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# Medical Art Therapy

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# MEDICAL ART THERAPY

by

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# Signature Page

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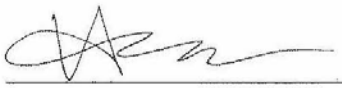

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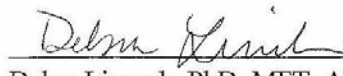

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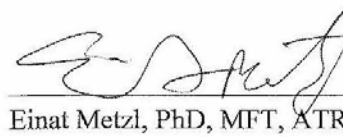

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## Abstract

This research explores the experiences and practices of Medical Art Therapists; specifically, how working with clients in a medical setting, often as a part of a multidisciplinary team, impacts the work of an Art Therapist. Researchers reviewed the general literature regarding children and adults' experiences of hospitalization and utilization of psychosocial services. Medical Art Therapy literature is reviewed next, emphasizing work with children, families, and adults. Informed by the literature, researchers invited Medical Art Therapists to participate in a focus group and/or follow-up survey. Researchers conducted a focus group in which participants discussed their experiences and created response art. A survey was then sent to focus group participants and other respondents who were unavailable for the focus group. Researchers identified four categories that emerged from the survey data: "art as self-expression," "categorization of Art Therapy," "considerations specific to the medical setting," and "range of utility" of Medical Art Therapy. Researchers used these categories to analyze data from the focus group and response art. An additional category emerged from these two data sets: "personal experience." The response art naturally offered another category for analysis: "features of the art." Researchers compared findings across all data sets and discovered meanings by setting these findings in the context of the general and Medical Art Therapy literature. Further research is warranted to support expansion in the field of Medical Art Therapy.

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# Introduction

## The Study Topic

The purpose of this research is to seek a deeper understanding of the practices and experiences of Art Therapists who use the Art Therapy modality within the context of a medical or hospital setting. Data is gathered by means of a focus group and through online surveys, both of which included verbal or written responses as well as art responses. Questions intend to explore the possible benefits and drawbacks of using the Art Therapy modality and of working as an Art Therapist within this context.

## Significance of the Study

Much has been written about other expressive arts therapies within the medical setting or with attention to Art Therapy treatment in pediatric units, specifically. This study is warranted to expand the literature on the use of Medical Art Therapy across different settings within the medical context and to illuminate possible areas in which this practice can be better supported. The researchers hope to bring awareness and deeper understanding of the usefulness of Art Therapy within the medical setting. While conducting this research, Hope Kinney was working as an Art Therapy Trainee at Children's Hospital, Los Angeles, where she had the opportunity to witness all that art can offer within the context of medical treatment. Hope is interested in Medical Art Therapy as a component of holistic treatment which bridges the medical model with alternate modalities in order to treat the whole person—body, mind, and soul. At the time of research, Elizabeth Mueller was working with homeless adolescents in a group home setting; she holds an interest in working within a medical setting and how this context would impact the therapeutic process.

## Background of the Study Topic

It has been noted that imagery has consistently played an important role in the treatment of illness for thousands of years (Malchiodi, 1999a, p. 13). McNiff (1992), for example, discussed historical contexts of art's use as medicine throughout indigenous, shamanic traditions. In exploring the concept of Art as Medicine, McNiff (1992) went on to cite the work of "Prinzhorn, an art historian who later trained as a psychiatrist [and who] was not interested in the intentional clinical use of the art works for diagnosis and treatment" but rather "suggested that the suffering soul should have access to the vital and natural medicine of art and imagination" (pp. 36-37). McNiff (1992) explored a "shift [in] perspective of art as medicine away from scientism to the treatment of soul" in order to contextualize art's potential contribution to people suffering from psychological and/or physical distress (p. 37).

Built upon the foundation of historically-employed healing practices, "the term medical art therapy has been applied to the specialized 'use of art expression and imagery with individuals who are physically ill, experiencing trauma to the body, or who are undergoing aggressive medical treatment such as surgery or chemotherapy" (Malchiodi, 1993, p. 66). Malchiodi noted that, while "the designation 'medical art therapy' is increasingly being used to describe the contemporary application of art therapy in medical settings, the practice of medical art therapy is actually [at least] several decades old"; British artist, Adrian Hill, for example, "noted that art making was helpful in his recovery and that of other patients hospitalized for tuberculosis(1945; 1951)" (Malchiodi, 1999a, pp. 13-14). In more recent years, "art therapists and other healthcare professionals have been active in introducing, developing, and applying medical art therapy in a variety of settings with both child and adult populations" (Malchiodi, 1999a, p. 14). Increased understanding and acceptance of the mind-body connection in Western

medical contexts, and prioritization of holistic, family-centered care have undoubtedly informed an increase in Art Therapeutic services in hospital settings.

Many hospitals now provide Art Therapy services (usually under the overarching umbrella of Expressive Therapies Departments), acknowledging their unique potential to support patients and their families while undergoing medical treatment. As of 2013, nearly half of the healthcare institutions in the U.S. report offering arts programming (Harter, Quinlan, & Ruhl, 2013). Current research supports the measurable effects of Art Therapy, including symptom reduction—specifically with anxiety and depression—in addition to positive outcomes related to coping skills and quality of life (Metzl, Morrell, & Field, 2016). There is a growing amount of Medical Art Therapy literature utilizing pre-and post-test methodology measuring the effects of art therapeutic interventions via pre- and post- test methodologies (Nainis, Paice, Ratner, Wirth, Lai & Shott, 2006). However, more standardized, larger studies, and especially ones that compare Medical Art Therapy interventions across different settings are needed to continue to ensure effectiveness of care; this is especially necessary, given the overarching context of the mental health field's move toward evidence-based practice, within which the field of Art Therapy may increasingly focus on quantitative research methodologies to support its practices.

In the following section, researchers will explore current literature on both hospitalization and corresponding psychosocial services in general and also Medical Art Therapy in particular.

# Literature Review

## General Literature

This section explores the general literature concerning two main topics: hospitalization and psychosocial services. Both topics are divided into smaller sections regarding the experience of children, adults, and adults in oncology. A substantial amount of literature reflected the study of adults who were diagnosed with cancer, specifically, which is why this is included and has its own section.

**Hospitalization.** The Healthcare Cost and Utilization Project reports data from the National Healthcare Quality and Disparities Report (QDR) that about 36.8 million people were hospitalized in 2014 (Barrett, Coffey, Houchens, Heslin, Moles, & Coenen, 2017, p. 39). Of these patients, 15.3% were youth ages 0 to 17, 24.7% were between the ages of 18 and 44, 24.7% were between the ages of 45 and 64, and 35.2% were 65 years or older, and 0.05% of patients' ages were documented as missing, invalid, or inconsistent (Barrett et al., 2017, p. 39). The most common reasons identified for a patient visit were normal newborn (7.5%), vaginal delivery without complicating diagnoses (6.1%), psychoses (3.0%), percutaneous cardiovascular procedures with drug-eluting stent without major complication or comorbidity (3.0%), major joint replacement or reattachment of lower extremity without major complication or comorbidity (2.9%), and simple pneumonia & pleurisy with major complication or comorbidity (2.9%) (Barrett et al., 2017, p. 41). The mean length of stay for a hospitalized patient was 4.7 days (Barrett et al., 2017, p.42).

***Children.*** The event of a child's hospitalization can have major impact on the children and their families. For example, Salmela, Salantera, and Aronen (2010) state that a hospital can become an important context for the development of a child with a chronic or severe illness.

Coyne (2006) and Salmela et al. (2010) observe that previous studies have relied on adult's perspective of child hospitalization. They assert the importance of gathering information from the child's point of view. Coyne (2006) reveals the lack of autonomy that children may experience during their stay at the hospital; children may not be included in discussions about their treatment because adults may not think they are developmentally able or they may have limitations because of the illness or limited ability to communicate (p. 327). In the study, Coyne (2006) reports that children expressed that they needed permission for daily activities such as getting up, getting dressed, eating, using the bathroom, and having their personal belongings. Salmela et al. (2010) supports that there is a lack of self-determination and freedom of choice that children must cope with. Alternatively, Coyne (2006) warns that if children adopt a learned helplessness, it will negatively impact their ability to adjust to their illness and their overall welfare.

Autonomy is only one aspect of loss that children experience during hospitalization. Children have reported missing aspects of the comforts of home including the "atmosphere, their mother's cooking, comfortable beds, their own room, music, facilities and pets" (Coyne, 2006, p. 329). Additionally, they reported missing time with their friends and a disturbance in activities such as attending school and sports activities (Coyne, 2006, p. 330). Coyne (2006) includes that children's descriptions of their treatment at the hospital reflected "feelings of intrusion and loss" and they were concerned about the potential changes in body image, mobility, and continued lack of control (p. 331).

Children's commonly shared emotion regarding hospitalization is fear (Coyne, 2006; Salmela et al., 2010). The changes in routine and environment and loss of autonomy previously described were sources of children's fear and concern about their hospitalization (Coyne, 2006,

p. 328). Timmerman (1983) outlined several fears of children who were undergoing surgery for the first time: “loss of control, the unknown, pain or discomfort, injections, lagging in school achievement, destruction of body image, separation from significant others, disruption of peer relationships and death” (as cited in Coyne, 2006, p. 327). Salmela et al. (2010) added that children had fears “of the impending operation, of sample-taking and tests, and of being left alone. Instruments, medicines, nurses and doctors, as well as the unknown environment, loud noises, nightmares and strange people also caused fear” (p. 1225). Some sources of children’s fear were what they had seen on television, previous experiences visiting others at the hospital, and the experiences others had shared (Coyne, 2006, p. 330).

In addition to fear, children and families often experience anxiety as a result of a child’s hospitalization. Children may feel anxiety because of the nature of their treatment, interruption to their routines, or feeling a lack of control (Coyne, 2006, p. 335). Tallon, Kendall, and Snider (2015) warn that if a child experiences ongoing stress, elevated cortisol levels “effects[sic] children’s capacity to cope with challenge, impairs learning capacity, increases insulin resistance, suppresses growth hormones, and impairs immune competence, all of which have long-term implications for later achievement, social functioning and health status” (p. 1431). Child patients are not the only people who may feel stress about their hospitalization, however. Parents’ health and wellbeing may be impacted by the level of stress experienced when a child is ill (Tallon et al., 2015, 1430). Tallon et al. (2015) also report that arguments between parents may be a result of financial strain during a child’s hospitalization and that stress may be intensified by experience of “socioeconomic disadvantage, poverty, mental health problems and low self-esteem” either by a family member or as a collective (p. 1429). Coping strategies may become important during this potentially stressful life event.

For parents, research shows that coping has been supported when they feel listened to by hospital staff, feel "valued and respected," and are able to discuss their concerns and name their strengths (Tallon et al., 2015, p. 1431). Salmela et al. (2010) studied the coping mechanisms of preschool children who had been hospitalized. They found that parents were essential to children's ability to cope (Salmela et al., 2010, p. 1229). In their study most children explained that they coped by looking to adults for security, retreating from the situations, or talking or crying about their fears (Salmela et al., 2010, p. 1225). Coyne (2006) adds that some children had an ability to adapt to unfavorable aspects of the hospital environment and that some displayed an ability to cope through developing friendships with other children at the hospital.

***Adults.*** Just as with children, the experience of hospitalization for an adult can stimulate a number of difficult emotions. Similarly, adults may face "a series of stressful stimuli, including physical symptoms, unpleasant medical procedures, fear of death, restrictions in usual activities and so on" (Karademas, Tsagaraki, & Lambrou, 2009, p. 1244). Castillo, Cooke, Macfarlane, and Aitken (2015) state that "confusion, fear, panic, and frustration" are typical reactions to the stress of being treated in intensive care (p. 226). According to Ely, Inouye, Bernard, Gordon, Francis, May, and Dittus (2001) 80% of patients treated in the ICU experience delirium at some point during their hospitalization. Castillo et al. (2015) explain that anxiety is often experienced in patients who are critically ill and explored this experience with patients who needed mechanical ventilation. Mechanical ventilation is invasive and may cause distress because it restricts a patient from verbal communication (p. 226). Further, Keefler, Duder, and Lechman (2001) report that medical patients may experience problems with dependency, loss, isolation, or regarding the hospital environment. Keefler et al. (2001) found that medical patients commonly dealt with social role problems including their roles as family members, employees or

homemakers, and as students (p. 10). Keefler et al. (2001) discovered that the severity of the social problem seemed to have a stronger influence on the patient's length of stay than did the severity of their actual illness (p. 10).

Karademas et al. (2009) maintain that illness acceptance in patients is correlated with higher abilities to cope (p. 1244). They acknowledge different ways of defining illness acceptance but suggest that it is generally understood as "a cognition that contains a positive meaning of the illness and restores a sense of personal control by integrating illness experience into the patient's lifestyle" (p. 1244). According to Keefler et al. (2001), denial is a common defense mechanism utilized by patients, impacting their ability to come to terms with their situation (p. 13). Karademas et al. (2009) propose that acceptance has to do with a change in the way a patient thinks about their illness. This may include "the enhancement of the sense of control over the illness, the perception of less negative consequences, the moderation of the emotional impact of the disease and so on" (Karademas et al., 2009, p.1248).

***Adults in oncology.*** The literature reflected a significant amount of research on adults in oncology, informing our inclusion of some of this literature here. The National Cancer Institute (2017) published statistics collected from 2010-2014 reflecting that "approximately 38.5 percent of men and women will be diagnosed with cancer of any site at some point during their lifetime." Further, they found that 91 percent of cancer of any site is diagnosed in adults over the age of 44 and is most often diagnosed in people ages 65-74 (National Cancer Institute, 2017). Matzka, Mayer, Kock-Hodi, Moses-Passini, Dubey, Jahn, Schneeweis, and Eicher (2016) describe an array of symptoms that cancer patients may experience as a result of their illness or because of treatment. Some of the symptoms include "fatigue, disturbed sleep, pain, nausea, lack of appetite and neuropathy" (p. 2). Importantly, the severity and number of symptoms experienced coincide

with the length of time a patient survives (Matzka et al., 2016, p. 2). Lamers, Hartmann, Goldschmidt, Brechtel, Hillengass, and Herzog (2013) study of patients who were diagnosed with myeloma reported that 25.2% of patients were experiencing symptoms of depression and 27.2% of patients experienced symptoms of anxiety. Patients diagnosed with lung cancer reported dealing with sadness and worry as well as other aspects of daily living (Sanders, Bantum, Owen, Thornton, & Stanton, 2010, p. 480).

Jones, Regan, Ristevski, and Breen (2011) further explains that patients commonly experience problems associated with several aspects of life including spiritual, emotional, and family problems (p. 213). Validating and legitimizing patient's needs is therefore an important quality of support (Jones et al., 2011, p. 213). Matzka et al. (2016) found that age was an important factor when it came to comparing levels of distress in resilient patients. Older patients were less likely to experience distress than younger patients, though they had comparable levels of resilience, highlighting a possible need for extra support in younger patients (Matzka et al., 2016, p. 10). This support may come in the form of psychosocial services, which are explored in the following section, first for hospitalized children and then for hospitalized adults, which will include those who have a cancer diagnosis.

**Psychosocial services: *Children.*** The psychosocial support of a hospitalized child varies depending on the hospital. After introducing the use of psychosocial services for children, this section will focus on a model that may inform how child patients are screened and assessed for different levels of service and care. Kazak (2006) describes the typical services a child receives at the hospital as "some combination of social workers, psychologists, child life specialists, and psychiatrists" (p. 388). Salmela et al. (2010) further explains that coping can be supported through therapeutic play, music therapy, and Art Therapy in the hospital setting (p. 1223). Coyne

(2006) states that in order to have successful outcomes, it is essential for children to be encouraged to express themselves and that their concerns be responded to (p. 334). Interventions that diminish a child's stress in the moment are likely to help them to manage future experiences (Coyne, 2006, p. 334).

Kazak (2006) outlines the Pediatric Psychosocial Preventative Health Model (PPPHM) as a tool to screen for the unique needs of each family entering a hospital setting for a child. The hospitalization of a child will have an impact on parenting, marital and sibling relationships, as well as the child's own development, which may result in permanent shifts within the family system (Kazak, 2006, p. 383). Several factors may indicate a family's risk for more psychosocial difficulties including "single-parent families, families headed by young (minor) parents, large families, low levels of social support, financial difficulties, parental psychopathology, or behavioral concerns related to other children in the family" (Kazak, 2006, p. 383). Kazak (2006) proposes that the PPPHM will assist health care teams to offer the appropriate amount of support for each family, specifically identifying families at risk to offer higher levels of care (p. 384). The support that each family receives depends on the specific facility, health care team, and family resources in all cases (Kazak, 2006, p. 386).

In the PPPHM, families are categorized into three groups depending on their level of risk: Universal, Targeted, or Clinical/Treatment (Kazak, 2006, p. 385). The Universal category is the largest. Families in the Universal category may be distressed in relation to the child's hospitalization but do not appear to have impairments in functioning otherwise. These families are identified for having a level of resilience and an ability to cope adequately at the least (Kazak, 2006, p. 385). The PPPHM designates a standard level of care for these families, including "general support, education, and access to resources that support and enhance child

and family coping" (Kazak, 2006, p. 388). This level of support might focus on highlighting resources the family has and building on their resilience (Kazak, 2006, p. 389).

