in a holistic way (tell them to take a break/care for themselves...go take a shower or go for a walk). Ultimately helping the child. The parent sees that the child expressing big/negative feelings can be challenging; parents want their child to be respectful, happy, smiling, but I help foster that that is okay during the therapy (to express big/negative feelings) and it's safe/healthy to express that.

13) Brings them into a state of awareness, which we know with research; mindful, open space to take in challenges, be present in their bodies, gives relevance to all parts of their bodies, not just the ill part (they are a whole being), connection to breath for soothing, option to express feelings not in an interview way; get there quicker and more direct...can't rationalize or be defensive. They move and you can see, honesty, this is how I really feel. Movement increases language...brings up ideas, thoughts, feelings. Flexibility & strength-plays into it, but that's not my focus. If you can't move your legs, let's visualize how it would feel to move and then it does move. It's not magic...just give them permission...when you want to move you can. Not a certain way to move: blink eyes, use sheets or gloves, toys, visual idea of movement.

14) The more we can help a child integrate and become aware of their control, potential, capabilities, which allows them to be healthier. Want a study to show what's happening in their body; know that when the session starts they are in pain and by the end they are relaxed, something has happened. Ultimately moving or smiling and laughing...all the stories and witnessing I know that it's making a difference. Positive psychology-give patients an opportunity to be happy, going to benefit their health. And I know there is a study that looks at what makes someone the happiest...number one thing was integration. Dance/movement therapy helps them integrate (we know that integration has to start with the body-that is how we regulate...if our body is in a state of isolation or pain or discomfort, they can't start to heal)...my dream...to have the research. We feel better when our bodies feel good. Integration has to start on a physical level. Bring wellness into the room with dance/movement therapy; start to feel better and handle surgeries. I don't tell them I can heal them, but I think it's a step toward healing. I tell them this will make them feel good for this moment. Gives them an outlet to express feelings, holding in emotions isn't good for mental health. These children don't get much time to communicate feelings in the hospital.

Anything else you would like to add?

Interruptions-need to be patient, medical needs to be priority. I always advocate and introduce myself to whoever walks in the room...let them know a session is going on and usually they will

leave the room. If a lot of emotional content is coming up during session, can be challenging...good thing is children are used to it and don't seem as shocked as if it happened another setting (private practice). Sometimes continue from session to session, but mostly short term treatment approach. Not always gonna pick up where we left off... Stay true to where they are in that moment.

## Appendix H: Interview Summary (Art Therapist)

In-person Interview (CHLA)

February 19th, 2016

1) I was in the field for a number of years working with foster kids, schools, and homes. Then, I saw the job posting for this and was like, “this is so different than everything I’ve ever done, why not?” And so, I figured it would be a good change of pace after doing the same thing for so long and that my identity as an art therapist would get to be centralized again. Instead of being an MFT intern, I’d be an art therapist first. So, that’s initially what drew me here...having never worked in a medical setting whatsoever...the opportunity to do something different.

2) Right now I am really digging working in the NICU, because I am working with parents specifically. There’s a lot more opportunities to provide that support for parents while music therapy is providing the support for the babies. So, that’s sort of something I’ve taken on a lot more in the last couple months since [former NICU music therapist at CHLA] left. So, I’m filling that role, but other than that I really love working in hemodialysis as well.

3) I feel like in the NICU I impact a lot of change by helping the parent. The babies are really helpless, and it’s medical intervention that helps them the most. The parents get forgotten quite a bit. So all the focus is on this little tiny baby, so I feel like providing art therapy for the parents makes it so they can be here longer, and they don’t burn out, can be there more for their child, and bond with their child more. I feel like that’s the best way I can support.

4) It’s so different from unit to unit and person to person. I think the biggest change when you come here is the supplies that you can use. If you’re in a unit where they have really high isolation, like our bone marrow transplant unit, I have to bring brand new supplies in. I can’t bring collage images in. It has to be brand new wrapped supplies, so it really tends toward way more structured art interventions that I can do...and not as many exploratory looser medias. Also infection control wise, I can’t have them use a paint that’s actively drying, because germs can get stuck in the paint. So, all this weird stuff you would never think of, with the kids being in isolation. That’s the biggest factor that I had no idea before I came here...that that would change my clinical decision making as to structure media to looser media isn’t just emotionally what they can handle, but what infection control can handle. Each unit has its own flavor. When you have kids who have chronic illnesses who are here for 2 weeks, are out for 3 months, here for 2 weeks, their stories are much different. And I feel like with those cases I can just pick up where we left off. They’ll create a piece of artwork, and the next time I come in I’m like “Hey! Do you remember what you made last time?” They’re like, “No.” So I’ll tell them...and we could just pick up on that theme...just where we left off. Or if you have kids who are here with cancer, and are here for months at a time, the work you can do is more in depth, but then the other consideration is they’re feeling really sick when they’re doing their chemo and so they

don't always have the energy to do the art in a way that they would before. Yeah, so it's so different by unit.

