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## Exploring Arts Based Assessments for Relevancy in Art Therapy Research

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EXPLORING ARTS BASED ASSESSMENTS

**Exploring Arts Based Assessments for Relevancy in Art Therapy Research**

By

Anjelica Cortés, Denielle Dominguez, Hayoung Lee,

Naomi Nessim, and Ciera D. Olson

A research paper presented to the  
Faculty of the Department of Marital and Family Therapy  
Loyola Marymount University

In partial fulfillment of the requirements for the degree  
Master of Arts in Marital Family Therapy  
With Specialized Training in Art Therapy

April 26, 2022

**Signature Page**

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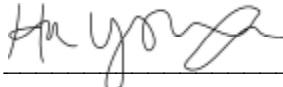
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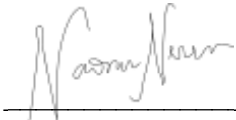
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### **Abstract**

This paper explores the integration of art assessments with cancer patients as a tool for determining potential scholarly value. Qualitative data was collected from two clinicians who ran weekly art therapy groups with women who are undergoing or who have survived breast cancer treatment. Both groups were 10 week modules structured as open studio groups, and each clinician was subsequently interviewed by the researchers who used a series of formatted questions to assess how the four art assessments were offered to participants, how participants responded to the invitation to engage in assessments, and how the clinician's reflected on patients' experiences of the assessments. The qualitative data collected was assessed to deepen the understanding of how clinician's imagined the art assessments could be clinically useful and/or potentially valuable for research. These findings were then examined and connected to findings in the literature that indicate the importance of sensitivity in regard to the unique lived experience of a cancer diagnosis, and the significance of offering control and transparency whenever possible to patients. Researchers concluded that offering art assessments in traditional context, when presented by clinicians who are attuned and considerate to the needs and impacts such assessments can have on patients, could deepen opportunities for exploring clinically efficaciousness alongside cultural and contextual sensitivity. Future research should continue to explore how clinician style can be clinically relevant and the impact art assessments could have on both research and clinical work.

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## **Introduction**

### **The Study Topic**

This study investigates the potential of arts based assessments as a tool in efficacy research, by exploring the experiences of cancer patients when provided with arts based assessments. The present study involves collaboration between patients with cancer, and the clinicians who both facilitate art therapy groups and administer the art assessments. The study intends to assess whether art assessments can deepen the clinician's, and potentially the researcher's, understanding of the participants' lived experiences with cancer. This study considers existing research conducted with cancer patients and attempts to address identified gaps in how the lived experiences of patients during treatment is understood , and the ways these experiences have historically been measured for research purposes.

### **Significance of the Study**

While there is a substantial amount of existing literature related to art therapy with people diagnosed with cancer, this study aims to take an in-depth look at the lived experience of cancer patients while receiving treatment and the ways in which this experience has been measured, specifically for research purposes. This work is informed by past research and literature that found that while some interventions were helpful for patients, formal assessment tools often failed to reflect that. The full literature review examines art therapy assessments that can be used with a wide range of cancer patients. This work may be a helpful tool for art therapists working with cancer patients in groups across different stages of treatment, but more importantly the research may also benefit the field of art therapy by examining the development and inclusion of

arts based assessments and measurements to evaluate the clinical efficacy of arts based treatment.



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

Research examining the lived experience of cancer patients indicates certain similarities in how participants experience diagnosis and treatment as well as discernable differences. The literature highlights shared experiences by patients across different stages of cancer including the importance of choice and access to information and support during treatment. The literature also indicates distinctions in how cancer patients understand, assimilate and assign meaning to their experiences with cancer, and indicates further need for the exploration of patient's unique lived experiences. The literature also reveals benefits when cancer patients are provided opportunities to tell their stories and express their narratives. Additionally, many of the studies refer to the importance of storytelling for a variety of reasons such as; making meaning of a new reality, revisiting a new sense of self, and an opportunity to address existential questions. However, there is a clear distinction between art therapy practices that help with themes such as spirituality and creativity, but lack strong correlations in the treatment of emotional distress and psychological states. Therefore, the literature reveals a need for further research in measuring the efficacy in relation to specific symptoms (emotional distress, anxiety, etc.).

Research and literature have regularly focused on quality of life as a measure to illustrate the psychosocial experience of cancer patients, in attempts to measure well-being and functioning.

Publications suggest that these tests are used throughout institutions, although researchers and clinicians struggle to operationally define their use or what they aim to measure. Literature also focuses on cultural understandings when assessing the psychosocial experiences among cancer patients was also examined. The literature indicates how consideration for cultural and

spiritual beliefs and socio-economic status are critically important and lead to more informed assessment and treatment for patients.

Additionally the literature examines the history and efficacy of art therapy assessments, the virtues of formal art assessments versus creative art interventions, and the utilization of art therapy assessments with cancer patients. The literature highlights how psychoanalysis and projective assessments historically influenced the formal art therapy assessments currently used for treatment and how formal art therapy assessments were encouraged to reflect validity and reliability, while maintaining the standardization of the assessments. The literature indicates overall how formal art assessments focus on the objectivity of gathering data and measurement, but lack the accuracy of the participant's subjective description of their art work. The literature also highlights the use of interventions in conjunction with standardized psychological tests to measure efficacy more prominent in art interventions with cancer patients.