The second to largest category in the PPPHM is the Targeted group. These families may experience stressors such as poverty or difficulties with employment, pre-existing child problems, or family problems. These families are identified as having difficulties with coping. The PPPHM would recommend these families for more psychosocial support than families in the Universal category (Kazak, 2006, p. 386). In this level of support, a family may "receive more intensive counseling from a social worker, work individually with a child life specialist around child issues, or be referred to a psychologist for more extensive evaluation and consideration of an evidence-based cognitive– behavioral or family therapy intervention" (Kazak, 2006, p. 389).

The Clinical/Treatment category is the smallest and comprises families that are identified as having the most risk. This risk may be indicated by factors such as elevated and persistent psychological symptoms such as anxiety and depression, substance abuse, or legal problems (Kazak, 2006, p. 386). Families in the Clinical/Treatment category will be referred most often for more traditional mental health services - "intensive consultation, psychotherapy, and/or psychotropic medications" - and Kazak (2006) asserts that collaboration between mental health professionals and medical and nursing staff is necessary for this integration of care (p. 387).

***Adults.*** The literature was lacking in regard to the psychosocial services available to adults in intensive care settings. In their literature review, Stucky et al. (2016) report that no articles were found that surveyed the use of psychologists in ICU or other critical care units, though many articles acknowledged the participation of a psychologist in such medical settings (p. 202). For example, Castillo (2015) reports that music therapy and other psychological interventions have been effective in decreasing anxiety levels in patients in intensive care, but

little is described about the availability of these services. Stucky et al. (2016) researched 175 health-service psychologists "engaged in hospital practice in the United States," of which 84 reported working in a critical-care setting on a monthly, weekly, or daily basis. They were most likely to be in a Level-1 trauma center or a pediatric trauma center (Stucky et al., 2016, p. 204).

The clinicians identified themselves as neuropsychologists, health psychologists, medical psychologists, and rehabilitation psychologists (Stucky et al., 2016, p. 206). Cognitive assessments and capacity evaluations were regularly implemented by all practitioners, and rehabilitation psychologists had more experience with family support and education, behavioral management, evaluating patients for rehabilitation admission (Stucky et al., 2016, p. 206). The psychologists who participated in the study identified an array of conditions that their patients had including brain injury, cardiovascular conditions, acute or chronic pain sufferers, cancer patients, amputees, and burn injuries, to name a few (Stucky et al., 2016, p. 204). Of these conditions, it appears that psychosocial support or supportive care for patients of oncology may be the most researched. The review of this literature follows.

Sanders et al. (2010) asserts that health-care providers may need to assess more specifically for supportive care needs as they are not included on patients' charts. In a study assessing the needs of lung cancer patients, Sanders et al. (2010) found that these needs are commonly unmet (p. 487). In their study, 78% of patients identified that they had unmet psychological needs; most common being uncertainty about the future (Sanders et al., 2010, p. 484). Lamers et al. (2013) supports that psychological and psychosocial needs are "among the most frequently reported" in cancer patients (p. 2313). In their study of patients with myeloma, trends were identified by age. They found that younger patients were more likely to request psychological support such as counseling, therapy, or relaxing techniques. Alternatively, older

patients were more likely to express desired support for their relatives and children (Lamers et al., 2013, p. 2318).

Jones et al. (2011) researched a screening tool for the supportive care needs of cancer patients, intended to develop higher levels of patient satisfaction and wellbeing of the patient physically and emotionally. The aspects of needs included physical symptoms, transportation, housing, employment, spiritual concerns, family issues, and emotional issues (p. 212). The research indicated that the screening tool and discussion of needs prevented feelings of reluctance that patients may feel about initiating communication with clinicians about said needs. It also encouraged the patients to be more involved in their treatment. Overall, the patients reflected that addressing supportive care needs was highly valued and that this discussion gave them confidence that their needs were not being overlooked (Jones et al., 2011, p. 213).

**Medical Art Therapy**

There are many ways in which the arts have already been integrated within medical settings as adjunctive supports for healing. According to Harter, Quinlan, and Ruhl (2013), nearly half of the healthcare institutions in the U.S. report offering arts programming. The more scientific evidence is published, detailing not only the mind-body connection, but also quantitatively studying the specific benefits and potential contributions of the expressive/creative arts therapies in general, the more those within the field of Art Therapy are calling for quantitative research expounding upon the unique contributions the field offers. Despite the wealth of information on both arts as healing and also expressive arts in general, this section focuses on Medical Art Therapy, in particular. This exploration of the Medical Art Therapy literature covers implications for utility in both the short- and long- term and also expounds upon the various forms which Art Therapy takes, within medical contexts.

**Pediatric Art Therapy.** Considering the stress that accompanies "the experience of illness, medical treatment, and hospitalization" and how this can affect a child's development, "pediatric patients' psychosocial needs are paramount in treatment and are the major concern in using art expression as therapy" (Malchiodi, 1999b, pp. 14-15). Malchiodi (1999b) noted specific circumstances in which Medical Art Therapy has proven invaluable to the treatment of children in pediatric settings: through "art-based assessment of the pediatric patient; addressing body image and physical symptoms; enhancing mind-body; encouraging resilience; and complementing the use of medical play with pediatric populations" (p. 17).

Malchiodi (1999b) stated that, "despite art's potential to alleviate trauma, encourage emotional reparation, and enhance mental and physical health in pediatric patients, relatively very little has been written about the specialized application of art therapy to medical populations" (p. 13). Although much has been written about Medical Art Therapy—especially with pediatric patients—in the almost two decades since, the field continues to expand, including through quantitatively measuring its therapeutic contributions (something which has been more prevalent in other disciplines, including music therapy). Existing literature details Art Therapy's particular relevance to medical settings, given its potential for "dual impact"—serving as both a "diagnostic and therapeutic" tool, which simultaneously provides the opportunity for patients' self-expression while also possibly providing pertinent diagnostic information to the treatment team—specifically when facilitated by a "qualified art therapist" (Malchiodi, 1999b, p.10). Malchiodi's distinction, here, is crucial, since there are a wealth of therapeutic art services provided in medical settings, including by professional artists, which are not approached with the same clinical intentionality with which Art Therapists inform their treatment (Bozcuk, Ozcan,

Erdogan, Mutlu, Demir, & Coskun, 2017; Geue, Goetze, Buttstaedt, Kleinert, Richter, & Singer, 2010).

According to Councill (2012), general goals of pediatric Medical Art Therapy are to "uncover strengths, coping mechanisms, and qualities of resilience" (p. 225). Councill (2012) further discussed ways in which art can be a coping strategy, mentioning its potential as a "proactive tool for coping with pain that is not fully relieved by medication" (p. 229). The theme of art as a coping strategy is echoed throughout the literature, as is the potential utility of art therapeutic interventions in symptom reduction (this topic will be covered more extensively in the subsequent section on Medical Art Therapy with adults). Councill (1993), for instance, suggested that Art Therapy may be used to reduce symptoms of depression and anxiety in pediatric patients with cancer diagnoses. Prager (1995) discussed specific ways in which Art Therapy can support patients in adapting to the limitations of the hospital setting—for instance providing opportunity for a sense of control through choice-making related to the art process. Malchiodi (1999b) similarly noted that physical engagement in the art-making process—through actively "making, doing, cutting, arranging, molding, gluing, and constructing" can foster a patient's sense of purpose and control (p. 16). Arnett and Malchiodi (2013) concluded that art provides a way for patients to process their internal experience and convey it without requiring words.

***Supporting the family unit***. A significant component of working with pediatric patients is supporting their family members, as well, considering the significant effects a child's illness has on the overarching family system. Childhood illness has a traumatic effect on both the child and their family, with parents of pediatric patients often displaying high levels of posttraumatic stress symptoms (Carlson & Galan, 2016 ;Councill, 2012; Malchiodi & Goldring, 2013; Martin,

2013). Councill (2012) also discussed the adaptation medical illness necessitates from all family members. Family Art Therapy in a medical setting provides the opportunity to support family members, potentially counter-acting some of the commonly-experienced feelings of "isolation, symptoms of stress, lack of self-care, and lack of understanding from extended family and friends (Martin, 2013, p. 305). Not only that, but Malchiodi (1999b) also highlighted Family Art Therapy's potential to support communication and to inform family members' perceptions of the child's experience, meanwhile fostering family bonding.

Medical Art Therapy with families necessitates systemic and contextual considerations. Martin (2013) specified overarching goals of this practice as the following "(1) evaluating the family; (2) working with a patient's siblings; (3) helping family members express feelings and trauma stories; (4) addressing medical crises; and (5) addressing grief and loss" (p. 307). Martin (2013) encouraged medical art therapists to "lead the way" in pediatric hospitals' progress "in inclusion of families in all aspects of the patient's care" by "involving the families and siblings in self-expression and stress reduction through creative activities," thereby "providing better family-centered care" (p. 314).

***Working with Trauma.*** Art therapeutic interventions have been shown to support children in dealing with trauma—whether related to their medical diagnoses and/or to the experience of hospitalization, itself. This is significant, since each year in the United States, over 2 million children require hospitalization after sustaining traumatic injuries (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2011, p. 100).

Linda Chapman developed the Chapman Art Therapy Treatment Intervention (CATTI) with the goal of reducing PTSD symptoms in pediatric patients who have experienced trauma. Chapman et al. (2001) described the CATTI as a brief, incident-specific, medical trauma

resolution method, which seeks to reduce symptoms through facilitating integration of one's traumatic experience into a larger autobiographical narrative. Incorporating child PTSD literature and neuro-scientific research, the CATTI was developed to utilize the brain's integrative capacity in order to maximize therapeutic potential—activating left and right hemispheres and corresponding neural pathways to create a visual narrative before translating it into a verbal one. According to the authors, not only does the creation of a coherent narrative involve hemispheric integration, but it also draws upon current understanding of how experience is transmitted to language, in the way that it accesses traumatic sensations and memories. Furthermore, as an Art Therapy intervention, the CATTI facilitates the concretization of remembered traumatic imagery. In discussing their outcome-based Art Therapy research project, utilizing the CATTI, and conducted at a large urban hospital trauma center, Chapman et al. (2011) noted that, although "early analysis of the data [did not] indicate statistically significant differences in the reduction of PTSD symptoms…there [was] evidence that the children receiving the art therapy intervention did show a reduction in acute stress symptoms" (p. 100).

This type of research project exemplifies the application of Art Therapy interventions within the framework of a medical model which aims to produce measurable results and prioritizes symptom reduction. This is in line with themes seen throughout recent Medical Art Therapy literature: for one, an increasing trend toward utilizing pre-and post-art intervention assessments to measure for efficacy in terms of specific symptom reduction—which will be further discussed in the following section.

**Working with Adults.** Medical Art Therapy has much to offer to adults receiving medical treatment, just as is true for pediatric patients. In looking at Medical Art Therapy Literature, overall, it appears that common elements are shared among the work, generally

speaking—though of course the specific context will vary based on individuals' needs and circumstances.

In one parallel to pediatric Art Therapy literature, for instance, Borgmann (2002) noted that, in her work with adult women with cancer, "art therapy offers a mode of control through self-expression" (p. 251). Borgmann (2002) further discussed how "art therapy promotes the connection between physical and mental health by offering the patient a means in which to express herself in private through art" (p. 245). She also highlighted the importance of art as "providing a concrete model of what the patient is experiencing that can serve as a permanent reminder of her strength and courage" (Borgmann, p. 245).

As was mentioned in the general literature review, much research exists pertaining specifically to patients with cancer diagnoses; the same is true in the Medical Art Therapy literature. Much of the non-pediatric Medical Art Therapy literature seems to come from work with adult patients with cancer—whether in coping to newfound diagnoses, as support during treatment, or adapting to life—including integrating a newfound sense of self—post-treatment. Although much literature focuses on patients with cancer, it is important to note Medical Art Therapy's utility being far-reaching across a range of diagnoses. Rafferty and Parcell (2016) noted "therapeutic art interventions provide an extraordinary range of clinical possibilities that assist patients and their family caregivers who are affected by a diverse range of health issues (e.g. post-traumatic stress disorder, autism, mental illness, pediatric oncology, neurological disorders)" (p. 5-6).

Another important note that may have implications for future directions of Medical Art Therapy literature is the current lack of research on long-term efficacy, in terms of measurable factors. Luz (2016) discussed the study conducted by Oster, et al., where "the researchers identified the

lack of long-term follow up studies on art therapy treatment modalities and conducted a 5-7 year (depending on the participant's initial study start year) follow-up study with breast cancer patients in an attempt to provide much-needed long-term research, publishing this study in 2014" (p. 23). Luz (2016) noted that "though this study did not support the long-term efficacy of art therapy interventions, it is noteworthy" since "the researchers report that this study was the 'only study of art therapy given parallel to cancer treatment which includes a long-term follow-up'(Öster et al., 2014, p. 38) that they could locate" (p. 24). Perhaps these types of studies might warrant more consideration, especially considering Luz's (2016) mention of the researchers' hypothesis that longer Art Therapy treatment periods may have resulted in longer-term effects, given the "positive results found six months after the original art therapy intervention" (p. 24).

Despite current lack of research detailing long-term efficacy, there is a growing amount of literature utilizing specific assessment methods in order to demonstrate efficacy of art therapeutic interventions in current practice. Pre-and post-test methodology, such as the Edmonton Symptom Assessment Scale (ESAS) and the Spielberger State- Trait Anxiety Index (STAI-S) have been used to measure effects of art therapeutic interventions before and after sessions (Nainis, Paice, Ratner, Wirth, Lai, & Shott, 2006). In addition, assessment methods have been employed to specifically measure interventions' effects on mood and symptoms. This is significant, considering that Art Therapy may be uniquely situated to address specific affective states, such as helplessness and hopelessness, which have been found to accompany certain medical diagnoses, such as cancer, by "introducing coping skills that enhance and increase perception of control" (Borgmann, 2002, p. 251). Published results of pre- and post-session assessments appear significant and certainly warrant continued studies. For example, Glinzak (2016), in her proxy pre-test study, working with adults with cancer, "identified

decreased distress in patients…after art therapy in four hospital settings, supporting the premise that art therapy can alleviate distress, which may enrich the mental, emotional, and physical healing process" (p. 32). Also, published very recently, analysis of pre-and post- results from Shella's (2018) study of working with hospitalized adults "demonstrated significant improvements in pain, mood, and anxiety levels of art therapy sessions for all patients regardless of gender, age, or diagnosis" (p. 59).

For some time, the potential for psychological support provided by Art Therapists who "[focus] on encouraging clients to find new ways to express themselves physically, psychologically, and spiritually" has been noted (as cited in Borgmann, 2002, p. 251). With continued research and publications detailing efficacy of interventions, awareness of Medical Art Therapy's contributions to psychological support and holistic care for adults receiving medical treatment will undoubtedly grow.

**Overarching Themes**. In looking at the existing Medical Art Therapy literature, there seem to be certain overarching themes repeated across work with pediatric and adult patients with a range of medical diagnoses. For instance, Art Therapy can support emotional expression, meaning-making, foster a sense of control and empowerment, provide creative outlet, offer potential symptom relief, facilitate post-traumatic growth, foster coping skills, and also offer integration—both of traumatic experiences and also of one's medical condition into their sense of self. Art Therapy offers the unique opportunity to work with existential concerns that may arise in medical settings, while also enabling support of the patient as a whole person, at once engaging mind, body, and spirit.

## Conclusion

Art as healing is certainly not a new concept, as it has been historically employed by various cultures the world over, including in ritual and ceremony. According to Malchiodi (1999a), "it has been noted that imagery has consistently played an important role in the treatment of illness for thousands of years (p. 13). The field of Medical Art Therapy, however, is newly burgeoning, situated at "the unique confluence of real world scientific, psychological, social and economic factors that have set the stage for wide acceptance of the full integration of the arts with [Western] medicine" (Malchiodi, 1999a, p. 10). As Malchiodi (1999a) notes, "it is only in recent years that art therapy, a modality based on the belief that the process of art making is healing and life enhancing has come to be recognized for its unique contributions in the treatment of physical illness" (p 13).

Throughout this Literature Review, both general literature on hospitalization/psychosocial services and also Medical Art Therapy literature were discussed. Considerations specific to both pediatric and adult populations, plus their families, were detailed. Discussion of pre-existing literature sets the foundation for the researchers to discuss their approach and methodology for gathering data on practitioners' experiences and current practices in the Medical Art Therapy field.

## Research Approach

This project follows a qualitative research approach focusing on emergent (ground-up) knowledge coming from participants' meanings and experiences providing Art Therapy services in medical settings. Creswell (2013) discussed how, in qualitative research design, the researchers keep "a focus on learning the meaning that the participants hold" about the research topic, "not the meaning that the researchers bring to the research or that the writers express in the literature" (p. 186). Not only that, but "the research process for qualitative researchers is emergent" (Creswell, 2013, p. 186). This makes sense for our project, considering we will be exploring our participants' views on and experiences within Medical Art Therapy.