5) *And how about maybe specifically in the NICU, since I know you said you like working there. How is that to engage the parents? And what considerations are there?*

You get the original resistance from any adult you will work with...who is like, "I don't know how to do art," "I can't do art," or "I'm not an artist." That's always there. Always there, regardless. I am always addressing that... "You know art therapy does not have to look a certain way...you can just explore."

I'm always having to do that education piece about art therapy, but I kind of call their bluff and say "Jump in. Let's see what happens." And they do and feel like they magically transported while making this art work. There is that initial resistance, but once they commit themselves "Like okay I'm just going to go for it" it becomes a very, very, very rich process. I've seen amazing things come out of the parents and what their hopes and expectations are for their babies. Ways they can show love to their kids is a directive I really like to use. I have them trace their hand and write or draw 5 ways you show love to your baby. These are parents who a lot of them can't physically touch their child...and so it's still about feeding their connections. So to see them come up with "I can read to them" or "I can sing to them." All of these other ways to connect...that if I didn't offer that art directive, they may not have been able to highlight that themselves.

6) My elevator speech is "Sometimes it's hard to talk about what's happening in the hospital. Sometimes it's easier to draw about it. Art therapy is another way for you to express yourself." That's my tag line. I walk in. That's my elevator speech. Every kid I get, gets that. And then, I just jump in. I'm like, "Hey, let's give it a try!" So I usually take a very casual approach and really meet them where they are and try not to be too eager or I don't overwhelm them with my art supplies either. I keep it really really basic and for sessions I'm like, "You have your choice, markers or colored pencils." So, I make the art very, very approachable from the beginning.

7) It's definitely different discipline to discipline. It's kind of finding how the patient's well-being benefits that staff person. If I have a kid who is super depressed, has their shades closed, is really withdrawing and the staff is really frustrated. "I can't get her out of bed." "I can't get her to take her medicine." All these things. So I say, "Well, you know what? After her Art Therapy sessions she usually feels a little better and is okay with opening the shades. Maybe that would be a good time for you to come in and try to give her meds." So, finding what the benefit is to that person. So social workers, they'll say "This family is so bogged down, they don't want me in the room. They won't tell me. They won't open up." I'll say, "You know what, they really opened up during the art process. How about you try..." So it's finding a doctor to say "they'll be here in the hospital fewer days if they're having art therapy or music therapy." So it's really shaping it. For child life, it's like the developmental milestones that they can meet with the art



therapy and also self-expression. It's really finding what each discipline values and how we fit into that value.

8) I definitely have co-facilitated with music therapy. When I first got here, I did the rehab group with music and art therapy. It's awesome and tricky at the same time, because we speak the same language, but a different dialect, which is how I like to say it. I have a Californian accent and they have a Southern accent, is what it feels like. We're both speaking English, but we are doing it a different way. So to find the common goals of how music therapy can meet this goal and how art therapy can meet this goal. And how to blend the approaches is always tricky, but when you get it, you get it. You really walk out of there like pumping your fists in the air, "Yeah! We did this!"

I haven't co-facilitated with dance movement therapy. That's one I have not done, but our team group right now is art and dance movement working together, which is awesome. Which is really a new opportunity, but mostly music therapy. I have co-facilitated with occupational therapy.

*What that might look like?*

With that, it's kind of hard because they (occupational therapy) has very rigid ideas what the kid has to accomplish and so they'll use art materials to accomplish certain goals and I'm using art materials to not accomplish those goals but to accomplish what the child needs. They'll want a kid to be sitting up and using an oil pastel in a certain way and I'm like, "Okay, we can co-facilitate but you can help the kid sit up and to grab the oil pastel, but whatever they want to do with it is what they'll do with it." So, working together saying whatever hits the page is my jurisdiction and they way the kid is sitting is their jurisdiction. So, finding a way to blend those approaches is really interesting. And child-life...I've co-facilitated with child-life a lot. And social work. I do a parent group in dialysis with the social worker.