Based on these understandings, this study includes the clinicians in the process of offering art therapy assessments as potential measurements of the efficacy of art therapy treatment for patients experiencing a cancer diagnosis.

## **Literature Review**

### **Introduction**

In this review of the literature, we utilize a sequence of sections to explore material that informs the research question. The first two sections explore current literature on the lived experiences of patients and individuals diagnosed with cancer, discussing studies that have focused on both understanding the psychosocial experiences of cancer patients, and the experiences people diagnosed with cancer have had with mental health treatment or interventions. The review then moves on to the third section which reviews literature concerned with historical positioning of Quality of Life measures, the theoretical understandings of how psychosocial experiences of cancer are assessed, and assesses the efficacy of psychosocial services. A final section investigates the practice of measuring and assessing efficacy in art therapy, including available material discussing the use of arts therapy assessments with cancer patients.

### **Experiences of Cancer Patients**

#### ***Lived Experience of Diagnosis and Medical Treatment***

This section explores current literature focused on the lived experiences of patients and individuals diagnosed with breast cancer. Included in this section are research studies specific to medical and psychosocial factors that inform how breast cancer in particular is experienced.

Ferlay et al. (2015) suggest that breast cancer is among the most common cancers globally and the most frequently occurring cancer for women. Commonly expressed on a numerical scale of 0-IV and determined by the cancer's characteristics, breast cancer consists of multiple stages affecting prognosis, treatment, and outcomes (Breastcancer.org, 2018). A review

of the literature indicates that breast cancer can have a range of psychosocial impacts on individuals, influencing how they experience both diagnosis and treatment.

According to DeSanto et al. (2021) the most common symptoms affecting breast cancer patients include “depression, anxiety, fatigue and pain,” which can present additional challenges for patients already coping with physical side effects from treatments and interventions (p. 19). In a long-term follow-up study of women diagnosed with primary breast cancer, Björneklett et al. (2012) similarly found that many women suffer from symptoms such as anxiety, fatigue, and depression, that can negatively impact their health-related quality of life for several years following diagnosis and treatment. Arora et al. (2007) emphasizes that while advances in screening and treatment for breast cancer have increased survival rates, a breast cancer diagnosis still results in significant emotional distress and trauma. Uncertainty about the future and loss of control impact the wellbeing of patients and their adjustment to illness as they seek ways to cope following diagnosis. Similarly, Williams and Jeanetta (2014) indicate how changes in the body during cancer treatment and side effects from medical interventions can be distressing and negatively affect coping and self-esteem in patients. Their findings emphasize how managing frequent fear and concerns related to side effects of treatment and possible recurrence are an important part of the “diagnosis, treatment, and recovery process” (pp. 635-639).

Smit et al. (2019) illuminates the existential nature of a cancer diagnosis and how individuals enduring a threat to their existence may experience angst and uncertainty about their purpose in life and possibility of death, while Guité-Verret and Vachon (2021) emphasize the existential distress and questions accompanying a cancer diagnosis and the pervasive effect a diagnosis can have on all aspects of a patient’s life. Guité-Verret and Vachon (2021) also identify how cancer can impact patients’ relationships with others, including loved ones. In a randomized

control trial of breast cancer survivors, Tabrizi et al. (2016) illuminate similar findings that show in addition to impacting physical and psychological functioning, a breast cancer diagnosis also impacts social and interpersonal relationships. The impact of treatment on lifestyle and self-image may also impact social interaction and disrupt engagement in social activities. This could potentially lead to greater isolation or loneliness in patients who are already navigating the complex aspects of living with a diagnosis.

However, not all aspects of breast cancer are perceived or experienced as negative by patients. A grounded theory study by Horgan et al. 2010 found that breast cancer participants across four stages of diagnoses experienced several positive changes while living with illness at different times. Amongst these were changes in priorities, increased empathy, and increased self-confidence, which emerged differently depending on whether patients were reflecting on suffering or illness management. However, the researchers also acknowledge some limitations in their study and its potential lack of applicability to breast cancer patients experiencing “significant levels of distress” (p. 1123). Smit et al., 2019 assert a need for researchers to study positive aspects of breast cancer, noting how people can experience “positive changes following trauma or illness” (Brunet et al., 2013; Hefferon et al., 2009; Stanton et al., 2006; Tedeschi and Calhoun, 2004, as cited in Smit et al., 2019, p. 241). Their findings revealed that changes in self-image amongst women who were post treatment were frequently positive and related to personal development and growth.

### ***Themes of Support***

The literature indicates that support from social and healthcare networks has a significant impact on the lived experiences of cancer patients. In a phenomenological study examining experiences of supports during pretreatment for breast cancer patients, Dickerson et al., 2011

indicate distress as a common finding amongst women experiencing breast cancer and identify how a lack of social support from providers and loved ones may occur, despite good intentions. They illuminate how unhelpful interactions with support networks can negatively impact patients and emphasize the importance of supportive interventions during the pretreatment phase, particularly for coping and adapting to circumstances throughout the cancer trajectory. While experiences and meanings of support may vary by individual, Dickerson et al. (2011) suggests that healthcare providers can significantly influence how patient's experience support during pretreatment. Mayer and Grober (2006) also highlight how healthcare providers, particularly when treating women with advanced breast cancer, have opportunities to provide support in addition to medical care and may be positioned to improve psychosocial adjustment for patients following diagnosis. Their research indicates the adaptive benefit of strong social supports from various social and community sources throughout the course of illness and the difference in coping and wellbeing that cancer patients may experience. Tabrizi et al. (2016) similarly indicate the adaptive and protective benefits of social support for reducing distress in cancer patients and found social support from groups correlated with decreased feelings of social isolation amongst breast cancer survivors.