Given the emphasis our research places on participants' points of view, a grounded theory approach was utilized. According to Denscombe (2010), the grounded theory approach is "appropriate for social research that focuses on human interaction, particularly where the researcher wishes to investigate…the participants' points of view" (pp. 109-110). Denscombe (2010) further discussed data collection methods that—though not unique to grounded theory—may lend themselves better than others to use within this approach. These are "methods that allow the collection of data in a 'raw' state—not unduly shaped by prior concepts or theories" (p. 110-111). Our research methodology similarly utilized a semi-structured interview format in the focus group and through using open-ended questions in the post-focus group survey.

As qualitative research informed by grounded theory, our project will also include a mixed methods approach, in that the data will include artwork made by focus group participants. Denscombe (2010) discussed "the term 'mixed methods' [as applying] to research that combines alternative approaches within a single research project" (p. 137). Aside from textual data gained from verbal discussions and written survey responses, participants' art will offer us another lens

through which to further understand their unique insights and experiences. Sullivan (2005) discussed the place of art in research methodologies, noting the "unique insight into human knowing and understanding" that can be gained (as cited in Kapitan, p. 35, 2010).

# Methods

## Definition of Terms

**ICU.** According to California Pacific Medical Center, 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, p. 2). Patients who are admitted to the ICU require a higher level of monitoring for a variety of reasons ("What is the ICU," 2014, p. 2). The ICU has a variety of staff including, "doctors, nurses, respiratory therapists, clinical nurse specialists, pharmacists, physical therapists, nurse practitioners, physician assistants, dietitians, social workers, and chaplains" ("What is the ICU," 2014, p. 2).

**Supportive Care and Psychosocial Services.** Jones (2011) states that supportive care needs include "physical, family, emotional, practical and spiritual needs" (p. 209). According to Sanders (2010) supportive care for lung cancer patients includes "tasks of daily living, psychological needs such as dealing with sadness and worry, access to professional counseling and additional health information, and social support from friends, family, and medical staff" (p. 480). According to Kazak (2006), psychosocial services in pediatric care might include a combination of services from "social workers, psychologists, child life specialists, and psychiatrists" (p. 388).

**Medical Art Therapy.** Malchiodi (1993) defines Medical Art Therapy as "the use of art expression and imagery with individuals who are physically ill, experiencing trauma to the body, or who are undergoing aggressive medical treatment such as surgery or chemotherapy" (p.13).

**Level 1 Trauma Center.** According to the American Trauma Society, the categories for trauma centers vary by state ("Trauma Center Levels Explained"). Level 1 offers the highest level of care and the common criteria is that it "is capable of providing total care for every aspect of injury – from prevention through rehabilitation" ("Trauma Center Levels Explained)".

## Design of Study

This research, intended as a step in creating a larger research plan with two different hospitals in the Los Angeles basin, will utilize a focus group methodology to explore current clinical interventions of therapists who use art therapy in medical settings or who have focused on responding to medical issues. Following the focus group, a brief survey will also be sent to participants, with the intention of learning about current medical art therapy practices and possibilities of developing relevant research.

**Sampling.** Researchers emailed alumni of the Loyola Marymount University (LMU) Marriage and Family Therapy with specialization in Art Therapy program and Art Therapists who currently or previously have worked at Children's Hospital Los Angeles (CHLA), where researcher Hope Kinney currently works. The names and emails of these Art Therapists were obtained by the Senior Administrative Coordinator of the LMU Art Therapy program and researcher Hope Kinney's Manager of the Expressive Arts and Therapies team at CHLA. The email (see Appendix C) invited Art Therapists who had relevant experience to participate in a focus group and/or survey. Three dates and times were offered to hold focus groups. Five respondents stated availability and willingness to participate in a focus group; because of their availability, one focus group was held with four subjects. All of the focus group participants were adults and identified as females. Their background varied in terms of the setting in which they worked and the length of time they had been working in the field. Including the four focus

group subjects, fifteen subjects were emailed surveys after the focus group was held. The demographic of subjects who participated in the survey included licensed professional clinicians, pre-licensed interns, registered Art Therapists, and some subjects indicated that they had other relevant trainings.

**Gathering Data.** Subjects were invited via email to participate in a focus group and/or survey and informed that the data would be used for a Masters level research project on Medical Art Therapy (see Appendix C). All subjects in the focus group gave informed consent (see Appendix B). The focus group was three hours in length and included a semi-structured format with two questions that requested art responses; these questions can be found in Table 1. Researchers Elizabeth Mueller and Hope Kinney conducted the focus group together.

Table 1. Semi-structured questions for focus group.

| |
|---|
| 1. Please introduce yourself in the way you want to be identified for this study. |
| 2. What are some of your professional experiences working with clients as an Art Therapist in a medical setting? |
| 3. Can you describe how you typically explore medical issues and related issues in your therapy practice? |
| 4. Please illustrate the process of utilizing art interventions through an art response. You might illustrate typical directives, common processes you have witnessed, creative responses of clients you have worked with or anything else that might help illuminate how you work. |
| 5. Please respond to the following in a second art response: What is your perception of systemic and developmental considerations for utilizing creative and verbal modalities in therapy? How is the use of Art Therapy similar or different, compatible or competing to other modalities offered in medical settings? |
| 6. What are some challenges or apprehensions you have about exploring medical issues with clients? |
| 7. What are some challenges or apprehensions you have about using creative/expressive tools with clients in hospitals? |

After the focus group took place, researchers sent an email that included a link to an online survey through Qualtrics. The survey began with informed consent (see Appendix B) and then included up to 13 questions, depending on subject's responses. These questions are included in Table 2 below. Questions on the left column are stand-alone questions while questions in the right column are follow-up questions pertaining to the question directly to its left. Follow-up questions were asked using survey logic depending on a participant's response to the question directly to its left. The table indicates when a follow-up question was not asked by a gray box. Questions 2, 3, and 9 were multiple choice. Answers to multiple choice questions are indicated by and indentation and the ">" symbol. Questions 2.A., 4, 5, 7, 8, 9, and 10 were essay response questions and included a text box for participants to type answers in. Question 6 requested response art and included a "File Upload" tool for participants to upload an image of artwork.

Table 2: Survey Questions.

| | |
|---|---|
| 1. Please read the following document (Informed Consent) and indicate whether or not you consent to participate in this survey.<br>> Yes, I have read the Informed Consent Document and I consent to my participation in this survey.<br>> No, I have read the Informed Consent Document and I do not consent to my participation in this survey. | |
| 2. Did you participate in the focus group for this research project on November 5, 2017?<br>> Yes<br>> No | If answer to question 2 was "Yes":<br>2. A. What are some of your responses – thoughts, feelings, questions, hopes, concerns – stimulated by the focus group? |
| 3. To what degree do you feel that expressive tools can help clients explore medical issues?<br>> Expressive tools are not at all a useful way to explore medical issues | 4. If you feel that expressive therapies are of no use / little use:<br>What are some concerns or apprehensions? |

| | |
|---|---|
| > Expressive tools are of little use of a way to explore medical issues<br>> Expressive tools are somewhat useful way to explore medical issues<br>> Expressive tools are very useful way to explore medical issues<br>> Expressive tools are the most effective way I know to explore medical issues | 4. If you feel expressive therapies are somewhat useful, very useful, or the most useful:<br>What are some ways you have integrated creative / expressive tools in your work successfully? |
| 5. When and how have these expressive tools been most beneficial for clients and what were some limiting factors? | |
| 6. Would you be willing to share a brief non-identifying case illustration depicting the work and grant us permission to include it in publications associated with this research? If so, please create a piece of art that is inspired by one of your clients and attach it below. | 7. If you created artwork for the previous question, please reflect below about the process and product. |
| 8. What are your thoughts / suggestions / desires regarding future research and interventions related to Medical Art Therapy? | |
| 9. Demographic information – professional information (check all that apply):<br>> Licensed professional clinician (LMFT, LMHC, PsyD, LPCC, MSW, etc)<br>> Pre-licensed / intern (if so, please indicate in which specialty)<br>> Certified expressive therapist<br>> Registered Art Therapist<br>> Other relevant trainings | Depending on the response to question 9:<br>9.A. If you selected that you are pre-licensed / intern please indicate which specialty / license you are practicing.<br><br>9.A. If you selected that you have other relevant trainings, please indicate what they are below. |
| 10. Please write any additional comments here: | |

**Analysis of Data**. Researchers collected from three sources of data: a focus group which was audio recorded, response art created within the focus group, and online surveys completed by both participants from the focus group and participants who were not present for the focus group. Each of the researchers transcribed half of the audio recording of the focus group. Researchers began analysis of the data by reviewing the online surveys. Categories and subcategories were identified in the survey data and these categories were used to organize the focus group transcription. Researchers were aware of any other categories that might pertain specifically to the focus group transcription and agreed that a fifth category emerged from this set of data. Finally, the researchers met with their research mentors to review the response art that had been created during the focus group.

# Results

## Presentation of Data

Three sets of data were collected and reviewed for this research. Questions and results from survey responses that were collected through Qualtrics are presented first. Although the survey data was collected last, researchers consulted with their mentors and agreed that looking at the surveys first allowed for a more concrete foundation in which to find emergent categories to guide later analysis of the focus group and response art. Following the survey data, the focus group findings are presented and finally, images of the response art are displayed.

**Surveys.** 22 surveys were partially or fully completed and returned to researchers. Upon reviewing the surveys returned, 10 surveys were excluded from the data analysis. One survey was completed but informed consent was not given, four surveys appeared to be "test" surveys that were likely completed by researchers and Qualtrics support graduate assistant when researchers experienced difficulty retrieving data, and the remaining surveys excluded were returned blank. As a result, 12 surveys were analyzed in this research. Table 3 includes each survey question and a narrative of the corresponding responses.

Table 3: Survey questions and responses.

| |
|---|
| 2. Did you participate in the focus group for this research project on November 5, 2017?<br>> Yes<br>> No |
| *3 participants (25%) responded "Yes" to this question. 9 participants (75%) responded "No."* |
| If answer to question 2 was "Yes":<br>2. A. What are some of your responses – thoughts, feelings, questions, hopes, concerns – stimulated by the focus group? |
| *Of the 3 participants who answered "Yes" to question 2, 1 participant (33%) did not answer* |

| |
|---|
| *this question, while the other 2 (66%) did. One participant reflected on the challenges that Medical Art Therapy seems to have and stated, "there appears to be a near but very little opportunity to actually work within the field as an art therapist as a career." The other participant began by stating "It's encouraging to see and meet enthusiastic peers supporting art therapy in the medical field" and identified a number of questions and thoughts that she identified were "stimulated by this group." She asked questions about how Art Therapy can become more mainstream in medical settings, how Medical Art Therapy might be integrated into the program at Loyola Marymount University, how Art Therapy relates to psychotherapy and when art expression becomes therapeutic.* |
| 3. To what degree do you feel that expressive tools can help clients explore medical issues?<br>> Expressive tools are not at all a useful way to explore medical issues<br>> Expressive tools are of little use of a way to explore medical issues<br>> Expressive tools are somewhat useful way to explore medical issues<br>> Expressive tools are very useful way to explore medical issues<br>> Expressive tools are the most effective way I know to explore medical issues |
| *9 participants (75%) selected "Expressive tools are very useful way to explore medical issues," and 3 participants (25%) selected "Expressive tools are the most effective way I know to explore medical issues." None of the participants selected "Expressive tools are not at all a useful way to explore medical issues," "Expressive tools are of little use of a way to explore medical issues," or "Expressive tools are somewhat useful way to explore medical issues."* |
| 4. If you feel that expressive therapies are of no use / little use:<br>What are some concerns or apprehensions?<br><br>4. If you feel expressive therapies are somewhat useful, very useful, or the most useful:<br>What are some ways you have integrated creative / expressive tools in your work successfully? |
| *The survey was created to use logic to display question 4 depending on a participant's response to question 3. Because no participants selected that expressive tools were "not at all" or "of little use" in exploring medical issues, the corresponding question was not displayed.*<br><br>*All participants were asked the questions "What are some ways you have integrated creative/expressive tools in your work successfully" which corresponded to the answers that using expressive tools is "somewhat," "very," or "the most" useful way to explore medical issues.* |
| 5. When and how have these expressive tools been most beneficial for clients and what were some limiting factors? |

| |
|---|
| *Eleven out of twelve survey respondents answered this question. Of those, eight discussed both benefits and limitations, while the remaining three only discussed benefits. Discussion of limiting factors included not only physical considerations related to patients' treatment (e.g. limited mobility or physical disability), but also systemic factors (e.g. specifications on media use or isolation in the hospital). Expression was highlighted by multiple respondents as a benefit of Art Therapy.* |
| 6. Would you be willing to share a brief non-identifying case illustration depicting the work and grant us permission to include it in publications associated with this research? If so, please create a piece of art that is inspired by one of your clients and attach it below. |
| *Data reflected that no images were attached in response to this question. Although test surveys were conducted to ensure that this function of the survey would work, there may have been a technical difficulty. In the comment section, one participant stated she would "have to get back to [us] on the art," however researchers did not receive any artwork following collection of survey data.* |
| 7. If you created artwork for the previous question, please reflect below about the process and product. |
| *One participant responded to this question; however, there was no image found to correspond with this response so researchers chose to exclude this from the data.* |
| 8. What are your thoughts / suggestions / desires regarding future research and interventions related to Medical Art Therapy? |
| *Of twelve participants, eight offered responses to this question. Six of these respondents addressed their belief in the importance of future research to the field of Art Therapy in general and also potential implications for more integrated, holistic patient care. Multiple participants expressed a desire for greater availability of Medical Art Therapy services, with two people promoting the importance of Art Therapy in all hospital settings or medical facilities.* |
| 9. Demographic information – professional information (check all that apply):<br>> Licensed professional clinician (LMFT, LMHC, PsyD, LPCC, MSW, etc.)<br>> Pre-licensed / intern (if so, please indicate in which specialty)<br>> Certified expressive therapist<br>> Registered Art Therapist<br>> Other relevant trainings |
| *Participants were able to select more than one option to identify their demographic information. The data reflects that 1 participant (8.3%) chose not to identify any demographic* |

| |
|---|
| *information, 5 participants (41.7%) selected one option to identify themselves, and 6 (50.0%) selected more than one option. With this in mind, percentage and response count for demographics identified do not add up to 100.0% and 12 respectively. 7 participants (58.3%) identified as licensed professional clinicians, 4 (33.3%) identified as pre-licensed / interns, 0 (0.0%) identified as certified expressive therapists, 4 (33.3%) identified as registered Art Therapists, and 3 (25.0%) identified as having other relevant trainings.* |
| Depending on the response to question 9:<br>9.A. If you selected that you are pre-licensed / intern please indicate which specialty / license you are practicing.<br><br>9.A. If you selected that you have other relevant trainings, please indicate what they are below. |
| *3 of the 4 pre-licensed / interns identified that they were practicing for licensure in marriage and family therapy; 1 added that they were also "working towards becoming a registered art therapist." 1 of the pre-licensed / interns did not identify what license they were practicing for. All 3 participants that indicated "Other relevant trainings" included an answer for question 9.A. Their responses are as follows: "addictions, trauma-focused CBT," "Specialization in Clinical Art Therapy from LMU," and "EMDR, DBT."* |
| 10. Please write any additional comments here: |
| *Out of 12 survey respondents, half added comments in this section. Two responses consisted of encouraging messages for the researchers. Two responses cited HIPPA regulations and hospital workplace policy for omitting case examples from responses to previous survey questions. Multiple participants used this section to add a final comment on the field of Medical Art Therapy; one person shared, "I believe strongly that art has an important place in the medical field" (participant C).* |

**Focus Group.** The Medical Art Therapy focus group followed a semi-structured interview format (questions listed in Methods section) and was led by both researchers. Four LMU MFT/Art Therapy alumnae participated in the group, which lasted for approximately two-and-a-half hours. Data from the focus group consisted of: audio recording/typed transcription and art made as response to two of the questions. This section discusses transcription data, with any pertinent information related to group dynamics and process also highlighted; art is included in subsequent section. Each participant has been identified by a letter; A, B, C, or D.

***Interpersonal dynamics and common themes.*** Before researchers asked their questions, participants began conversing with one another, already beginning to share about past experience with LMU, the Medical Art Therapy field, and also delving into personal medical histories. Participants were quick to point out the burgeoning nature of the field and the significance of Art Therapists' contributions currently, whereas in years past "you had to be a social worker to work in the hospital" (Participant D). Participants introduced themselves to the whole group, after which they began sharing professional experiences working with Medical Art Therapy. In responding to this question, two participants also shared details about their own medical histories—specifically how their personal experiences informed their professional interest in the field. It is notable that these two participants are cancer survivors and that cancer was the illness most commonly discussed in the focus group. It was mentioned 46 times; 22 times in relation to personal experience and the journey of friends who had been diagnosed with cancer, 13 times about cancer patients in general, 10 times about the participants' work with their patients, and once about a Medical Art Therapist who focused primarily on cancer.