9) Every room you walk in is a completely different system and a cultural value system...and being a white female, my experience of me is different than their experience of themselves and their families. So, I really have to come in at a very humble place..and to just meet them where they are. I have had sessions where I do not speak the same language as the child or family. I can speak really bad Spanglish, but in other situations it's been like families that speak Chinese or speak Arabic. It's difficult, but the art is the medium which cuts through all the language barriers. So, I can walk in and show my supplies and do kind of like a [gesture made here] kind of body movement.

*So the kids respond nonverbally?* Nonverbally. And I narrate those sessions, even if they don't understand what I am saying. I still narrate the session, because through tone of voice, they can get an idea of what I am intending. And...holding the space is very, very important. I'm still an active observer and still very much in the process even if we're not speaking the same language. But, I found that some of the cultural pieces I was not expecting are cultures where women are

not seen as being equal. In those situations, I have to come in at a much quieter place in myself and not be quite as bold and colorful as I would be with other families, but to sort of be a little more subtle and to not have as much eye contact or to just change my approach that some men don't feel comfortable shaking women's hands. So to not necessarily offer my hand in those situations. That's been a huge cultural thing I've had to traverse since being here, but the art cuts through it. It just cuts through all of it. It's just about being very humble, but also being very assured that the art can do the work even when I can't communicate it, the art communicates it.

10) Being eclectic I really love narrative approaches...that works so swimmingly with art therapy. So, narrative therapy is a good one to go to, especially when working with younger kids. They draw their picture and create a story to go along with it very readily. Patient centered, family centered, family dynamics, sometimes we get into cognitive behavioral, that's not all that often for us – music therapist a little more. I'll step into that when I have a really hyperactive kid and I can change the behaviors through the art response.

Existential. We're dealing with life and death. We're dealing with people at their hardest moments and time. I can't control what is happened before I got here or what's gonna happen after I leave the room, but where the marker hits the paper, that's where I can exist with them. So having a really mindfulness approach really works. It's about being where that medium is. Being exactly where they are in the moment. Humanistic...of course...because every room is so different, it's really blending my approach to what that family needs, what they kid needs. Here, it is "Who is this child as a whole person? Who is this family as a piece of this child? Where do I fit into that? How can I assist?"

11) Being trained psychodynamically to just really walk in and be a blank screen and be open to whatever happens. I can accept whatever happens in the room. Having a breadth of theories and also being very present in the room is how the art happens and how the magic happens.

12) I'd say 50% of the time I work with the families. I always allow the children to choose if they want their family involved, because at the hospital they don't get many opportunities for choice. The doctors are telling them what they have to do. The nurses are telling them. So in their art therapy, they have the choice. So I'll sit with them and I'll be like "Hey...do you want your mom to be involved?" "What do you think, should we have a family session today?" But I give the kid the choice. So if they wanna include their parent, I also will have the invitation come through them. So I go, "Why don't you ask your mom?"...because the kid asking gets better results than me asking.

It's up to the patient's discretion. But sometimes the parents need a minute to step out and to take a break. Providing an individual session gives the parent a moment to get some coffee or go outside for the first time in 7 days. It also provides the child time to be an individual and not that unit for a little bit of time.

13) It's just really amazing because it is choice, it is providing them choice in a place they don't have much choice. Not only that but it's impacting how they can express themselves. It's not necessarily my approach, but the art approach – it gives them a way to express themselves in a comfortable way since others are pushing their agenda. The art meets them where they are. Sometimes the metaphors are dead on and speak to everything that is happening in their lives. It's so individualized, and it's so different with each kid and that the amazing thing about art therapy – it can expand to all those populations and all those needs and blend to what they need most.

14) Their mental wellbeing, their feelings about themselves definitely contribute to how quickly they get better. I just know that when I walk into a room and a kid is rising in pain and we can do art therapy and say “Oh my god, I feel better!”...that is everything. That's been an hour where they were able to transform their pain into something different. And that impacts the rest of their day. So that means they're less likely to push their pain medicine button because they're not feeling that pain while they're doing the art and the art has relieved them in some way and has created more of an ease for them.