Williams and Jeanetta (2014) identify "relationship and support system" as a major theme of importance affecting the lived experiences of cancer survivors during diagnosis, treatment and after recovery (p. 634). They highlight support as a critical component of physical and mental health throughout treatment, particularly from family as well as friends and work colleagues. Their findings emphasize how post treatment, breast cancer survivors can feel abandoned and in need of continued support during their transition, particularly as they manage ongoing fears. Williams and Jeanetta (2014) suggest further need for additional research to deepen the

understanding of how to effectively support patients in the transition period after treatment when they are more likely to feel a reduction or drop in social support. Arora et al. (2007) emphasize how different members within a patient's social network may inhabit different roles in helping patients cope and manage throughout their cancer experience. Their findings indicate that the social support needs of patients may evolve over time, and how family and friends more often assist in emotion focused coping while healthcare providers offer information support and problem-solving coping, although they also highlight how a gradual reduction in support can still occur following the diagnosis period. Arora et al. (2007) suggest that interventions addressing the evolving support-based needs of cancer patients can benefit both patients and their social networks. Taken altogether, Arora et al. (2007) and Williams and Jeanetta (2014) highlight the necessity for a deeper understanding and response to cancer patients and survivors' need for support from social and healthcare networks as they seek ways to adapt and cope throughout their cancer trajectory.

### *Considerations Across Stages*

The literature points to shared changes experienced by individuals in different stages of breast cancer such as the need to access and assimilate information about the trajectory of the disease and the importance of patient participation in decision making. For example, Williams and Jeanetta (2015) found that knowledge of breast cancer risks was an essential component in the process of decision making amongst survivors in the recovery process as it assisted them in feeling empowered, especially while navigating decision making during treatment and recovery. Halkett et al. (2007) indicate similar findings amongst women diagnosed with early breast cancer who face decisions about the trajectory of treatment while processing the implications differing medical interventions may have on their survival. Their research asserts the importance of

additional decisions women will make following diagnoses including decisions about themselves, their interpersonal relationships, and the effects these decisions may have on their overall experience of cancer. Lilliehorn et al. (2010) also identify access to information as targeted psychosocial needs for newly diagnosed breast cancer patients treated with radiation and connect these findings to patients' sense of security, while Meyer and Grober (2006) highlight the role of information in advanced breast cancer diagnoses and how access to information is an adaptive way for patients to maintain a sense of control in coping with advanced disease (Lilliehorn et al. 2010; Mayer and Grober, 2006, p.15).

The literature also highlights discernable differences in how individuals experience stage specific diagnoses and manage their everyday lives, especially amongst patients with advanced stage and metastatic breast cancer diagnoses. Guité-Verret and Vachon (2021) found that existential questions related to meaning and uncertainty about death were experienced differently by metastatic breast cancer patients than patients in earlier stages of cancer or facing the potential of remission, while research by Lewis et al. (2016) noted the range of "negative physical, social, and emotional health impacts" associated with advanced and MBC diagnoses (p. 1168). Emotional distress, fear about the cancer's progression, as well as end of life uncertainties may heavily affect patients and compound the feelings of social isolation found to accompany advanced diagnoses. According to Vilhauer (2011) treatment for advanced stage or MBC may prolong life, but the side effects can be debilitating and create further stress for individuals already experiencing advanced symptoms. Similarly, Mayer and Grober (2006) found that advanced breast cancer patients face challenging and painful emotions in the face of ongoing treatment and declining health. They point to the emotional distress that is connected to the presentation of advanced symptoms and how this distress appears heightened in severity



immediately following advanced diagnosis and the terminal phase of illness. Mayer and Grober (2006) also emphasize the roles that support, information and resources have in the lives of women living with advanced breast cancer and how limitations regarding access and consideration have historically prevented these needs from being met in comparison to women with early and less advanced stages of breast cancer (pp. 1-6). Ultimately, advanced cancer diagnoses have been reported to have various distinct psychosocial implications on quality of life and the experiences and needs of individuals with these diagnoses may differ in comparison to earlier stage diagnoses.

### *Understanding Unique Experiences*

While current literature exploring the experiences of breast cancer amongst patients and individuals is available, targeted research concerning how the lived experiences of breast cancer are perceived, understood, and assimilated by patients appears slim. Lewis et al. (2016) address some of these considerations through a qualitative study consisting of structured interviews with metastatic patients that explores their “views, perceptions, and experiences,” in order to better understand the meaning patients assign to these experiences (p. 1169). Their findings indicate a greater need to acknowledge the contextual factors that shape their unique experiences with cancer, even amongst patients who share the same diagnosis. Similarly, in a thematic synthesis of the literature, García-Rueda et al. (2016) found that while there may be common features of the cancer experience shared amongst patients and understood by providers, living with diagnosis is “a unique process for each person” involving both negative and positive aspects. Their research emphasizes the importance of helping patients feel the different aspects of their experiences are understood, and how this deeper understanding may lead to targeted care strategies and informed provider relationships that center patient empowerment and agency (Kitson, Marshall, Bassett, &

Zeitz, 2013; Endo et al., 2000, as cited in García-Rueda et al, 2016, p. 552). Smit et al. (2019) also suggest a lack of research concerning how breast cancer is experienced and attempt to bridge this gap through a review and meta-synthesis focused on women's lived experiences and narratives across the breast cancer trajectory. Their data synthesizes patient experiences ranging from the onset of concerns and symptoms to advanced progression and recurrence. Ultimately Smit et al. (2019) indicate core themes and considerations across different stages and provide an empirical framework for future research that incorporates women's breast cancer narratives that center around their unique processes and perspectives.