***Sharing professional experience.*** Group members discussed the range of medical settings in which they previously worked and where they currently practice. Two participants

related personal experience having both worked at Children's Hospital, Los Angeles. One group member questioned the distinction between types of medical settings, seeking clarification on whether or not the group's focus was solely on physical medical settings (as opposed to psychiatric hospitals, which had been brought up previously). Discussion of professional experiences included not only a range of settings (including recent expansions, such as into home health) but also approaches. Participant A noted that she finds herself "doing art as therapy, not Art Therapy." Participant C spoke to a range in approaches to the work, as individualized to each patient: "some kids can do Art Therapy and go through the process of Narrative and all the different types of theories. And other kids are—it's art as therapy…everything is basically what the family needs in that moment and it's very experiential and humanistic." Participant D noted, "there's so many ways to do art…you don't have to exactly draw, but then that is the big debate: 'is that, you know, psychotherapy? Is that art as therapy?'"

Across different questions, multiple participants consistently brought up their experience of the process-oriented nature of Medical Art Therapy.

***Collaboration and community in the field.*** The importance of collaboration was discussed—not only across disciplines (as with different expressive arts therapists in hospital settings)—but also within the field of Art Therapy, itself. The importance of community within the Medical Art Therapy field was also noted, given its "drastic" (Participant C) and "intense" nature (Participant B) and the unique considerations to which other Art Therapists might not be able to relate (such as the trauma of a patient's death). Participant C noted how "comforting" it was to "[talk] to people that have been there" and that "it offers a good community because you have to be so on check with your own mental health."

***Existential themes.*** One participant pointed out the importance within the field in general of "developing our own self-care" (Participant A). This same participant mentioned that, through her Medical Art Therapy work, she "[feels her] own mortality, [her] friends' mortality, [her] mother's mortality," and also acknowledged that "besides working in hospice, besides working in this type of medical community, there's just life." This participant, along with another—identifying themselves as "older" and "more peers" in comparison to the other two younger participants—discussed their "grief and loss" in relation to not only patients who have died but also personal friends. In response to this discussion, Participant A commented, "we're dealing with…an expansion, it really is very broad when you say "medical," it's like, "where is 'medical'?...It doesn't end here and start here. It kind of all mixes together." While two participants had discussed personal experiences being older adults, themselves, another participant segued into professional experience working with older adults.

***Meeting patients where they are.*** Multiple participants noted the non-traditional nature of Medical Art Therapy, and that there is no "regular scenario" (Participant C). Two participants related with each other on the basis of having an "intuitive" approach—something that they attributed not only to having years of professional experience but also to their "nature" (Participant A). Group members highlighted different ways Art Therapy was supportive to both patients and their families: from addressing family dynamics to working with behavior and developmental stages or fostering coping skills. The majority of participants expressed a resonance with a statement made, identifying a "trusting therapeutic relationship" as "the most important thing"—regardless of the type of therapy (Participant A). Statements that were continually expressed included the importance of meeting patients and families where they are

and that through the art "what doesn't get expressed gets expressed…It will come out; all of it will come out" (Participant B).

***Classification of Medical Art Therapy services.*** Within the Medical Art Therapy umbrella, the range of patients worked with—from toddlers to older adults, all with a variety of medical diagnoses—was discussed. All group members expressed agreement on Medical Art Therapy being considered an "adjunctive therapy" (Participant D), with one participant noting "as a primary therapist, it is a huge shift to know that you may be a part of the medical treatment team but you are totally secondary" (Participant B).

Two participants, having both worked at the same hospital, discussed the variance in how Art Therapy was viewed and received, based on both the individual staff member and/or the culture of the unit in which they were working. Growing awareness of the nature of Art Therapy services within the medical field was also acknowledged. Group members compared different ways in which they felt relatable to their patients—whether due to amount of life experience or having had specific experience from personal medical histories.

***Art's humanizing contribution.*** One participant, having shared her experience with meaningful care during her own medical journey, connected this with the potential of Medical Art Therapists to "be the human junction for people, of humility [and] expression" when they are in "the most vulnerable part of [their] life" (Participant A). Adding on to the discussion of Art Therapy's contribution within patients' treatment, one group member noted, "the art…doesn't always have to be directed at this medical issue" (Participant D)—to which another participant agreed: "it's just a human element" (Participant A).

***Discussion of art media.*** When the group switched its focus to art-making (as a response to one of the questions), conversation was sparked related to use of art media, as informed by

some participants' use of a collage box supplied for them. Three group members compared personal approaches to how they would prepare their collage materials—"whether you tear your papers out, or whether you cut them out" (Participant D)—a discussion which they noted having begun while still in school at LMU. Clinical implications were also discussed, including patients' responses to how the paper was presented serving as "information" (Participant B). Two participants disagreed with each other on the notion of intentionally tailoring collage imagery based on the individual(s) with which they are working. One person said "let's be honest…as Art Therapists, when we know our audience we tailor it" (Participant B); while another person responded "I actually don't…I don't necessarily try to form what I want to expose to them"—noting that she "kind of just [puts] it all out there because [she doesn't] want to manipulate the outcome" (Participant A).

***Applications of Medical Art Therapy.*** During the art-making process, conversation also shifted to the importance of the burgeoning field of Medical Art Therapy. A group member stated, "it's important from zero to ninety-nine, and to extended populations, it's important. Medical considerations are extremely important to our mental health" (Participant B). Potential overlap between physical and psychological illness was also touched upon.

***Sharing art responses.*** Participants began to discuss their art responses to the question about "the process of utilizing art interventions." One participant named that her art highlighted the "most important thing that [she] learned" –"to be 100% present… it didn't matter how much training I had… it was really about being present… meeting them where they were, and... being authentic, too" (Participant B). Two participants reflected on specific art interventions that they used with their clients and described their process in creating the art response. As the participants shared their work, discussion occurred organically as participants related to each other. While

Participant D shared, the metaphor of a pearl emerged and she commented "it's growth out of roughness and the hardness." Participant A described her art response as similar to the way that she works as an artist and reflected the idea of the journey - "it could be spiritual, it could be emotional, it could be physical" - which sparked a discussion between a couple of the other participants about their own medical journeys or those of people in their lives. Reflecting on her personal journey, Participant B stated, "what I learned was that Art Therapy and specifically Medical Art Therapy affects the entire family forever."

***Relaying personal and professional insights.*** Participants were given the second art response question and it is notable that the participants asked for the question to be repeated a number of times. One participant related this to her own practice as a therapist and said, "you can interpret it any way that you want because you're hearing what is most important to you," and researchers affirmed this statement. As participants looked through art materials available, participants became excited about a bag of miniature thermometers. One participant shared a story about one of her group therapy members stealing art supplies from group. As the researchers informed the participants of how much time there was left to create art, one participant related it to how she communicates with her therapy groups (Participant D). She and another participant agreed that they both thought group therapy "is the best" (Participants C, D). As the participants finished their art responses, a participant asked about researchers current practicum placements.

***More shared art responses: unique contributions of Medical Art Therapy.*** One participant began sharing her artwork and explained that she focused on "something special" that Art Therapists bring to the diagnostic team - being attentive to "all these things that are impacting [a client's] life" rather than focusing primarily on what is or is not clinically

diagnosed. She stated, “feelings and symptoms over diagnosis and diagnostics” (Participant B). Another participant explained what she had noticed about the busy schedule of rehab patients, commenting: “they’re just overwhelmed with all of these different therapies and I think all the other therapies compete for the time and attention and progress of the kid because they have issues like insurance and they have to deal with all these bigger problems but that aren’t the kid’s problems” (Participant C). Another participant echoed this observance and stated: “when you’re chronically, medically ill, the most important thing is that you have control of something and so even being able to say, ‘no,’ to an Art Therapist is a very powerful thing and holding space for that is a very powerful thing” (Participant B). These two participants shared stories about their work at the same hospital; one shared a personal story about giving her client permission to say that she did not want to do therapy and the other shared a sentiment that another therapist had told her - “what you did with them was enough” (Participant B).

Another participant shared her response art stating that it was about the organic nature that therapy fosters as opposed to the “rigid modalities of medicine” (Participant A). The fourth participant shared her art response and named that she was reflecting on the way that certain events or situations can affect a person’s development and maturation and that she was thinking about DNA and “all those things that go along with our being” and “processing how it all fits” (Participant D).

***Diagnoses and identity.*** The conversation shifted to talking about how medical diagnoses might become part of a person’s identity. The importance of person-first language was discussed, which seemed to spark a conversation about pronouns and language related to the LGBTQ community.

***Unique considerations for medical settings.*** Researchers acknowledged the relevance of this conversation and shifted the focus back to the last couple of questions for the focus group. The sixth question naturally brought about discussion of challenges and apprehensions in exploring medical issues with clients. Terminality and death seemed to be a shared challenge that was named. Another challenge was knowing medical information from charts that clients might not know. One participant noted that she did not have charts to look at, so she does not know the diagnoses of her clients. She told a personal story about a client of hers who was terminally ill and expressed thoughts of suicide and the participants' struggle with hearing that. She expressed that she felt strongly about having an interest in her clients and that she does not care about being an adjunct therapist or a main therapist (Participant D). Another participant commented about the differences between working with the aging population as opposed to a pediatric hospital and named that the family was always involved in the treatment plan when it came to her work at the pediatric hospital (Participant B).

The final question asked about challenges and apprehensions for using expressive tools with clients in a hospital. One participant explained the importance of "the textile and the sensory aspect of materials and what that triggers," for example, if "the kid is throwing up or going through a lot of sensory issues then probably not having too much fluid things that resemble that" (Participant C). Safety issues were named as a shared concern, specifically the way that shared materials might spread illness. One participant noted that she thinks this is one reason why Medical Art Therapy is difficult to fund and described the difficulty of being limited to choose one material to give to a patient who is in high isolation (Participant C).

A participant added that she likes Medical Art Therapy because medical issues affect everyone, "black, white, native, not, you know, female, male, whatever - it affects everyone"

(Participant B). As the focus group came to an end, participants communicated appreciation and encouragement to researchers for focusing on this research.

**Response Art.**

Figure 1: Participant A, question 4.

Figure 2: Participant A, question 5.

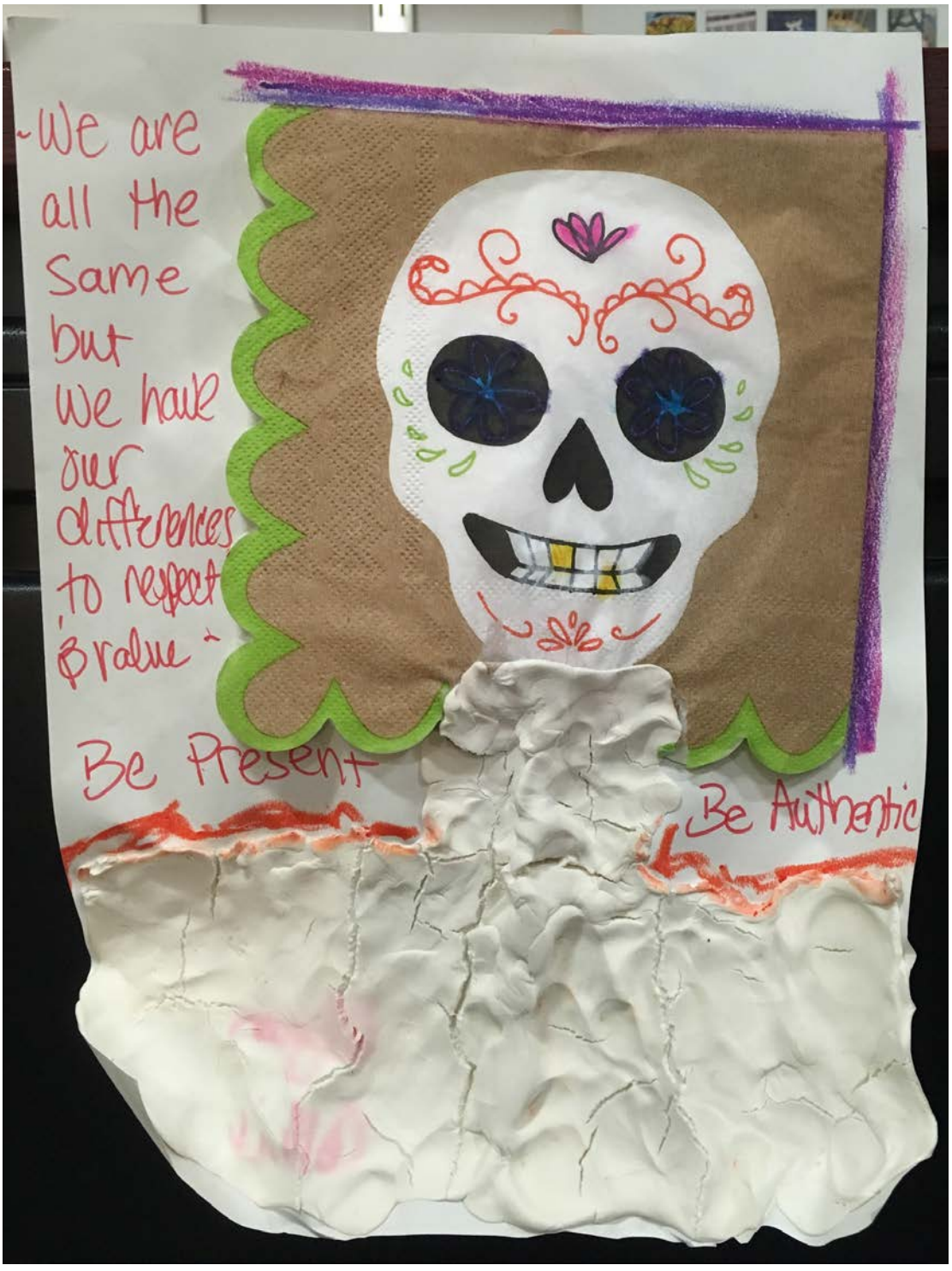



Figure 3: Participant B, question 4.

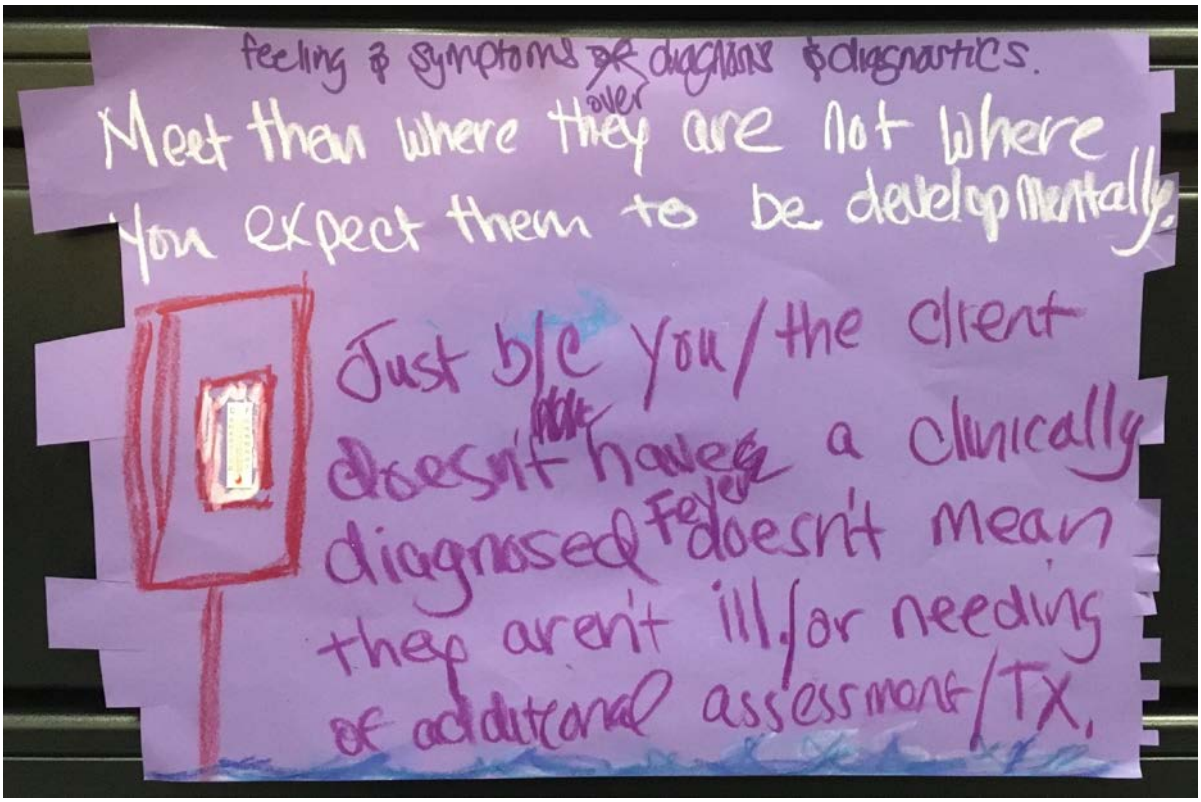



Figure 4: Participant B, question 5.