15) I really like the central image there, the perfectly cloudy blue skies and the green field. The silhouette really appealed to me, not just the color choice of it, but even the hairstyle is sort of short like mine. It feels like a real profile of a whole person, so I wrote “whole self” underneath it. And then I put different elements. The cookie that says “sweet and colorful”...I think a lot of this in terms of how people see me here, they can tell I'm an art therapist pretty readily, by the way I dress and the color of my hair, so I have sprinkles colored hair. The keys that say “they key to unlock the emotions of others”...sometimes I just have the right key. That people have been trying the wrong key and I have the right one. The little Lego blocks “piecing it all together” sometimes the Legos are all over the floor and other times they're starting to build them. So it's kind of cool to see that process as well...being present to watching the maker build their art and what they're doing. The top one is “wolf in sheep's clothing” so it's this little wolf disguised as the sheep amongst the herd. I know that one seems weird to write but I see people think the art is so innocuous. “Oh they're just doing art and crafts”, but really we're doing some major wolf work. We can get in the door...“Oh, we're sheep it's no big deal...” and then get to this really deep content that other people can't get to. At times it feels, not deceptive, but I think we are being underestimated and really we're much more powerful. The “hello sparkle”...I feel like I already have a sparkling personality and that impacts who I am as a therapist and how people react to me. The “whole self” would be the title to the whole thing.

**Appendix I: Interview Summary (Music Therapist)**

In-person Interview (CHLA)

February 26th, 2016

1) Sure, when I was doing my music therapy training we worked with older adults, children with developmental problems/autism, inpatient psych and also with adolescents. The last one was with medical and I fell in love with it then. I loved the immediacy of the work; tough setting, especially a pediatric one. It was difficult, but it seemed to fit so well with what they were going through, to meet the immediate needs to make it easier for them to be there. So I just loved that, that it was fast paced, I chose an internship after that in the field and got this position fairly quickly after that. In this hospital all kinds of things come up (gender, chemical dependency, identity). Intense, always different.

2) Hard to choose; I always love working with parents and their kids...helping empower parents; you're still their parents. I love when I can work with families who will dig in and do some work while they're here and are looking for that support. I also love working with teens who have a lot of mental health issues that come up during that time of life; resistant teens.

3) I think the immediacy of the work we do in the ICU is important...too intense, but those are the moments when it's really beautiful. Even when patients are non-responsive and the family is undergoing so much stress and pressure and maybe end of life we can make a positive impact and bring light when it's really needed.

4) It's always different, don't know how this is going to go. It's not really about the music we're talking about it's about how does music connect to this patient and or this family. How is this a tool they already use; how can I build on that. Movement of the session that comes from that. Never know what to expect, always learning something.

5) I work in the dialysis unit here, it's outpatient. I mostly work with teens there and it's set up like a ward where there's not individual rooms and I'm a music therapist, so much is auditory. I have to be creative to maintain confidentiality and adapt it to make it more contained such as looking at lyrics, listening to it together through headphones and interpreting it together in a different way, but less active music making. Reinterpreting our role because it's not the typical way to do music therapy. Then looking at the ICU's, people have to come in every few minutes; you have to be good at flexing how you work with the patient/family and being open when they come in, but still holding the integrity of the session. But that's a reality, need to let that be and find a flow. That is important in all sessions, how to respect the time we have.

6) I usually say my name is \_\_\_\_, I'm a music therapist here at the hospital and I wanted to come in today for a visit if now is a good time. From that usually they say yeah we love music therapy or they're like who are you and what is music therapy or they look at me blankly and I try to take one of those and say what I'm saying kinda sounds funny doesn't it. Could I sit down for a minute and tell you more about it. Or if they know about it, "oh you know about it, tell me what you love about it, when did you receive it before? What stuck out to you the most?"

Reinterpreting how I'm a therapist in the moment. I usually explain that music therapy is something that builds off of music being a really powerful tool in our lives. You probably have 5 ways you could name for me how you use music even if it's listening to it in the car, etc. it has an impact on your life. Unspoken connection we feel when we listen to music, it's so powerful. What we do in music therapy is we hone that into a science that can help you while you're here, cope with what you're going through, bring down pain, all kinds of things we can do. I say that if they want more information or keep it simplified if that seems like too much information. I try to get to know them first if they're more anxious so I can tailor how I describe music therapy. How has it been going in the hospital for you? What's been the toughest part? Then I say this is how music therapy can help with that.

7) I think it's different. I let them know if it's a nurse, doctor, social worker that they can order it for a patient that needs additional support. I let them know it's not about teaching music, it's about using music as a therapeutic tool. I like to give some examples: for a patient who is having pain management issues we can teach them mindfulness exercises with music to help them control their pain or if they're having anxiety we can do breathing exercises/interventions to help them feel empowered and comply with treatment more. We can be a good adjunct to your work. I turn to them as an expert in their field and let them know how we can support them. Do you incorporate the music therapy research? Yes I incorporate the research we've done here: 20% improvement in pain/mood, or in NICU-increased caloric intake, weight gain for 1-2x per week. And helping parents feel more empowered etc. Nurse-territorial, I can tell you're concerned, ease your mind about what we're doing here. It's not something the patient needs to be actively engaged in; check vitals to tailor things so it's meeting them in the moment.