Overall, the literature points to a greater need to explore breast cancer patients' unique lived experiences and acknowledge the contextual factors that shape, inform and influence how they make sense of and attribute meaning to their experiences. By centering these considerations providers may be in a better position to understand patients and in turn patients may feel increased empowerment as they navigate and make sense of their experiences.

### **Mental Health Interventions with Cancer Patients**

This section examines literature focused on the mental health and treatment of people diagnosed with cancer including general and targeted art therapy interventions.

#### ***Meaning Making in Mental Health Treatment***

A common thread through much of the literature appears to be the need for patients to find ways to make meaning out of their life through and beyond their cancer diagnosis. In a qualitative study, La Cour et al. (2016) references the meaning-making element of stories by describing the intersection with Ricoeur's (1984) theory of narrative employment. La Cour et al., (2016) explains how linking events, actors, motives, and desires are useful for understanding the processes of meaning-making" (p. 464). Additionally, when applying this consideration to the

mental health of cancer patients, the challenge of finding a sense of self is one that appears often in the literature. Radl et al. (2018) highlights the importance of the relationship between the patient and the therapist, a relationship that, when coupled with the act of creative expression and storytelling, has the ability to move patients towards a more positive sense of self.

A cancer diagnosis affects many aspects of the patient's quality of life. Concerns for the future are frequently accompanied by fear of a cancer recurrence and worry about how this diagnosis will affect the family and this new reality may bring up existential distress for the patient. All of these factors can present themselves as a search for meaning (Guité-Verret & Vachon, 2021). Martino and Freda (2016) and Guité-Verret and Vachon (2021) illuminate how the act of telling stories can assist the patient in finding meaning surrounding their health. The creation of narratives serve to help the patient find their place within their new reality, while also allowing them to share their feelings about how cancer has changed their "personal life story."

### ***A Brief History of Mental Health Treatment of Cancer Patients***

This literature examines the incorporation of mental health treatment for cancer patients. Grassi et al. (2000) and Gregurek et al. (2010) agree that the examination of psychosocial needs associated with a cancer diagnosis have only recently been studied. There is a need to address the psychological well-being that involves the management and processing of loss, and ways to address depression and anxiety associated with a cancer diagnosis. These domains of care include the patient's self-perception, their social and economic needs, family support, and their spiritual needs regarding meaning-making. Recent findings by Gregurek et al. (2010) have accelerated the development of international guidelines for oncologists to increase awareness and to be able to identify mental health distress and suicidality. However, it is important to note that

not all oncologists are equally equipped to identify distress in their cancer patients (Gregurek et al., 2010).

### ***Different Disciplines and Mental health Treatment of Cancer***

This section looks at the different disciplines that play a role in the mental health care of patients receiving treatment for cancer. While cancer patients interact primarily with oncologists, other healthcare professionals can offer a wide range of support systems. Newton et al. (2020) mentions the importance of incorporating various support services which typically consist of oncologists, nurses, social workers, general practitioners, and psychologists; these formal relationships with healthcare professionals can ensure that the social, emotional, and physical needs of the patient are being met. Kristiansen et al. (2010) emphasize how the increasing number of people who are living longer with cancer suggests that long-term support may be necessary. Kristiansen et al. (2010) further describes the help that nurses can provide to patients in relation to coping with feelings and emotions that a cancer diagnosis may bring up. The interaction of offering empathy is an important one for all medical caregivers. The role of establishing the necessary emotional support for cancer patients often requires a team of providers (Kristiansen et al., 2010). In regards to oncologists, Granek et al. (2018) specifically points out:

The manner regarding how oncologists respond to mental health distress, when they do identify it, shows that out of 450 oncologists 47% reported that they initiated a referral for psychosocial services while 48% reported making both a referral and starting the patient on psychiatric medications such as an antidepressant. (p. 1735)

Gregurek et al. (2010) suggest how psychiatrists often take on a dual role when working with cancer patients including helping the patient throughout their diagnosis until the end of

treatment, as well as collaboration with the medical team. Current literature and clinical studies show that about a third to a half of cancer patients have different psychiatric/psychological comorbid disorders (Gregurek et al., 2010).

***General Psychosocial Treatment and Cancer / Interventions with The Creative Process***

This section highlights the incorporation of psycho-social treatment offered to cancer patients. A common need that may arise in the process of any diagnosis is the desire to live normally, while also facing the closer proximity of death (García-Rueda et al., 2016).

García-Rueda et al. (2016) support this claim by defining normalcy as the desire and need to adjust to the new reality that the disease brings and to live as similar as possible to life pre-illness. The literature regarding the effects of psychosocial interventions offered specifically to cancer patients illuminates some common themes. These include but are not limited to emotional, social, and spiritual wellbeing (Radl et al., 2018).