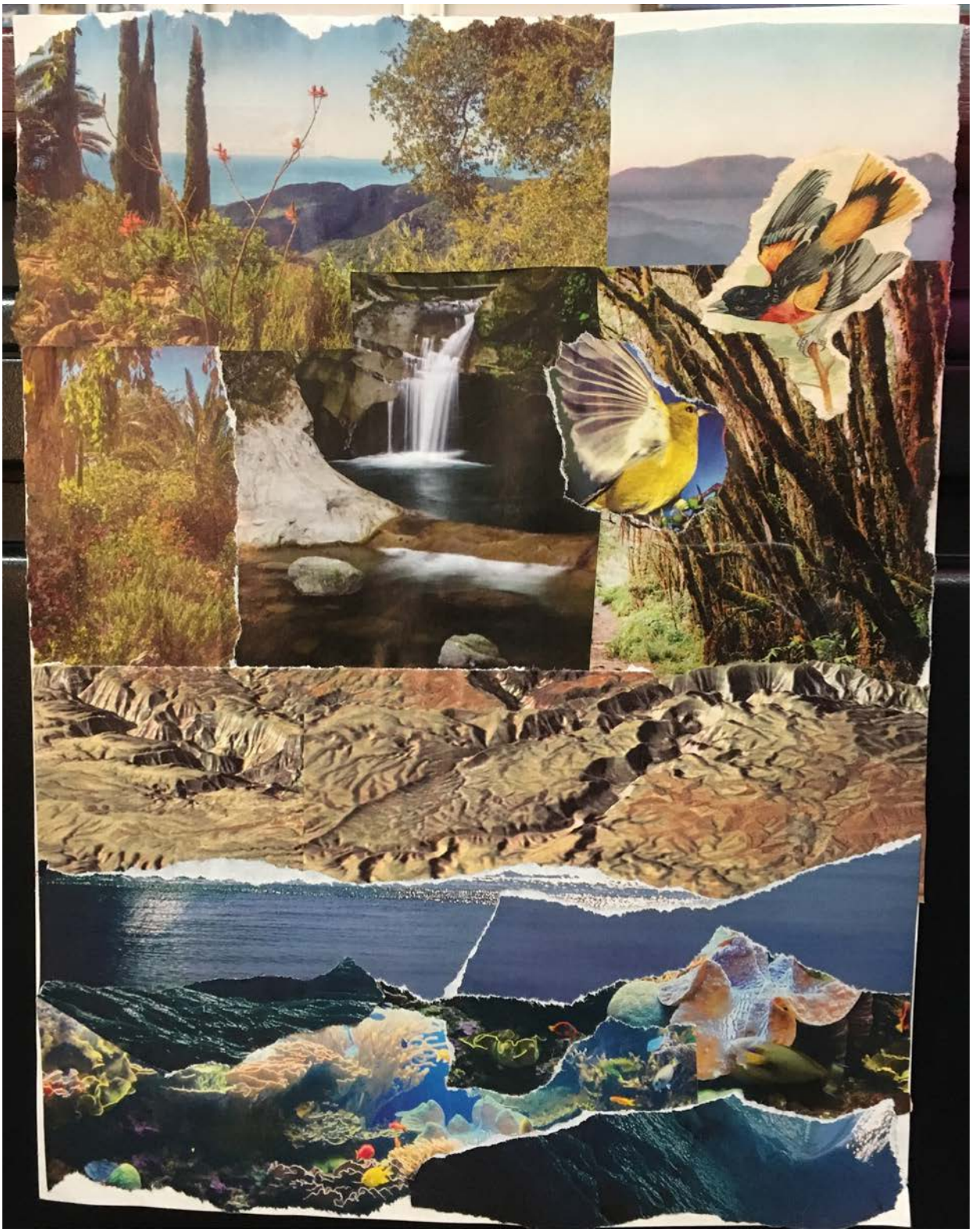


Figure 5: Participant C, question 4.

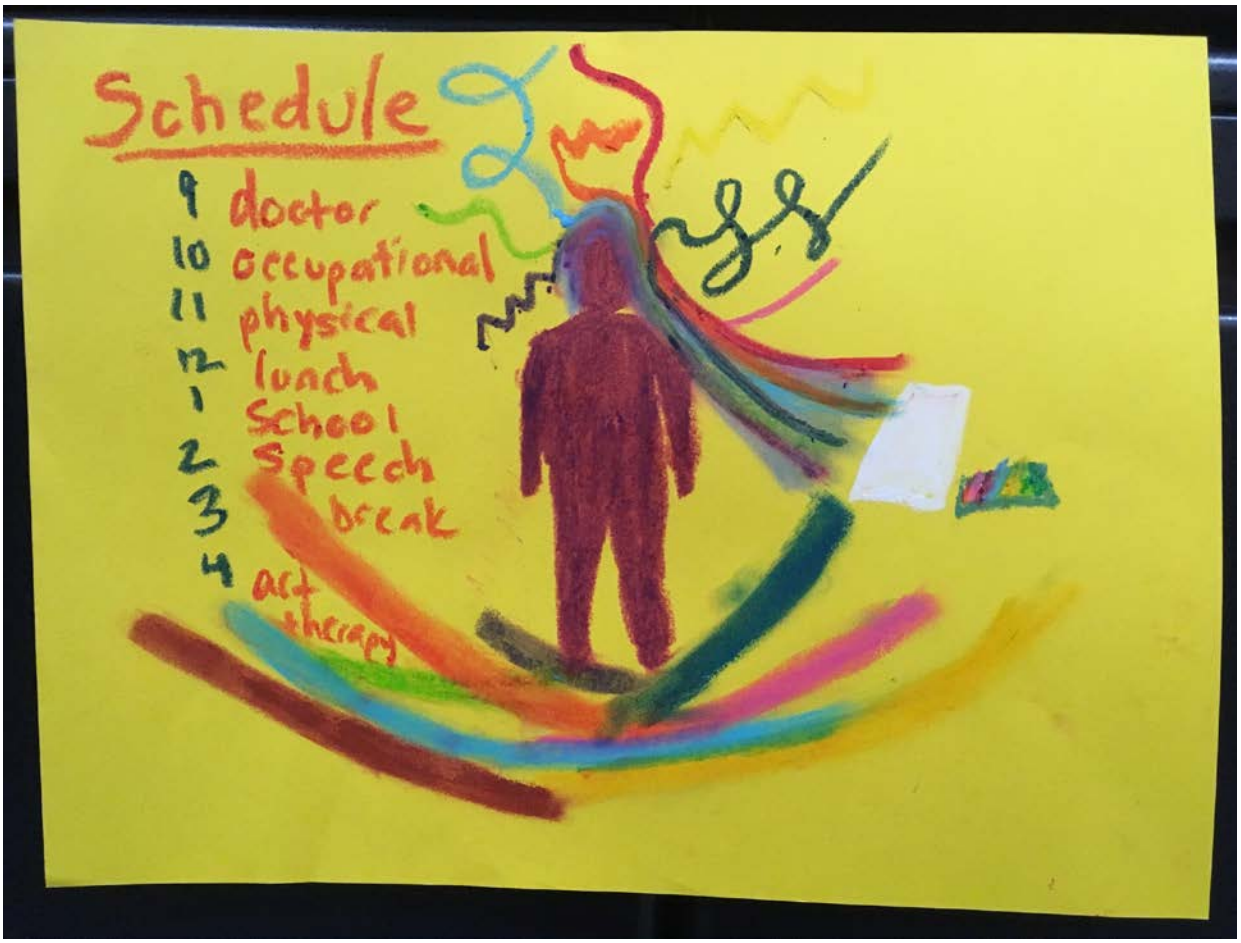



Figure 6: Participant C, question 5.


Figure 7: Participant D, question 4.

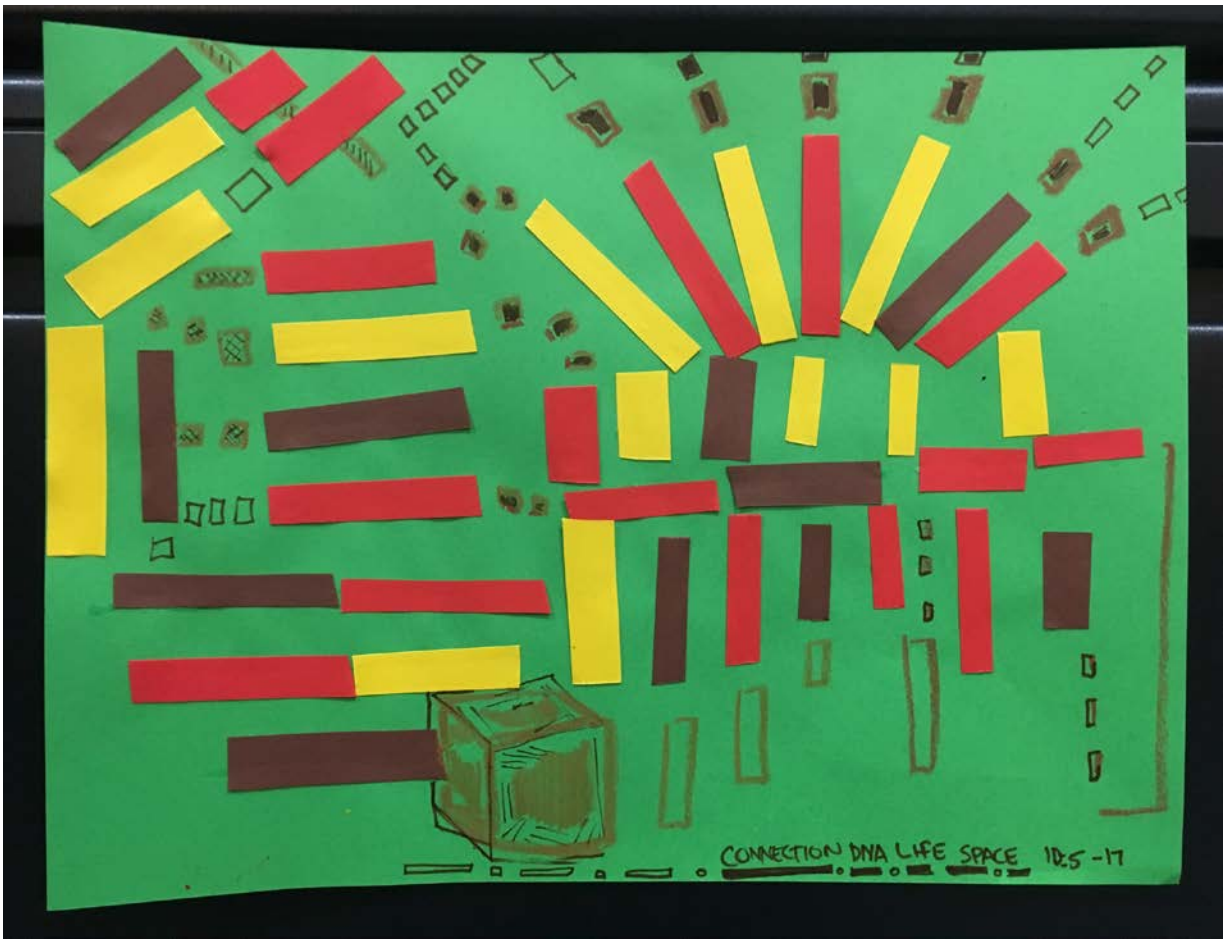



Figure 8: Participant D, question 5.

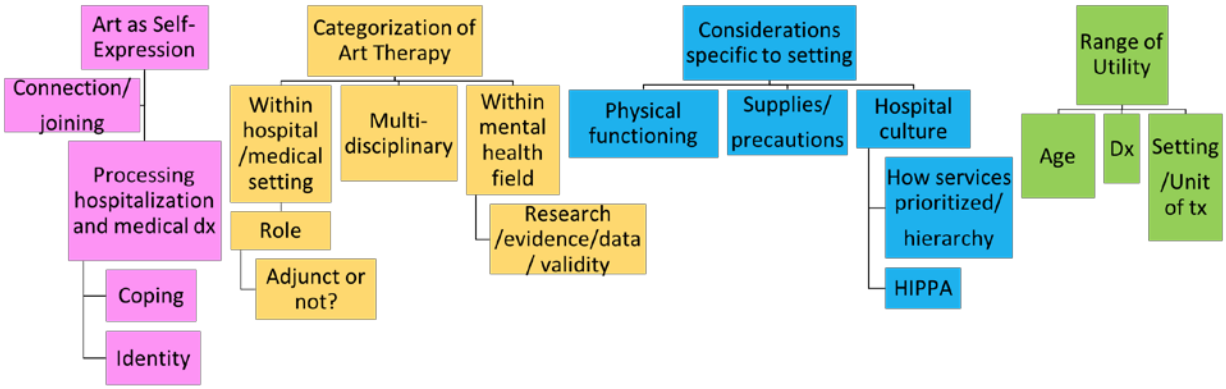
**Analysis of Data**

Researchers began analysis by studying the survey data to find emergent categories. After these categories were established and agreed upon, the focus group transcription was viewed through the lens of these categories. In this process, a fifth category was identified in the focus group data. The five categories from the focus group were used to analyze the response art and another category emerged specific to the artwork.

**Surveys.** Researchers reviewed the data collected from the surveys which were given with informed consent; twelve surveys were analyzed. (Initially, there had been thirteen responses in total, however one response was excluded as informed consent was not given.) Survey responses are discussed below, according to their number (1-12). The data was reformatted from the Qualtrics database into a spreadsheet. Each researcher read through the data individually several times to familiarize herself with the information. Independently, the researchers identified categories and subcategories that emerged from the data as they became familiar with it and then met together to compare what they each found. Researchers discovered that each had identified the same ideas found in the data, inconsistent only in what was considered a main category and what was considered a subcategory. Both had independently found the following three categories in common: "art as self-expression," "considerations specific to hospital setting," and "range of utility." Researchers discussed the reasoning for identifying certain ideas as categories or subcategories and came to a consensus, agreeing upon "categorization of Art Therapy" as a fourth main category, rather than included as a sub-category. This process also included streamlining what was considered a subcategory; under "art as self-expression," for example, while the researchers had initially discussed "communication" and "feelings identification" as possible sub-categories, they decided that these were

encompassed within pre-existing sub-categories of "connection/joining" and "processing hospitalization and medical diagnosis." The four main categories identified in the survey data were "art as self-expression," "categorization of Art Therapy," "considerations for the medical setting," and "the range of utility" for Medical Art Therapy. Researchers made the intentional decision to name one of the categories "*considerations*" rather than "*limitations* of the medical setting" (as it had been termed in one of the survey questions), in order to discuss these matters in a humanizing, holistic way. Researchers chose four different colored highlighters and paired each with a category. Together, researchers read through the survey data and highlighted the supporting data for each category. Researchers returned to the conversation of what subcategories had emerged (see chart below for categories/sub-categories). Each researcher was assigned to two categories and individually reviewed the supporting data to organize it into subcategories. Analysis within specific categories is discussed below.

**Initial Categorization Chart**




*a) Art as self-expression*

*b) Categorization of Art Therapy*

*c) Considerations specific to medical setting*

*d)Range of utility*

***Surveys: Art as self-expression.*** Among the written responses, the concept of "Art as self-expression" came up numerous times, across all questions and respondents. Respondent 1 explained, "I encourage clients to use art media to visualize their emotions and create a tangible representation of their experiences." Art was discussed as an "expressive tool" (4) which allows for a "deeper understanding and expression of a person's experiences and feelings in a medical setting" (6). Respondent 3 also noted that "art allows for a new pathway to emotions and memories that have been blocked as an attempt to reduce stress, and in this way is most

beneficial for the integration of a trauma narrative and self-reflection. Not only are patients able to express themselves in alternate ways, but the integrative nature of Art Therapy allows for patients to "gain new insights and deeper understanding of themselves" in the process (1). The variance in forms that art expressions can take speaks to the individualized nature of what the therapeutic process can offer to each patient.

***Surveys: Categorization of Art Therapy.*** Ten out of twelve surveys were recorded as having commentary about the categorization of Art Therapy. Two respondents commented about integration with science. One stated "further research needs to be mixed method or quantitative, as scientific journals may write art therapy off as a 'soft science,' although we know that it can create lasting changes in brain chemistry and even the brain's structural makeup" (3). The other communicated curiosity "about how we can integrate art with science in helping patients - a) feel more understood with regards to what their condition is like and b) contribute to whole body/soul/spirit healing" (8). One other responded seemed to distinguish the importance of a "qualified professional" Art Therapist, supporting the same idea of validity.

Five respondents touched on the way that Art Therapy might fit into the hospital setting. One stated that she would "like to see it [used] not only as an adjunctive therapy but very much as a primary method of psychotherapy" (4). The four other participants included how they personally use Art Therapy within medical settings, stating: "utilizing Art Therapy is my primary focus at the hospital," "I use Art Therapy and Art Therapy principles in my work at the hospital," "in this setting I use Art Therapy during assessment, beginning, middle, and termination phases," and the fourth explained that she finds Art Therapy most effective with her patients "when pain is manageable, boredom is beginning to set in, discharge is not soon, and patients are beginning to emotionally process what is going on for them" (5, 9, 10, 11). One of these respondents also

shared that "Art Therapy is one of the few professions at the hospital that a [patient] can decide if they want to engage in or not and therefore help them gain a sense of autonomy" (9).