8) I've been lucky cause I've done it with therapists I've worked with for awhile and know well. I've facilitated with both dance/movement therapist and art therapist in different ways. In groups with art therapist, which has been really great; we flow well. I've worked with dance/movement therapist beside and we both have similar ways that we approach patients and families. So it's been easy, but I've also dealt with interns who are trying to feel it out and that's challenging. Art therapists are psychotherapists and that's not the traditional training for music therapists so it's challenging. It's about asking questions so you can be curious about what the other person is doing and bringing what you have to the table and knowing how to own that. But I feel like I've been spoiled so I can't say it's been hard for me here.

9) I think of cultural that it's happening all the time, about our family, who we are as a person, etc. I try to be very curious about what makes them who they are, what's special to your family. I usually take the family lens, if I'm lucky enough to work with the family: What's important to you as a family? Is that how it is as individuals? Being curious and mindful and I try to weave that in. When I ask about what music they use, show/share what they want to. I always assume that I'm walking in to so many different cultures. It's always interesting how cultural plays out here because they are put into a system and they might have to adjust. Always taking that role to advocate for what's important to them, have they been able to do that, how can they do that more.

10) Before I got my masters in marriage and family therapy I worked as a music therapist with my bachelors-that informed getting my masters. I felt that lack of understanding and really being able to help families on a deeper level. It was trickier I think to figure out how to combine MFT with music therapy. Working with families has informed my work and who I am informs it. Being a mother is the most important thing I am no matter what they're situation (teen mother, addiction, lack of resources) I always come from a place of love guiding us who we are as people. Even a teen mother who didn't get prenatal care until 7 months in etc. Help them feel like you have this moment now; there are a lot of other factors you and I can't change, but what you're doing right now is working. So from attachment theory-encourage what they do well to reinforce positive attachment. We are working with families in an intimate way. With CBT I hated it when I was learning about it; now I'm doing CBT work, and I think it works, especially with teens. They deal with a lot (self harm, drugs, social media) and these are the tools they need. And family systems-we are all a part of a system, even if we don't want to be. It can feel empowering or frustrating, but we are all in one.

11) I think empowerment is the word I keep coming back to. That is our role here, to empower families. CBT can be empowering to know our thoughts affect our emotions which affect our behaviors. I've drawn the triangle so many times and it's eye opening. You have the power to do that-you are not your thoughts. You can change. Same with attachment-it's so empowering to sit by a mother and say you're doing this right now. Maybe she hadn't been until that point, but now you're holding him, singing to him, this is amazing/important.

12) It has changed as my role here has changed...It's once a week for the families I do see here. I work more in dialysis now, some in the ICU. With more intense cases-DCFS involvement, possible abuse, on a hold or an eating disorder. Challenges-everything, sometimes it can be challenging to figure out what my role is-let this mother have a break, engaging her, what does she really need. Can be a challenge to engage them. Music therapy comes with an interesting challenge because people still think performance so we're trying to work against that. Educate that it's not about that-give it context toward what we're trying to work towards.

13) It's easy to quickly engage in-oh this is a song you like, let's listen to it together, it takes you somewhere, it transports you quickly. My work-cutting to the heart of the issue, music is so immediate so you can jump right into it, which is good and bad, sometimes it's too quick. Sometimes we hear a song that is too impactful and it's a lot, a full body experience.

14) Empowering is the biggest piece of it. It's great when it can be immediate. If you had to give your mood a number (10 being the best ever, 1 being the worst) where is it right now? Where would you like it to be when we're done? What can we do to move it up half a point. Use solution-focused to help the families who are really in a negative space, what's that one moment where it feels like a little less stressful. I try to see what change can be done right now and how that can happen throughout the week.

Anything else you would like to add?

It's amazing work, it always amazes me how powerful it can be; so rewarding, it makes a big impact.

15) This picture stuck out to me-who I am as a person, wanting them to feel this connection and feel empowered as a family...I feel like there's this light around that and I want to help that shine as much as I can. Who they are as a person/family outside of this illness, outside of this experience. I felt the empowerment piece I talked about as I was making it.