The use of psychosocial treatment has expanded to incorporate various domains such as expressive writing interventions and residential rehabilitation retreats. Both examples aim to support patients in managing the challenges that accompany a cancer diagnosis. They also incorporate steps to help patients reinterpret the illness and aid in improving their quality of life while living with cancer (La Cour et al., 2016; Gripsrud et al., 2016). In a narrative review, Fann et al. (2008) examine how psychosocial interventions have had inconsistent findings as related to a patient's emotional state, while Williams and Dale (2006) found psychosocial interventions useful in responding to depressive symptoms in cancer patients. Nevertheless, the use of various therapeutic domains may be helpful in reaching cancer patients through different approaches.

### *Art therapy and Mental Health Treatment for Cancer*

This section examines how the various modalities of psychotherapy, specifically art therapy, emphasize the expressive capability of clients to creatively reflect their lived reality through the art process. In the various literature related to art therapy, cancer patients are guided, through art, to examine their life while also addressing their diagnosis (MN et al., 2020; Reilly et al., 2021). Additionally, Radl et al. (2018) states that this form of creative expression allows patients the opportunity to gain post-traumatic growth and a restoration of any existential beliefs that may help improve their quality of life. Several studies that explain the methods and objectives of art therapy, describe the nature of expressing emotions non verbally and creatively (Forzoni et al., 2010; Radl et al., 2018; Sabo et al., 2016). This form of self-expression, because it is not dependent on a verbal explanation, allows patients to move deeper into the unexpressed parts of their experience (Reilly et al., 2021, p. 246). The movement back and forth between artistic expression and words is referenced as a means of supporting cancer patients on a path of self discovery. Forzoni et al. (2010) further supports this point by stating that the movement from artistic expression to a self-narrative is a dyadic relationship that facilitates the therapeutic process.

In two systematic reviews, Wood et al. (2011) and Puetz et al. (2013) demonstrate how the use of art can assist patients in coping with and decreasing anxiety, addressing fear, depression, and pain. Conversely, Radl et al. (2018) found no statistical differences in emotional distress and psychological state of being between participants in the art therapy group and the control group. The findings did, however, indicate an increase in the spirituality and creativity connected to making meaning, which in turn contributed to a stronger sense of self. Forzoni et al. (2010) and Reilly et al. (2021) support the importance that creative meaning-making provides

for patients responding to a disruptive event, such as the cancer diagnosis. Taken together, the literature indicates that treatment approaches that emphasize how individuals living with various stages of cancer perceive their experiences can position patients, providers, and researchers to develop greater person-centered approaches to treatment and supportive care services.

The specifics related to art interventions were shared in some of the literature, although not all. Art directives consist of a variety of means to address topics related to emotional expression, quality of life, creative flow, and self-discovery (Reilly et al., 2021; Radl et al., 2018; MN et al., 2020; Puig et al., 2006). Puig et al. (2016) and Radl et al. (2018) indicate how some art directives are done individually between therapist and client, while Reilly et al. (2021) emphasize an open studio method in a group setting. Contrary to the individual intervention, the open studio method does not apply firm time constraints to the artistic process and allows participants to work at their own pace, alongside other participants, not solely with an art therapist (p. 248). Additionally Puetz et al. (2013) convey how some intervention practices incorporate a combination of both individual and group settings. The use of directives such as magazine collaging, creating Self-Books, or structured and freeform drawings are a few examples of how art therapy attempts to help patients make meaning of their current life experience. Overall the literature related to art interventions conveys the importance that the art experience can offer to patients dealing with a cancer diagnosis.

### **History of Quality of Life and Psychosocial Measures**

This section explores the origin of the study of Quality of Life measures, provides an overview of the debate among researchers and health care providers in how to define such a measure, and explores how it is utilized in cancer treatment. According to Post (2014), the term “Quality of life” originates back to 1948, when the World Health Organization defined health as

a “state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity (p. 167). Post references the 1966 *The Annals of Internal Medicine* where the following was stated: “what every physician wants for every one of his patients old or young, is not just the absence of death but life with a vibrant quality that we associate with a vigorous youth. This is nothing less than a humanistic biology that is concerned, not with material mechanisms alone, but with the wholeness of human life, with the spiritual quality of life that is unique to man. Just what constitutes this quality of life for a particular patient and the therapeutic pathway to it often is extremely difficult to judge and must lie with the consciousness of the physician” (p. 168). Between these statements, there is an emerging definition in which the scope of “health” is broadened, and the level of subjectivity is highlighted. In other words, for as long as the medical field has pondered health at large, there has been a desire to capture and define what a quality or *wholeness* in life really means, and how to measure it.

The first QOL measure was called Spitzer’s QL-Index, which was predicated on the idea that many variables constitute health. According to Post (2014), this measure was designed to be administered by physicians, and looked at variables including physical, social, emotional, attitudes towards illness, personal interactional patterns, and even the cost of illness (p. 168). Over time, there was an additional push to consider more than the disease’s impact and morbidity, but to also consider how people evaluate their own wellbeing and function in everyday life. Tate (2002) explains that by the mid 1980s, “health-related quality of life” (HRQOL) became a more common topic and researched entity, with some arguing that adding the prefix of “health related” was an attempt to conform to the biomedical model and derive legitimacy (p. s18). Conversely, researchers such as Fuhrer (2000) argue that QOL needs to be



further distinguished from health, and instead understand it as something specific to a patient's lived experience, highlighting the importance of capturing subjective experiences of individuals.