Hospitals were named as a "multidisciplinary" setting (9), and five respondents wrote about this. One responded stated, "I would like to see Art Therapy integrated into more medical settings," (1) while another asserted, "I believe medical art therapy is essential in all hospital settings (3). Another participant seemed to reflect on difficulties in integrating Art Therapy into medical settings: there appears to be a near but very little opportunity to actually work within the field as an Art Therapist as a career (2). Lastly, a respondent explained, "medical staff (including nurses) usually reward those patients who find ways to be positive/cheerful and negatively reinforce patients who outwardly express negative emotion. Giving patients an opportunity through verbal or non-verbal means to express and explore their emotions is so crucial" (11)—highlighting the distinct qualities that an Art Therapist might add to the setting.

***Surveys: Considerations specific to medical settings***. This category emerged from responses to all of the questions that required a written response. The prevalence of this concept makes sense, given the focus on Medical Art Therapy—the practice of which is necessarily bound by the system in which it takes place. While this is true for all practitioners, there are unique considerations within medical settings in particular which respondents noted affecting their day-to-day practice in significant ways. One respondent noted the lack of "continuity in the therapy"—which often follows a more short-term, crisis-oriented model, given the setting (7). Other respondents also discussed some of the unique needs of patients during their treatment, including "pain management assistance" and fostering skills of "self-advocacy in [the] medical setting" (10). Multiple survey respondents noted the potential utility for Medical Art Therapy in addressing some of patients' specific needs; for example, respondent 9 highlighted that "Art

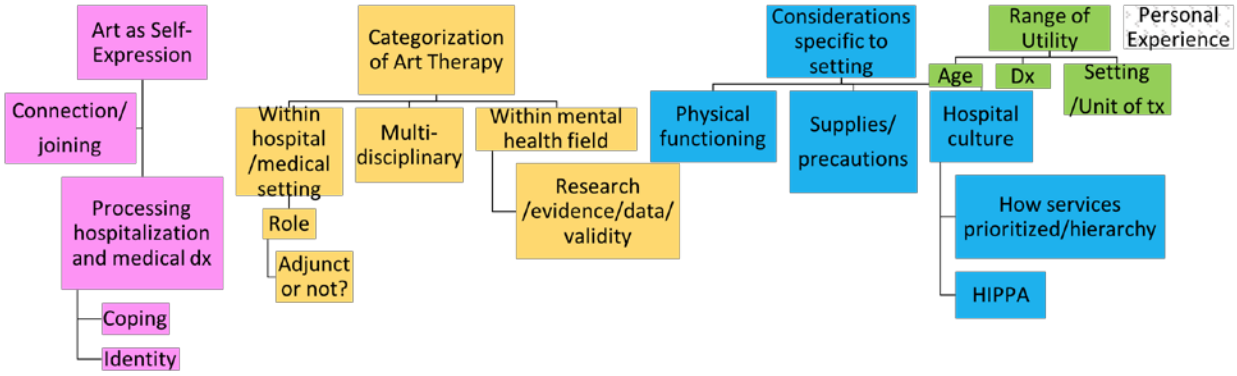
Therapy has…been beneficial for [patients] who are seeing-impaired or physically limited due to the diversity of art materials available."

***Surveys: Range of utility.*** Ten out of twelve surveys included identification of age, diagnosis, or unit of treatment that indicated the range of utility of Medical Art Therapy. One responded stated, "art therapy tools integrated smoothly across the hospital setting with the most wide variety of ages and medical diagnoses" (6). Specific references to the age of clients included, "adults ranging in age from 18 to 90" (4), "children" (8), "a variety of patient both very young and older" (9), and "children, teens, and families" (10). Respondent also commented on the diagnoses that they might work with, which included: "Alzheimer patient" (2), "terminal patients" (3), "patients facing a wide variety of disabilities and complex medical needs," "families facing a new diagnosis," "patients and families in crisis" (10), "outpatient settings, where the patients by definition are functioning at a higher medical level and therefore may be better able to address questions of quality of life, mental well-being, identity shifts, etc" (11). The settings or unit of treatment indicated were "one on one" (8), "group settings" (7), and "families" (5, 9, 10).

**Focus Group.** Next, the focus group transcription was analyzed. Each researcher had transcribed half of the audio recording of the focus group. For analysis, the researchers read the portion of the transcription that the other had worked on. Researchers used the four categories that had emerged from the surveys as an analytic frame and identified supporting data for these categories in the transcription, cognizant of other categories that may have pertained to ideas addressed in the focus group specifically. Researchers met after each reviewing her portion of the transcription and discussed if any new categories had emerged. Both agreed that a fifth category, "personal experience," came out of the transcription from the focus group, with a

corresponding sub-category of "shifts in perspective/practice." While it had initially appeared that additional alternative categories were emergent in the transcription data, it was decided that these categories actually corresponded with overarching categories originally decided upon. Data from the focus group is discussed within the framework of the pre-existing four categories, plus the additional fifth category (see category chart below).

**Categorization Chart with Added Category**




*a) Art as self-expression*

*b) Categorization of Art Therapy*

*c) Considerations specific to medical setting*

*d)Range of utility*

*e) Personal experience*

***Focus group: Art as self-expression.*** The focus group naturally brought an element of art as self-expression as two of the questions included art responses. One participant reflected on her process of creating response art and explained that a collage image she chose had "freaked [her] out" and that she still chose to include it. This started a conversation between participants about fear and the unknown and the participant who was discussing her response stated "there's the art to at least express that" (Participant C), suggesting that the art deepened her process of self-expression.

Through supporting patients and families in utilizing their art-making processes for self-expression, clinicians are at once able to provide a "human element" (the art) while also serving as a "human junction…of humility [and] expression" during a patient's medical treatment—when they are in "the most vulnerable part of [their] life" (Participants A, B).
Engaging in the art process is humanizing for patients, who are able to express themselves however they need to, whether or not that self-expression is related to their medical treatment. As Participant D noted, "the art…doesn't always have to be directed at this medical issue…this medical procedure that you're going to have this week…You can say, 'what are you thinking about that and let's do the art around it,' but…a lot of times that's not all…it's so many things."

The relational dynamic of the therapeutic process, within the specific context of the medical setting, may shed light on existential themes in particular—not only for the patient, but also for the clinician—both of whom are connected by their shared humanity and mortality. One group member stated that through her Medical Art Therapy work she "[feels her] own mortality, [her] friends' mortality, [her] mother's mortality," and also acknowledged that "besides working in hospice, besides working in this type of medical community, there's just life."

The clinicians in our focus group discussed the witnessing of patients' art therapeutic processes as informing their own notions of what Art Therapy could be. In letting go of expectations of what Art Therapy "should" be—a theme that continually came up—there was a parallel process at play; not only were there implications for informing patients that there is no singular "right" way to do Art Therapy, but also clinicians' own notions of what Art Therapy could be were shaped along the way.

For Medical Art Therapists to serve as witnesses to the ways in which patients choose to express themselves through their art—both process and product—provides a unique opportunity not only to foster rapport by "developing…a trusting therapeutic relationship" but also to engage with them in ways medical staff might not have the opportunity to (Participant A). The unique contributions of Medical Art Therapy, which serve to differentiate clinicians' roles from other medical staff, will be discussed further below.

***Focus group: Categorization of Art Therapy.*** The question of "what is Art Therapy?" came up in different ways and challenges related to its categorization were discussed. Defining and differentiating the role of Art Therapist while advocating for the service's value all have unique implications within medical settings, which are often multidisciplinary, though focus on symptom reduction and measurable, observable results. One of the main topics stimulated in the focus group concerned the way that an Art Therapist might be situated in the medical setting, specifically "being adjunct or not adjunct" or "last on the totem pole" within the multidisciplinary team (Participants D, B). Although Art Therapists may have the unique opportunity to work within the treatment team in a medical setting, being an "adjunctive therapy" may constitute a shift in some clinicians' mindset vis-à-vis their practice (Participant D). One participant explained, "you have a psychiatrist, you have a psychologist, you have a

social worker… and we came last and we had to be flexible" (Participant B). There seemed to be an agreement that "you have to be okay with being a secondary therapist" as the therapists shared their common experiences. Participant 2 noted, "as a primary therapist, it is a huge shift to know that you may be a part of the medical treatment team but you are totally secondary."

Whether Medical Art Therapy takes the more process-oriented, "art as therapy" approach or follows a more specific theoretical frame, for the practitioners to whom the researchers spoke, there is no question it is beneficial. Focus group participants discussed a range of ways in which they observed Art Therapy's unique benefits—from witnessing patients being "able to vocalize for the first time" to offering a "different environment for the family to communicate and just coexist and…have that moment of…connection" (Participant C).

Two of the participants added some unique qualities that Art Therapists might bring to a team. One referred to diagnosable features, using the example of a "diagnosed fever," that medical staff might be more interested in and stated that Art Therapists might show more care toward "all these things that are impacting your life" (Participant B). The other participant also stated that "most of the time [her work with patients] was processing all of the different things that were happening throughout the day" and specifically that "I'm here for [my patient's] benefit and… we can use this hour, this time, for whatever is going to help [them] and help our therapeutic relationship" (Participant C).

Since there are so many forms Medical Art Therapy can take, maybe a singular definition isn't possible—which actually speaks to the significance of its potential for contribution within medical treatment. Medical Art Therapy can be adapted in order to meet the individualized needs of patients and their families in the hospital—offering support in a flexible way, well-suited to the setting. Participant 3 shared about her work at a pediatric hospital, saying: "everything is

basically what that family needs in that moment and it's very experiential and humanistic and just…whatever that person, that family member, needs." Unique considerations, given the medical setting, will be discussed further below.

***Focus group: Considerations specific to medical setting.*** Medical Art Therapy fits within many hospitals' family-centered-care approach, adapting to the needs of patients and their families in the here-and-now; this is significant, given that "the whole hospital is a mini crisis" (Participant C).

The participants offered considerations for what the experience of a patient might be like. One participant explained the busy schedules that some patients have and that sometimes patients are tired by the end of the day and might think or say, "another thing? Really?" (Participant C). Another participant offered that in moments like those giving them a choice is the most important thing: "when you're chronically, medically ill, the most important thing is that you have control of something and so even being able to say, 'no,' to an Art Therapist is a very powerful thing and holding space for that is a very powerful thing" (Participant B). This participant also named that patients might experience "stigma" or the "disconnect between… how people perceive you as a sick person or a disabled person" (Participant B).

Further considerations for the setting included the way that information might be passed on within the medical team, the termination process, and the use of art materials. Participants discussed the possibility of knowing about the patient's diagnosis and progress. They seemed to agree that it was important to make "sure that what the patient says, what the family says, is what you're going by even if you have more information" and go by "how much they want to reveal to you" (Participants C, A). One participant explained that she did not have access to any charts and

reflected, it's kind of nice because I don't see that other side" (Participant D). There seemed to be a consensus of the importance of patients leading their therapeutic treatment in this way.

Another point of discussion was the way that termination might play out differently in a medical setting. Two participants shared that they experienced the death of patients they were working with—either by the natural course of their illness or by suicide. One participant explained that termination might seem abrupt for other reasons: "they would be there for a week and get diagnosed with something and then they would go and you would never see them again" (Participant B). Another participant added, "there's so much termination" (Participant C). Participants seemed to relate to the experience of terminating often due to circumstances outside of their control.

Not only does each Art Therapist have a different style, but their personal, stylistic approaches are shaped by the systems in which they work. Multiple participants discussed their use of media as informed by considerations within the medical system—whether due to isolation precautions or mobility considerations, for example. Participants acknowledged the developmental considerations that are always necessary and stated that for Medical Art Therapy it's "another level because it's all these physical things also going on" (Participant C). Concerning the "textile and the sensory aspect of materials," one participant offered the consideration of what "triggers the kids throwing up" and "not having too [many] fluid things that resemble that" (Participant C). Safety concerns were also addressed, with specific attention to the way that art materials have the potential to spread illness. The participants outlined the importance of considering "what can I spread with my materials?" and the thought process of choosing what art materials to bring to a session (Participant B). One participant shared the difficulty in choosing a limited number of art materials to give away to a patient in high-isolation

and described it as "limiting" and the reason why she "[thinks] it's so hard to fund Medical Art Therapy most of the time…[since] you're giving away packets of markers," for example (Participant C).

In some cases, using a different type of material or approach—although initially a stretch for clinicians, perhaps—ended up providing a unique opportunity to join with and support patients in a novel and significant way. One participant discussed her process of "[getting] really into using stickers" in working with her youngest patient who was fearful of staff and seemed wary to engage otherwise (Participant C). She also "started doing hand-over-hand art-making with one of [her] patients who had limited mobility and…had cerebral palsy and was having constant…seizures and just having a really hard time. And by the end of it…she was actually able to grab her own materials and make art on her own and…she didn't have many words but it really came across in her artwork" (Participant C).

***Focus group: Range of utility.*** Within the Medical Art Therapy umbrella, the range of patients worked with—from toddlers to older adults, all with a variety of medical diagnoses—was discussed during the focus group. Participants offered several diagnoses or circumstances that might bring their patients to the hospital. They named working with patients undergoing bone marrow transplant, several forms of cancer, lupus, chronic illness, heart disease, autoimmune disease, chronic disease or disability, and patients who are mute. They also named working with children, adolescents, adults, older adults, and the entire family. One participant expressed that she was drawn to working within the medical field because it affects people of all ethnicities and walks of life (Participant B).

Part of the significance of Medical Art Therapy's contribution, according to participants, is its ability to be adaptable and flexible to the individualized needs of patients and families

throughout different phases of their medical treatment. Multiple participants also noted the ability for clinicians to simultaneously support both physical and psychological needs—especially considering that the two can often go hand-in-hand. This is significant, since "medical considerations are extremely important to our mental health (Participant B). Participant B noted, "when you have early existential crises, like many of our patients do who suffer…physical illness…and sometimes psychological illness…you have to…be open to and thoughtful of…all these other considerations of relationships and lifestyles, [etc.]". Participant C shared how art directives often opened up conversations with patients which shed light on "what's going on with their bodies and what's going on in their heads and developmentally." In this way, Medical Art Therapy is a tool through which clinicians are able to holistically support patients as whole people with complex "bio-psycho-social-spiritual" needs (Participant A).

***Focus group: Personal experience.*** It seemed apparent early on in the focus group that the interpersonal dynamics of having a dialogue between a small group of the Medical Art Therapy community was conducive to sharing the more personal elements of this work. Focus group members noted the importance of community for clinicians' own mental health and wellbeing, given the "drastic" and "intense" nature of the field and how necessary it is to be "on check with your own mental health" (Participants C, B). Participant C also acknowledged how "comforting" it was to "[talk] to people that have been there." It should be noted that clinicians' expressed need for combatting a sense of isolation by connecting to others in the field has parallels to the potential for Medical Art Therapy to combat the sense of isolation that many hospitalized patients often feel. Given that all four participants had worked within the field of Medical Art Therapy, perhaps they found a sense of comfort through commonality and were able to share more deeply, trusting that their peers could relate on some level.

All participants shared about their personal experiences working with clients. These stories naturally emerged when participants created art responses and utilized certain art materials that related to art their clients had created or in discussion about considerations and limitations for their work. One participant shared the experience of having a group member who stole art materials and another client who she seemed to believe committed suicide because of the toll that her illness seemed to have on her family (Participant D). A couple of participants also discussed their love for group therapy and experiences facilitating groups (Participants B,D).

Participants shared their personal experiences in relation to their training, personal development or journey, and work with their clients. One participant named a couple of important lessons that she learned: "it doesn't matter how much training I had… it was really about being present and… meeting them where they were and… being authentic, too" and trusting the words of a previous mentor of hers: "what you did with them was enough" (Participant B). This participant also disclosed about her history of being a childhood cancer survivor and how that impacted her work in the field. She named her experience of being "labeled 'disabled' [her] entire life" and how she had accepted that label when she was in her Master's program. She recalled the experience of others not perceiving her as a disabled person and that she does not "have a need or desire to [explain]" (Participant B). Another participant recalled her experience of disliking her first job in the field and wondering "how can I do this? How can I survive this?" and identifying "I just did not like family therapy" (Participant D). A participant stated that she had been "doing a lot of multicultural training" and discussion included person-first language and the use of pronouns.

Not only was personal experience shared, but it was also bridged to professional roles. Through the insights and experiences multiple group participants imparted, it became evident

that their professional and personal capacities were not distinct, separate categories, but rather that one informed the other (and vice versa). Participant 1 commented, "I adapt to a lot of my clients very differently because my…life experience is so full in comparison to some…of my counterparts…where I can give a different dimension than somebody else…or I'm relatable to a sixty-year-old woman who's out of work…I am a very relatable person because I get it."

**Response Art.** For the final step of analysis, the researchers met with their research mentors to look at the response art that was created in the focus group. This art was made as a response to focus group questions numbers four and five. Researchers began analysis by looking at individual pieces of art within the pre-existing categorical frame before looking at them as a whole. Researchers then considered responses according to each individual question—first comparing all four responses to question four before comparing all responses to question five. After considering the art within the analytical frame of the five categories, researchers then moved on to consider specific aesthetic features of the art. It should be noted that, although this section analyzes the art as a data set mostly independent from that of the focus group transcription, pertinent information is included in order to deepen meaning of the art, contextualizing it within the focus group as appropriate.