Since its introduction in the mid 20th century, QOL has been a common topic of research and practice. However, according to a study conducted by Gill and Feinstein (1994), cited by Post (2014), of the 75 papers reviewed that had “Quality of Life” in the title, only 15% of articles conceptually define the term (p. 170). Post (2014) advises researchers to strive for clarity when operationally or conceptually defining Quality of Life, and to separate the philosophical study of its meaning from the actual measures used.

### *Can quality of life be defined?*

Quality of Life is a multidimensional concept that has been utilized to understand elements of life and often employed in medical settings to understand the socioemotional aspects of a health care experience. Health Related Quality of Life (HR-QOL) has evolved the scope of QOL to include other health-affecting determinants of life. According to the CDC, the HRQOL includes perceptions of physical and mental health and can be expanded to the community and utilized to help health agencies to address a wider circle of health partners, including social service agencies, community planners, and business groups.

Barofsky (2012) addresses the fact that researchers have regularly questioned whether quality of life can in fact be measured. Barofsky explores the disconnect between the researchers questioning quality of life and those assessing it, and postulates that quality of life is actually a distinct “pattern of thinking” constructed out of many different cognitive-linguistic traditions and qualitative assessments (p. 625). Barofsky highlights the fact that among researchers who study quality of life, there is a felt frustration. For example, Ferrans (2005) notes the “bewildering array of characterizations” that encompass quality of life in the literature, acknowledging the

way the term sprawls across health status, symptoms, psychosocial adjustment, well-being, happiness, and more (p. 14). According to Barofsky (2012), Angus Campbell (1916), one of the original quality of life researchers in the early 1900s, has described the concept as vague and ethereal, “with many people talking about it but few knowing what to do about it” (p. 626). According to Rapley (2004), much of this concern about quality-of-life definitions derives from the term being used so liberally as to become nondescript and inconsistent. Barofsky (2011) conceptualizes this as a “problem of definition” explaining that there are varying measurement approaches, content-based definitional approaches, and cognitive-linguistic issues that must be understood to resolve this problem. The concept of quality of life is inherently abstract, vague, and ethereal, but research points to a need for it to be further studied and concretized as to increase applicability and usefulness.

### *Quality of Life Measures*

HRQOL is an important measure when considering an individual’s experience with a cancer diagnosis, experience, and treatment. Additionally, HRQOL is used by the US Food and Drug Administration when considering the approval of new anticancer medication (FDA). The combination of standardized and self-administered measures is also leveraged to manage and adjust individual treatment in real time, focus the development of new therapies, and to document the quality of cancer care at large.

Much of the literature evaluated the use of various measurement tools that assess quality of life (QoL). Svensk et al. (2009) discuss the increasing importance of QoL when examining treatment outcomes in cancer research seeing as cancer and its treatment introduce stressors that directly affect QoL.

### *Other Common Psychosocial Measures used in Cancer Care*

The literature demonstrates that researchers also frequently select tools of measurement for other physical and mental symptoms that are particularly common among cancer patients. This section examines the assessment tools utilized to assess psychosocial measures of cancer, alongside or instead of QoL measures. In assessing quality of life, psychological disorders, and general psychosocial well-being, many different measures are used in clinical settings. In a study by Grassi et al. (2005), The Diagnostic Criteria for Psychosomatic Research (DCPR) is compared with the DSM-IV and the Brief Symptom Inventory (BSI) to ascertain which tool is the most useful in identifying psychological needs of patients with cancer. This study identifies that 71.2% of patients with cancer have psychosocial comorbidities, whereas when the DSM-IV was used in isolation, only 44.5% presented symptoms of psychosocial comorbidities (Grassi et al, 2015, p. 104). The researchers suggest that DCPR was more useful in psychological conditions, but that more specific constructs are necessary to assess the symptoms of cancer patients. Jiang et al. (2020) conducted a systematic review of 12 studies exploring the effects of art therapy in cancer care and identified QoL and symptoms of fatigue, anxiety, and depression as the main indicators measured when assessing efficacy. Studies not included in Jiang et al.'s (2020) review also follow this trend: for example, Bar-Sela et al. (2007) assesses efficacy of art interventions using the Hospital Anxiety and Depression Scale (HADS) and the Brief Fatigue Inventory (BFI).

Wasteson et al (2009) conducted a systematic literature review designed to identify assessment and classification methods of depression among palliative cancer patients, identifying that The Hospital Anxiety Depression Scale (HADS) was the most frequently used assessment tool (p. 239). Payne et al (1999) illustrates other frequently used assessment tools, including the

Edmonton Symptom Assessment Scale (ESAS), the European Organization for Research and Treatment of Cancer Quality of Life questionnaire, and the Beck Depression Inventory. HADS is a self-report scale that measures the cognitive symptoms of depression and anxiety (not somatic symptoms) (p. 65). The BSI consists of 53 items across 9 psychiatric symptoms, including somatization, obsessive compulsive ideation, depression, and anxiety (p. 66). Of note, 65 assessment tools were only used once, further emphasizing the magnitude of tools that have been created that are not broadly utilized (p. 66).

### ***Patient Reported Measures***

The Patient Reported Outcomes Measurement Information System® (PROMIS) conceptual model is often used to allow patients to self-report their state of health and measures the impact of psychological illness. According to Rothrock et al (2021) this instrument is very common and can be adapted for various illnesses and populations. In order for these measures to be used most effectively, they are sometimes administered regularly, for example in each Chemo visit, in order to track changes over time. Williams et al. (2013) emphasize the importance of including patient input in the development of PRO measures and the relevance of patient input early in instrument development. They also emphasize the importance of making sure that the information that the patients see as most important is included in understandable terms. Williams et al. (2013) further explore the reliability of the PRO instrument known as the The M. D. Anderson Symptom Inventory (MDASI) for assessing cancer symptom burden, and report that the use of an open-ended, and in-depth interview can be used to incorporate patients' input into PRO symptom measure development.

### ***Cancer-Specific Measures***

In the literature examined, standardized measurement tools frequently have specific relevance to the cancer population being studied. Radl et al. (2018) select some of their tools, including the Perceived Emotional Distress Inventory and the National Cancer Care Network Distress Thermometer and Problem List, in part because they were developed for use with cancer patients in order to assess for emotional distress and mood disturbance. Even when the measures are not designed to be cancer-specific, researchers consider their well-documented use with relevant populations.

### ***Validity and Reliability of Measures***

In much of the literature, when the researchers list their chosen measurement tools, they make a point to state whether the instruments have demonstrated validity and reliability. For example, Radl et al. (2018) and Czamanski-Cohen et al. (2019) identify reliability and validity as key rationale for their chosen standardized measurement tools. Similarly, Svensk et al. (2009) note the meticulous nature of reliability and validity testing done with WHOQOL instruments. This theme is present across the literature, indicating the importance of choosing standardized measurement tools that will bolster the accuracy of study results. Despite all these common measures, research suggests that perhaps many important elements of the psychosocial cancer experience is not fully captured by the measures. As such, according to Caruso and Breitbart (2019), psychiatric disorders affect 30-35% of cancer patients during disease trajectory (Caruso et al, 2019, p. 1). These “disorders” do not include the many other psychosocial, existential, and spiritual distress that are also common among patients with cancer. Interestingly, Geue et al. (2018) found that one third of cancer survivors continue to experience psychosocial

consequences. Psychosocial issues including various mood disorders, trauma, somatic-symptom, neurocognitive, and sexual disorders are found to be quite common.

As indicated in the above section, when assessing the psychosocial experience of patients in a hospital setting, including those with cancer, there are many different measures used and motives for their use. In the research and study of these measures, there is considerable attention paid to the “subjective” nature of them and supporting discourse on reflecting this subjectivity and *lived experience* in measurable ways.

### **Culture and Psychosocial Assessment with Cancer Patients**

This section explores current literature on how cultural experiences are evaluated when assessing psychosocial experiences among cancer patients with specific emphasis on spirituality, differing knowledge about cancer prevention, and treatment across ethnic and socioeconomic status (SES) backgrounds, Frick et al. (2006) discuss a phase-I study that was conducted to test the practicality and utility of brief clinical interviews for the assessment of cancer patients’ spiritual needs and preferences. They highlight how physicians assessed the spirituality of their patients using the semi-structured interview SPIR, a brief interview that focuses on the meaning and effect of spirituality in the patient’s life and coping system. Frick et al (2006) shared that Visual Analogue Scales (VAS) and Questionnaires were done upon completion of the clinical interview to rate whether SPIR had been helpful and evaluate to what extent spirituality seemed important in the patient’s life and in coping with cancer. The results of the study suggest that a short clinical assessment of cancer patients’ spirituality is well received by both patients and physicians, suggesting that the SPIR interview may be a helpful tool for addressing the spiritual domain, planning referrals and ultimately strengthening the patient–physician relationship (Frick et al, 2006, p. 242). However, assessments of spiritual

needs are not equally available across patient populations. Astrow et al. (2018) used the Spiritual Needs Assessment for Patients (SNAP) to measure spiritual needs in cancer patients. According to Astrow et al. (2018), this assessment is a validated questionnaire consisting of 23 items and was administered in four languages.

In examining the relevance and impact of socioeconomic status (SES) in relation to cancer patients' experiences, Wilkinson et al. (2009) discuss how differing knowledge about cancer prevention and treatment across ethnic and socioeconomic status (SES) backgrounds can directly impact individuals' decisions to engage in preventive healthcare. In their study they explore the relationship between sociodemographic-based differences in cancer knowledge and individuals' personal health philosophies. Wilkinson et al. (2009) also examined differences in the accuracy of cancer knowledge based on health philosophies and found there were unadjusted differences in cancer knowledge observed by gender, age, ethnicity, household income, educational attainment, and smoking status. Their research further emphasizes the need to develop health education programs that enhance cancer knowledge among individuals of low SES, and that help to foster protective health beliefs. In further literature, Hunter (2005) discusses the connection between cervical cancer and underdeveloped countries and states, "cervical cancer is a significant public health concern in poor regions globally. More than 80% of the 231,000 annual deaths occur in underdeveloped countries, disproportionately affecting the world's poorest, most vulnerable women (pp. 322-323)." Hunter (2005) expands further by addressing this as a local issue in addition to a global one. While cervical cancer is of significant concern in underdeveloped countries, it is also a concern in the United States, "particularly in immigrant populations, within which the prevalence of screening is low" (Hunter, 2005, p. 323).