***Art responses: Art as self-expression.*** Due to the nature of questions being answered in the form of art, all participants' responses would necessarily fall under this category. Themes of metaphor and clinicians' personal art processes emerged in different ways. In sharing about her artwork, Participant C discussed the content as metaphorical saying, "I kind of see it as a metaphor of…they're trying to fly, they're trying to be themselves and there's something that's in their way, there's something that's kind of pushing them back but…there's the art to at least express that" (Figure 5); here she was linking the patients she had worked with in the hospital

with the bird imagery she had utilized in her collage. Similarly, Participant 4 also discovered metaphorical content in her artwork in the process of sharing.

When sharing their artwork with fellow focus group members, participants spoke to not only the content in their art pieces, but also how they were representative of their personal art processes. One group member stated "I do a lot of doodling in the beginning" (Figure 7) while another shared, "I kind of like to…just do free art a little bit" (Figure 1); participant 1 went on to discuss her conceptualization of this free art process, saying "journeys are journeys and it could be spiritual, it could be emotional, it could be physical…it doesn't have to have any sort of form, it's completely open, it could be interpreted in different ways" (Figure 1). Here, the experiential nature of a more free-form art process speaks to the potential for therapeutic support to be individualized according to the dimension (or combination of dimensions) through which a patient seeks to explore their experience. This topic led to a conversation exploring the belief that, through allowing for open-ended art-making, what a person needed to express would get expressed. Participant 1 stated, "this is even how I paint…and I don't even…necessarily have a plan…I just let things expand and…when I paint, I will…almost just mess up the canvas first so that it doesn't…stop me from producing whatever it's going to be." Clinicians' trust in the art's expressive potential and therapeutic benefit applies not only in their own relationships to art-making but also in how they perceive patients' art processes: "most of the time [they were] processing all of the different things that were happening throughout the day onto paper and that would come out [in the art]" (Figure 6).

***Art responses: Categorization of Art Therapy.*** Participants' discussions of their art served to highlight ways in which the therapeutic process helps differentiate the contributions Medical Art Therapists can make within a treatment team. Participant B offered the following explanation of her art:

> I think that that is something special that we might bring in the diagnostic team and…just because…the client doesn't have a clinically diagnosed "fever" doesn't mean they aren't ill or needing additional assessment or treatment, so just…use that…medical scale to say, ok maybe…they don't know what's wrong with you and you have all these things that are impacting your life and we can really kind of get into that where maybe doctors and nurses aren't as interested in those minute details. Then I said "feelings and symptoms over diagnosis and diagnostics" (Figure 4).

Participant C further highlighted the unique contributions which Medical Art Therapists can offer to patients, saying

> I think for Art Therapy something we offer that's different is I'm here for you and your benefit and you can see that…I want you to see that I'm here for your benefit and…we can use this hour, this time, for whatever's going to help you and help our therapeutic relationship…and…I think just being flexible and being there for the client as a way to…be an individual… and not feel like you have to rely on…those other therapies (Figure 6).

While Art Therapy services may be considered adjunctive within medical settings, they have unique potential to contribute to patients' treatment in a holistic, humanizing way—offering an avenue through which patients can express aspects of themselves on which other disciplines (e.g. medical staff) are not able to focus.

***Art responses: Considerations specific to medical setting.*** Two art responses seemed to reflect considerations specific to the medical setting—both from the second art response question. One participant simply framed her artwork initially by stating the context of being within "the rigid modalities of medicine" (Participant A). The other participant seemed to depict the possible experience of a patient and a list of what might be in their schedule. As she described her artwork, the participant stated, "what came up the most for me was rehab and how tight their schedule is… these kids know that it's there to help them, but they're just overwhelmed with all of these different therapies" (Participant C). She added, "all the other therapies compete for the time and attention and progress of the kid because they have issues like insurance… bigger problems but that aren't the kids problems but they somehow get dragged in" (Participant C). Her artwork includes a variety of colorful lines that represent "all of the different things that were happening throughout the day" that might be put "onto paper" in an Art Therapy session (Participant C). This participant named the importance of "being flexible and being there for the client" while practicing Medical Art Therapy (Participant C).

***Art responses: Range of utility.*** When it came to the art responses, only one participant named the range of utility of Medical Art Therapy. When describing her response shown in Figure 2, the participant described her approach to working with an "adolescent and an adult, a child," seeming to describe a full range in age of clients that she might work with (Participant A).

***Art responses: Personal experience.*** The first art response question seemed to draw out personal experience from each of the participants. Two of the participants explained that their response incorporated artwork that their clients have made; one explained the utilization of collage images of nature for visualization of "a place that is serene or that you would want to be

in right now", the other described artwork that represented all of the different forms of cancer and called it "the coolest thing I've ever made with my patients" (Participants C, D). The other two participants reflected on themselves as Art Therapists. One shared an important lesson she learned: "to be 100% present… meeting them where they were and… being authentic, too" (Participant B). And the other reflected on the "journey" of the work and seemed to hint at experience or something observed by stating "we could be blinded by what we think we know" (Participant A).

***Art responses: Features of the art.*** The analysis of features of the art include a comparison of the art responses for each question, presented first, as well as a comparison of the art responses by each participant. Commonalities as well as distinctions are highlighted for features such as material use, space, colors, and content.

*Features of the art: focus group question 4.* In terms of materials used, three out of four participants chose to use white paper in a vertical orientation (Figures 3, 5, 7) and the other participant used red paper in a horizontal orientation (Figure 1). All participants glued or attached objects to their paper; half of the participants incorporated collage images (Figures 1, 5) while the other half utilized found objects (a napkin, geometric wooden pieces, beads) (Figures 3, 7). Model magic was also included in one participants artwork, pressed into her paper (Figure 3). One participant made marks with oil pastels (Figure 1), while another used markers (Figure 7), and a third used both (Figure 3).

All participants seemed to use the full page for their response art (Figures 1, 3, 5, 7) and a full range of colors seemed to fill the page in three out of four responses (Figures 1, 3, 7). The other participant seemed to use a number of colors but left her artwork mostly white, utilizing the white color of the paper, model magic, and in the napkin that she glued to the page (Figure 3).

The style of each art response is unique. Two of the responses seem to have a kinetic quality through the gestural use of oil pastels (Figure 1) and in the way that the model magic seemed to be pressed into the page (Figure 3). Energy seems to also be expressed in the other two responses, in different ways. One displays movement found in nature through the waterfall and what appears to be an interaction between two birds (Figure 5). The other seems to reflect energy by the use of color and movement through a patterned abstract drawing. All responses seem to incorporate an aspect of nature as seen in the gestural trees (Figure 1), a skeleton with floral-like design (Figure 3), collage images of nature (Figure 5), and floral-like shapes in the abstract pattern (Figure 7). Lastly, three out of four drawings do not include words (excluding the title that is written in the bottom corner of Figure 7). One participant utilized words in her artwork which read "we are all the same but we have our differences to respect & value," "be present," and "be authentic" (Figure 3).

*Features of the art: focus group question 5.* All participants' art responses utilized colored construction paper and were oriented horizontally. In addition, all four art responses included at least some use of oil pastel; of these, one utilized pastels as the only medium (Figure 6), one used both oil pastels and markers (Figure 2), one used mostly oil pastels with a found object (Figure 4), and one used cut-up paper, markers, and a minimal amount of pastels (Figure 8). All participants mostly filled up the page, with Figures 2 and 6 leaving more empty space than Figures 4 and 8. Three out of four participants included words on their art; Figure 4 consisted mostly of words, Figure 6 utilized words to list a patient's schedule (though included accompanying imagery), and Figure 8 included words for a title.

*Features of the art: Participant A.* Participant A utilized a combination of oil pastels and an alternate medium in both of her art pieces. In Figure 1, she utilized oil pastels and collage images, while in Figure 2 she used markers with the oil pastels. Participant used larger red construction paper for her first art response (Figure 1), while she used smaller purple construction paper for the second (Figure 2)—both oriented horizontally. Both Figures 1 and 2 included drawn imagery of nature. There appeared to be more movement conveyed in Figure 1, with materials and images placed in various directions on the page and with more variance in line quality. Figure 2 consisted of fewer elements on the page, with less motion conveyed on the page.

*Features of the art: Participant B.* Participant B used white paper, horizontally oriented for her first response (Figure 3). For the second response, she used larger purple construction paper, horizontally oriented (Figure 4). Both responses utilized words, with the text taking up significantly more space in Figure 4. Figure 3 utilized markers, white model magic, and an additional item (a napkin with a skull design) that participant re-purposed for her art-making. Figure 4 consisted almost entirely of text, written in pastel (whereas markers were used for Figure 3's text), and also included an additional item—a "found object" from the supplied art materials, consisting of a small thermometer. Imagery in Figure 4 was drawn around the thermometer, and appeared to be a sign sticking out of water drawn at the very bottom of the page.

*Features of the art: Participant C.* Both pieces of Participant C's artwork contain a full range of colors and use the full page, but contrasts in terms of materials, style, and content. Her first response was created on white paper in vertical orientation with collage images while her second is on yellow paper in horizontal orientation with a drawing in oil pastels. For each

response she seemed to use one art material to focus on: collage images in Figure 5 and oil pastels in Figure 6. The content of the first includes images from nature; the ocean, land, mountains, a waterfall, trees, and birds. The use of landscape seems to have an expansive quality to it, while her second response seems to focus in on the experience of an individual. It includes an oil pastel drawing of a schedule and a figure with gestural and abstract lines that seem to depict the things that happened throughout the figure's day and perhaps the figure's experience of it. There also appears to be a white paper and art materials to represent the experience of "processing all of the different things that were happening throughout the day onto paper" (Participant C).

*Features of the art: Participant D.* Participant D used the full page for both pieces. Her first response is on white paper in vertical orientation and includes a full range of colors while her second is on green paper in horizontal orientation and though it is colorful, it has a more limited color palette. Both art responses seem to have an abstract, patterned quality. The first is drawn mostly using curvy, organic shapes and the second is more geometric, created from several rectangles drawn and made from paper cut-outs. Something unique about this participant is her natural process of titling and dating her artwork; her first response is called "Time Fly's" and her second is "Connection DNA Life Space."

## Findings

Through analysis, researchers discovered several categories that emerged from the data. In the survey responses, four categories were identified: "art as self-expression," "categorization of Art Therapy," "considerations specific to the medical setting," and "range of utility" of Medical Art Therapy. Data from the focus group and art responses maintained these categories and included a fifth category, "personal experience." The art responses inherently offered a visual quality that was analyzed under a sixth category, "features of the art." Researchers reviewed each category, across data sets. These findings are included below.

**Art as self-expression.** A theme that consistently arose from clinicians' personal experiences, as reflected in the data, was the power of patients' art to express what might not otherwise get expressed. Not only that, but art-making processes allow for adaptation to the range of ways in which patients may communicate, including non-verbally. Research participants highlighted the ways in which Medical Art Therapists are uniquely situated to provide holistic, integrative care for patients who are empowered to express themselves and their experiences on multiple levels, aside from just the physical.

**Categorization of Art Therapy.** All three data sets maintain the idea that Medical Art Therapists offer unique contributions to a treatment team. In all three data sets participants and respondents seem to agree that Medical Art Therapists offer a sense of autonomy to clients within the therapeutic relationship and that these therapists maintain a flexible approach, viewing the client as a whole person. The breadth of experiences and possible needs are welcomed into the therapeutic space; the specific diagnosable symptoms of a client are not the only focus of treatment as in other modalities. Acknowledging that medical settings are multidisciplinary, both the survey respondents and focus group participants distinguished the Medical Art Therapist's

current role in the treatment team as adjunctive or secondary. Most respondents and participants indicated hope that Medical Art Therapy would become a primary method of treatment, although one participant in the focus group voiced that she did not feel strongly about this. The survey data held commentary about the importance of focusing Medical Art Therapy research on quantitative or mixed methods studies in order to heighten a sense of validity of this treatment within the medical setting.

**Considerations specific to the medical setting.** As with any type of support services, Medical Art Therapy is necessarily shaped by the system in which it takes place and also the individuals to whom clinicians are of service. Given the evidence-based direction in which the mental health field is moving and systemic considerations of the medical field, it may perhaps be increasingly important for research to continue to quantifiably demonstrate what many practitioners and patients alike already intrinsically or experientially know to be true about the benefits of Medical Art Therapy. As this niche field continues to expand, it is important to note that, as multiple participants discussed, de-lineation around what is considered "Medical Art Therapy" is, in some ways, arbitrary, as what this work may uncover are, ultimately, existential, human concerns that we all share. The Medical Art Therapists who participated in this research project noted how their understanding of Art Therapy was shaped and informed by practicing specifically within medical settings. Some of the considerations they emphasized included the importance of being present and flexible in order to meet patients and their families where they were in the here-and-now--considerations which are certainly relevant and applicable in contexts outside of the medical realm.

**Range of utility.** The data reflected that Medical Art Therapy has the capacity to offer support to people of all ages who may experience a broad range of medical diagnoses. On

several occasions, survey respondents and focus group participants identified that Medical Art Therapists could work with people of all ages, from toddlers to older adults, and identified several illnesses and diagnoses that clients may have. Focus group participants emphasized how Medical Art Therapy addresses by psychological and physical needs and how connected these two may be.

**Personal Experience.** Much of this research project's meanings were emergent from participants' sharing of their personal and professional experiences. Through especially the focus group process, it became evident how much personal and professional identities were not only intertwined but also informed one another. A sense of community and the ability to relate were fostered by this in-person meeting and dialogue between clinicians who have engaged in the practice of Medical Art Therapy--whether in the past or present. The importance of continued opportunities to foster community and discuss this challenging and complex work among peers was emphasized.

## Meanings

**Meanings related to general literature.** The general research outlined in the literature review focuses on the experience of hospitalization and for children and adults, with specific attention to the literature on adults in oncology, and psychosocial services offered in medical settings for children and adults. The findings of this research connect to the general literature regarding a child's experience of hospitalization and receiving services and the emphasis on oncology.

The general literature reflected that children may experience a lack of autonomy when it comes to their treatment (Coyne, 2006; Salmela et al., 2010). Focus group participants seemed to echo this experience and offered the importance of giving autonomy to their patients:

> when you're chronically, medically ill, the most important thing is that you have control of something and so even being able to say, "no," to an Art Therapist is a very powerful thing and holding space for that is a very powerful thing (Participant B).

Further, Kazak (2006) outlined that treatment for children typically is "some combination of social workers, psychologists, child life specialists, and psychiatrists" (p. 388). The experience of this treatment appears to be illustrated by Figure 6, which seems to highlight the value of utilizing Art Therapy to process "all of the different things that were happening throughout the day" (Participant C). This participant also echoed the value of giving a patient autonomy while describing her artwork by stating, "we can use this hour, this time, for whatever's going to help you and help our therapeutic relationship" (Participant C). The importance of this expression and sense of control in the therapeutic relationship parallels the process of encouraging children to express themselves and having their concerns responded to that Coyne (2006) describes as essential for successful outcomes (p. 334).

Additionally, the general literature offered research that often focused on adults in oncology. According to 2010-2014 data, approximately 38.5 percent of men and women will be diagnosed with cancer of any site at some point during their lifetime" (The National Cancer Institute, 2017). Though other reasons for medical treatment were named, it is notable that cancer was the most commonly discussed illness within the focus group and that two of the participants are cancer survivors.

**Meanings related to Art Therapy literature.** Much of the meanings that emerged from all forms of data in this project supports information from the Medical Art Therapy Literature. The significance of Medical Art Therapy's ability to provide patients a sense of purpose and control through choice-making in the art process—qualities which tend to be otherwise limited

within the hospital setting—is a theme that was echoed throughout participants' art, survey responses, and in the focus group (Malchiodi, 1999; Prager, 1995). According to Participant B, "when you're chronically, medically ill, the most important thing is that you have control of something and so even being able to say, 'no,' to an Art Therapist is a very powerful thing and holding space for that is a very powerful thing."

Prager (1995) also discussed implications for Art Therapy's potential to support patients in adapting to limitations of the hospital setting; an emergent theme in the data was the ways in which clinical practice was shaped by these same systemic considerations. While specifications of medical treatment and systemic considerations sometimes presented challenges to clinicians, these very same challenges are ones which affect patients' experience of hospitalization, and through which Art Therapists can offer support. The considerations by which Medical Art Therapists are bound give them the unique opportunity to grow in understanding and compassion for the experiences of patients and families navigating a complex system, not to mention the added stress of having a young family member combating childhood illness. In the process, Family Art Therapy in a medical setting can potentially counteract some of the commonly-experienced feelings of "isolation, symptoms of stress, lack of self-care, and lack of understanding from extended family and friends" (Martin, 2013, p. 305). Clinicians' direct experience supported this notion, and also illuminated an additional theme: just as combatting feelings of isolation was significant to patients and families during treatment, there is necessity for Medical Art Therapists to have a sense of community with which to support their work.

As was discussed in the Literature Review, Martin (2013) encouraged Medical Art Therapists to "lead the way" in pediatric hospitals' progress "in inclusion of families in all aspects of the patient's care" by "involving the families and siblings in self-expression and stress

reduction through creative activities," thereby "providing better family-centered care" (p. 314). The clinicians who participated in this research project spoke to the fact that their work within the field of Medical Art Therapy is accomplishing those very goals. As Participant 3 shared about her work at a pediatric hospital: "everything is basically what that family needs in that moment and it's very experiential and humanistic and just…whatever that person, that family member, needs."

Borgmann (2002) discusses how "art therapy promotes the connection between physical and mental health by offering the patient a means in which to express herself in private through art" (p. 245). Not only that, but Borgmann (2002) also highlights the importance of art as "providing a concrete model of what the patient is experiencing that can serve as a permanent reminder of her strength and courage" (p. 245). Both of these concepts were directly supported by research data, which highlighted Medical Art Therapy's ability to holistically support the "bio-psycho-social-spiritual" aspects of patients (Participant A). Multiple participants noted how inextricably linked physical concerns were to psychological ones for patients receiving medical treatment. Medical Art Therapy allows clinicians to treat the "whole person" (Participant A)—discussion of which led Participant A to comment, "we're dealing with…an expansion, it really is very broad when you say "medical," it's like, "where is 'medical'?...It doesn't end here and start here. It kind of all mixes together."

As previously stated, an important note with potential implications for future directions of the Medical Art Therapy field is the lack of research on long-term efficacy, in terms of measurable factors. This consideration was reflected especially within survey responses—which makes sense, given that one of the questions specifically asked participants to share their thoughts regarding future research and interventions related to Medical Art Therapy. Respondent

7, for instance, suggested that Art Therapy continue "with a patient even when they are discharged from the hospital [which would] ensure continuity in the therapy;" this respondent went on to consider whether gathering information such as "additional feedback about how patients feel" and finding patterns "could lead [the field] in a different direction with regards to offering healing or pain alleviation or cures."

## Conclusion

Rich content and informative data emerged from all components of this research project. Focus group participants were able to relate on the basis of shared experience—whether professional, personal, or some combination thereof—which at once fostered an experience of community and emphasized the importance of continued opportunity to collaborate and share experiences within a community of Medical Art Therapists.

Participants shed light on the lived experience of practicing Medical Art Therapy—acknowledging systemic challenges and wishes for the field's future growth, while mostly emphasizing the incredible range of unique benefits which this service can contribute within patients' medical treatment. Multiple participants—some of whom had worked in other capacities in medical settings (e.g. as social workers) before working as Medical Art Therapists noted the significant and unique benefits of the practice for patients and their families. To highlight the importance of this service's availability within medical settings: the majority of survey respondents indicated that expressive tools were the most effective way they knew to explore medical issues. For many who shared their experiences working in the field, employing Medical Art Therapy allowed them to holistically support patients as whole people, in addition to their entire family systems.

Through sharing their personal experiences, participants shed light on the link between their professional and personal identities, including how some of their own medical histories allowed them to have greater understanding of and compassion for the complex needs patients may have. The art-making process in the focus group and corresponding discussions allowed participants to gain new insights related to not only their own art processes but also to integrate understanding of potential implications for patient care from an alternate modality.

This project was limited by the fact that, due to the emergent nature of the field, not many people have professional experience as Medical Art Therapists to begin with. Many Art Therapists were unable to attend the in-person focus group due to a number of circumstances, which may have limited the range of experiences that could be shared within the group setting. Another limitation pertained to the survey data; the possibility of technical difficulties in attaching images of response art for Question 6, resulting in no images in the data returned. One participant offered a response for Question 7, implying response art created, but this data was excluded from the data because no image was found.

In conclusion, this research project contributes to further understanding from multiple modalities of the lived experience of Medical Art Therapy clinicians. Meanings and categories emerged across a range of professional and personal experiences united under the umbrella of "Medical Art Therapy" and also, as participants pointed out, by the shared humanity which existential themes and the humanizing element of art helped elucidate. Future research is warranted and will likely include more quantitative data, given the direction in which not only the mental health field in general but also the burgeoning field of Medical Art Therapy in particular are moving (including as shaped by the medical system's emphasis on observable quantifiable data). It would be important to contextualize increased quantitative research and

assessment within the framework of holistic treatment, considering that Medical Art Therapy tends to be person- and family-centered and is supportive of the whole person, through supporting the integration of mind, body, and spirit, while also fostering quality of life.

As this research and the insights of participants have shown, there is certainly a way to utilize the interplay of scientific understanding and Art Therapy interventions—including to demonstrate evidence of efficacy— in a way that is humanizing rather than reductive—that contributes to external understanding of why and how Art Therapy works in a holistic way, without focusing solely on symptomatology.

It should be noted that this research project expands upon past ones, discussing the implications not only for pediatric Medical Art Therapy but also for Medical Art Therapy across the lifespan. The researchers look forward to seeing how the field will continue to grow and expand.

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## Appendix A: IRB Letter of Approval and Questionnaire

Dear Professors Linesch and Metzl,

Thank you for submitting your IRB application for your protocol titled ***Medical Art Therapy: Current Practices and Future Possibilities***. All documents have been received and reviewed, and I am pleased to inform you that your study has been approved.

The effective date of your approval is **May 16, 2017 – May 15, 2018.** If you wish to continue your project beyond the effective period, you must submit a renewal application to the IRB **prior to April 1, 2018.** In addition, if there are any changes to your protocol, you are required to submit an addendum application.

For any further communication regarding your approved study, please reference your **IRB protocol number**: **LMU IRB 2017 SP 72.**

Best wishes for a successful research project.

Sincerely,

Julie Paterson

Julie Paterson I Senior Compliance Coordinator I Loyola Marymount University I 1 LMU Drive I U-Hall #1718 I Los Angeles, CA 90045 I (310) 258-5465

**LOYOLA MARYMOUNT UNIVERSITY**

**Medical Art Therapy: Current practices and future possibilities**

**IRB Application Questionnaire**

## RESEARCH BACKGROUND

Current literature supports expressive therapies as uniquely beneficial for hospitalized clients of all ages, and specifically – helpful in reducing anxiety and depression while processing related adversities from a strengths based model (Metzl, Morrell, & Field, 2016). Art therapy in medical settings, specifically, had been linked with increased wellness measures (i.e. Stuckey & Noble, 2010). Hospitals are increasingly using art therapy to enhance wellness, with an "intentional shift from art on the walls to art for healing" (Lane, 2006, p. 71).

However, more standardized, larger studies, and especially ones that compare medical art therapy interventions across different settings are needs to continue to assure effectiveness of care.

This research, intended as a step in creating a larger research plan with two different hospitals in the Los Angeles basin, will utilize a focus group methodology to explore current clinical interventions of therapists who use art therapy in medical settings or who had focused on responding to medical issues. Following the focus group, a brief survey will also be sent to participants, with the intention of learning about current medical art therapy practices and possibilities of developing relevant research.

2. SUBJECT RECRUITMENT

The researchers intends to email alumni of the MFTH / art therapy program regarding the research project and invite therapists who utilize creative expression in medical settings to respond to attend focus groups (up to 3 grps of 10 participants in each), exploring current practices and imagining new frontiers in medical art therapy application and research. Participants are also invited to respond to a follow up survey regarding lingering reflections and curiosities stimulated by the focus group.

**3. PROCEDURES**

An email sent to all alumna of the MFTH program (see appendix C), will serve as an invitation for student / alumni with relevant experience to participate in a semi-structured focus group and a brief survey which would be emailed to them (Appendix D)

The researchers, who are faculty at the department of MFT / art therapy, will collect all responses to the survey and conduct up to 3 groups of no more than 10 participants in each over the course of a month. The audio recordings will be transcribed and coded, survey data will also be coded, and all data will follow protocols of systematic analysis as qualitative data. At this point the plan is for the IPs to directly collect the material and begin to analyze it. Should we decide to include graduate students / research assistants in the analysis in the fall, we will submit a separate addendum with their NIMH certificates and they will only be engaged in the research after the IRB approves the addendum.

**4. RISKS / BENEFITS**

There are no foreseeable risks for participants, as participants are willing volunteers, discussing professional experiences and perceptions based on their work with clients.

Nevertheless, should a participant decide she / he does not want to contribute to the study – they will be reminded that they can withdraw at any time (prior to publication) with no penalty and their part of the audio / narrative or photographed art contribution, will be deleted.

In addition, to minimize chances of discomfort, researcher will make transparent the structuring questions that they would be asked to respond to during the informed consent preceding the audio-recorded focus group and answer any questions or responds to hesitations participants might have in advance.

## 5. CONFIDENTIALITY

Participation is completely voluntary and focuses on participants' professional experiences. While it is impossible to assure confidentiality in focus groups and while there is a possibility that other colleagues would identify participants due to the highly specialized nature of their positions, researchers will attempt to de-identify data as much as possible and remained participants about their right to withdraw at any time, their choice as to how they wish to be identified (by initials, first name, full name or pseudonym) and the expectation that they will not discuss other participants' experiences outside the focus group.

Visual images, which may to be part of the focus group and brief survey, are pertinent to illustrating therapy work and are inherent to the way art therapists' work and process intuitively. The artwork participants are invited to create will help illustrate how they utilize art making with their clients in medical settings.

The researchers will utilize research assistants who will not interact directly with participants at any time will help transcribe the audio-recorded discussion and photograph

the artwork, and all information will be stored in unidentifiable and coded folders on the researcher's computer to assure secure and privacy of data.

6. INFORMED CONSENT

Please see attached informed consent (Appendix B).

7. STUDENT RESEARCH

**N/A**

8. RENEWAL APPLICATIONS

**N/A**

9. PAYMENTS

**N/A**

10. PSYCHOLOGY SUBJECT POOL

**N/A**

11. QUALIFICATIONS AND TRAINING

The researchers are full time professors in the department of MFTH with a doctorate degree specializing in art therapy. In addition to our work as professors, scholars, and practitioners, the researchers have developed art therapy research in two different medical settings and hope to utilize this study as a first step in

designing those studies. The Human Subject Protection certificates are attached (Appendix F).

RANDOMIZATION

**N/A –** purposive sampling

13. USE OF DECEPTION

**N/A**

14. QUESTIONNAIRES AND SURVEYS

Please see attached survey and semi-structured interview guide (Appendix D and E, respectively).

15. PHYSICIAN INTERACTIONS

**N/A**

16. SUBJECT SAFETY

**N/A**

17. REDUNDANCY.

**N/A**

18. COUNSELING

**N/A**

19. SAFEGUARDING IDENTITY

**N/A**

20. ADVERTISEMENTS

**See Appendix C for initial email for alumni of the art therapy / MFT department.**

21. FOREIGN RESEARCH

N/A

22. EXEMPTION CATEGORIES (45 CFR 46.101(b) 1-6)

If you believe your study falls into any of the Exemption Categories listed below, please explain which category(ies) you believe it falls into and why.

Please deliver to: Julie Paterson, IRB Coordinator, University Hall, Suite 1718 or jpaterso@lmu.edu.

## Appendix B: Informed Consent

## Medical Art Therapy: Current practices and future possibilities

1) I hereby authorize Prof. Debra Linesch and Prof. Einat Metzl to include me in the following research study: Medical Art Therapy: Current practices and future possibilities
2) I have been asked to participate on a research project, which is designed to explore my professional experience with medical art therapy, my understanding of current practices and my wishes / interests in future research opportunities related to medical art therapy. The research includes a focus group dialogue, which will last for approximately 2 hours, and will be followed up with a brief electronic survey.
3) It has been explained to me that the reason for my inclusion in this project is that I am an art therapy intern / licensed professional with experience in delivering medical art therapy or has related personal experience that I deem relevant to developing medical art therapy services.
4) I understand that if I am a subject, I will participate in a focus group, in person or via video conferencing, and will then responds to a brief survey.
   These procedures have been explained to me by professors Linesch and Metzl.
5) I understand that I will be audiotaped and/or photographed in the process of these research procedures. It has been explained to me that these recordings will be used for teaching and/or research purposes only and that my identity will not be disclosed, unless I choose to be identified professionally with my statements. I have been assured that the recordings will be destroyed after this research project is completed. I understand that I have the right to review the recordings

made as part of the study to determine which parts I permit the researchers to use - in whole or in part – of my participation.

6) I understand that the study described above may involve the following risks and/or discomforts: remembering challenging experiences related to supporting medically ill individuals through art therapy and considering current limitation / barriers to this kind of work.

7) I also understand that possible benefits of the study include formulating a clearer presentation of current practices of Medical art therapy across settings in the LA basin, and that envisioning concrete research and service opportunities related to Medical art therapy might emerge from these distilled understandings.

9) I understand that professors Linesch and Metzl who can be reached at 310-338-4561 and will answer any questions I may have at any time concerning details of the procedures performed as part of this study.

10) If the study design or the use of the information is to be changed, I will be so informed and my consent re-obtained.

11) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to.

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

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

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

22) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Moffet, Ph.D.

Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 at david.moffet@lmu.edu.

23) 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 C: Email to potential participants

Medical Art Therapy Focus Group

Dear Alumni,

If you have experience working in a medical setting as an art therapist, or have other relevant experience that you would be willing to discuss with us –we need your help!

Specifically, in the interest of building on our collective experiences and developing a solid research exploring Medical Art Therapy, we want to invite you to a focus group exploring current practices and possible future research and intervention with clients in hospital settings. We will be holding a few semi-structured focus groups, followed by an individual survey that would be emailed to you.

We would like to hold focus groups on Saturday, October 28, from 9am-noon and Sunday, November 5, from 1pm-4pm. If necessary, we will have an additional focus group on Monday, October 30, from 6pm-9pm. All focus groups will be on the LMU campus in the department suite.

If you are unable to physically attend one of the focus groups but would like to participate, please let us know and we can send you a survey or create a way for you to attend the focus group remotely.

Please email Hope or Elizabeth (email addresses below) directly ASAP if you are interested in participating.

Thank you so much for considering contributing from your experiences,

The Research Team,

Hope Kinney hkinney@lion.lmu.edu

Elizabeth Mueller emuelle1@lion.lmu.edu

Debra Linesch & Einat Metzl

Dept. of Marital and Family Therapy / Specialized Training in Art Therapy

Loyola Marymount University

## Appendix D: Survey Questions

| |
|---|
| 2. Did you participate in the focus group for this research project on November 5, 2017?<br>> Yes<br>> No |
| |
| If answer to question 2 was "Yes":<br>2. A. What are some of your responses – thoughts, feelings, questions, hopes, concerns – stimulated by the focus group? |
| |
| 3. To what degree do you feel that expressive tools can help clients explore medical issues?<br>> Expressive tools are not at all a useful way to explore medical issues<br>> Expressive tools are of little use of a way to explore medical issues<br>> Expressive tools are somewhat useful way to explore medical issues<br>> Expressive tools are very useful way to explore medical issues<br>> Expressive tools are the most effective way I know to explore medical issues |
| |
| 4. If you feel that expressive therapies are of no use / little use:<br>What are some concerns or apprehensions?<br><br>4. If you feel expressive therapies are somewhat useful, very useful, or the most useful:<br>What are some ways you have integrated creative / expressive tools in your work successfully? |
| |
| 5. When and how have these expressive tools been most beneficial for clients and what were some limiting factors? |
| |
| 6. Would you be willing to share a brief non-identifying case illustration depicting the work and grant us permission to include it in publications associated with this research? If so, please create a piece of art that is inspired by one of your clients and attach it below. |
| |
| 7. If you created artwork for the previous question, please reflect below about the process and |

| |
|---|
| product. |
| |
| 8. What are your thoughts / suggestions / desires regarding future research and interventions related to Medical Art Therapy? |
| |
| 9. Demographic information – professional information (check all that apply):<br>> Licensed professional clinician (LMFT, LMHC, PsyD, LPCC, MSW, etc)<br>> Pre-licensed / intern (if so, please indicate in which specialty)<br>> Certified expressive therapist<br>> Registered Art Therapist<br>> Other relevant trainings |
| |
| Depending on the response to question 9:<br>9.A. If you selected that you are pre-licensed / intern please indicate which specialty / license you are practicing.<br><br>9.A. If you selected that you have other relevant trainings, please indicate what they are below. |
| |
| 10. Please write any additional comments here: |
| |

## Appendix E: Semi-structured questions for focus group

1. Please introduce yourself in the way you want to be identified for this study.
2. What are some of your professional experiences working with clients as an art therapist in a medical setting?
3. Can you describe how you typically explore medical issues and related issues in your therapy practice?
4. Please illustrate the process of utilizing art interventions through an art response. You might illustrate typical directives, common processes you have witnessed, creative responses of clients you have worked with or anything else that might help illuminate how you work.
5. What is your perception of systemic and developmental considerations for utilizing creative and verbal modalities in therapy? How is the use of art therapy similar or different, compatible or competing to other modalities offered in medical settings?
6. What are some challenges or apprehensions you have about exploring medical issues with clients?
7. What are some challenges or apprehensions you have about using creative / expressive tools with clients in hospitals?

# Appendix F: Human Subject Protection Certificate

**Certificate of Completion**

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Elizabeth Mueller** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 09/18/2017.

Certification Number: 2498338.

**Certificate of Completion**

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Hope Kinney** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 09/18/2017.

Certification Number: 2499080.

## Appendix G: Bill of Rights

### Loyola Marymount University: Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.

2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.

4. I will be given an explanation of any benefits to be expected from the study, if applicable.

5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.

6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.

7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.

8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.

9. I will be given a copy of the signed and dated written consent form.

10. I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.