Hunter (2005) proposes this as likely related to lack of resources, adequate infrastructure and issues with quality control (p. 327).

Taken together, the literature in this section suggests consideration for cultural and spiritual beliefs and SES to be critically important in the treatment of patients and in the assessment of their psychosocial experiences.

### **Historic Development of Art Therapy Assessments**

This section reviews the history of art therapy assessments, the efficacy of art therapy assessments, the virtues of formal art assessments in comparison to creative art interventions, and the utilization of art therapy assessments with cancer patients. Art assessments are interchangeably referred to as art directives, tools, and interventions throughout this section.

The foundational history of psychology has influenced art therapy's history, impacting the development of art assessments. A brief review of 20th century psychology history and theory aids to illuminate the role of art therapy assessments. Gantt (2004) reviews how psychology stemmed from Freudian personality theory in the 1940s and 1950s when projective tests were first developed, and assumed a larger role in the 1960s influencing behavioral theory while personality traits were being simultaneously studied by therapists throughout the same time period as the creation of the Rorschach and the Thematic Apperception Test (TAT) (Gantt, 2004, p. 21). Penzes et al. (2014) highlight Buck's House Tree Person (HTP), a projective personality test created in 1948 and a psychoanalytic theory initially emphasized by art therapy pioneer Margaret Naumburg in the 1950s that led to the perspective of 'art *in* therapy' (Penzes et al., 2014, p. 484). Additionally, Tripp (2019) elaborates that while the style of early psychoanalytic therapists was to offer a one-sided interpretation and maintain clinical distance



from their clients, therapists have presently become more relational and art therapy has shifted from an interpretative to a collaborative experience between clients and therapists.

Penzes et al. (2014) identifies the purpose of an art assessment as a tool to gather information on the client's mental health by assessing strengths, weaknesses, and client's functioning (Penzes et al., p. 484). Oster & Crone (2004) list the multiple interventions created by the various pioneers of art therapy: Elinor Ulman and Gladys Agell's "Ulman Personality Assessment", Hanna Kwiatowska's "Family Therapy and Evaluation through Art", Barry Cohen's "Diagnostic Drawing Series (DDS)", Rawley Silver's "Drawing series", and Myra Levick's "The Levick Emotional and Cognitive Art Therapy Assessment" (LECATA) (Penzes et al., 2014). Gilroy et al. (2012) explores how the development of art directives by art therapists differ from projective tests in regard to how the art directives are facilitated and the process of the scoring system.

### **Efficacy of Formal and Informal Art Therapy Assessments**

#### ***Formal Art Therapy Assessment***

Formal art therapy assessments are considered established standardized tools that have been utilized for research and have data to reflect efficacy, reliability, and validity (Gantt, 2004). According to Betts (2006), art assessments are used to provide methods of measuring client's level of functioning, understanding client's strengths and presenting problems, guiding treatment formulation, and creating opportunities to observe client's progress throughout treatment. The effectiveness of art therapy assessments used in research comprises a common topic that highlights different formal art assessments and interventions and provides insight into the efficacy of these assessments, as explored in articles by Betts (2006), Betts and Deaver (2019), and Darewych, Newton, and Farrugie (2018). Darewych et al. (2018) examines the efficacy of

the Scribble Drawing, Bridge Drawing with Path (BDP), and Future Trip Drawings to evaluate imagination and symbolic development in adults with medium to high functioning autism spectrum disorder. Their findings show that through written and verbal discussions with the participants, art assessments are effective methods to measure imagination and symbolic development.

Betts and Deaver (2019) express the value in establishing content validity using the Formal Elements Art Therapy Scale (FEATS) by combining observational data and verbal participant data for optimal results. Using established assessments for research also contributes to understanding the validity and reliability of the art assessments. Betts (2016) also considers the most effective use of the formal assessments: Person Picking an Apple from a Tree (PPAT), DDS, along with scaling systems such as FEATS would work best with incorporating subjective approaches as well. The article goes on to explore the combined usage of objective scoring and assessment tools to provide standardized methods during research. The article also includes a subjective approach by interviewing the participants about their artwork. This approach of using formal art assessments and integrating interviews seems to be a necessary perspective included in finding efficacy of art assessments of results in research (Betts, 2016).

### ***Comparison of Informal versus Formal Assessments***

The use of projective drawings for assessments appears to have changed over time, with much of the literature pointing to criticisms of projective drawings. According to Gantt (2011), projective drawing tests such as “HTP, Draw-a-Person Test (DAP), and Kinetic Family Drawing (KFD) are mentioned in research to have general issues such as:

Lack of standardized administration of the drawing tasks, numerous and conflicting scoring systems, almost exclusive reliance on personality theory, poor test-retest

reliability, unacceptable interrater reliability, and lack of research results demonstrated the validity of the tests. (p. 20)

There are many considerations when choosing certain assessments or interventions in order to ensure research is done scientifically and objectively, while also yielding results that inform funding and treatment. Informal assessments also reflect general difficulties for art therapy assessments such as them being widely used for other research because of the specificity towards a certain population or research method in addition to a “lack of consensus” as to how much information should be covered through an assessment (p.19). Tripp (2019) explores the importance of the participant’s underlying meaning and thoughts behind their artwork, and to follow the participant’s lead in how much information they enclose instead of interpreting their artwork to gather a more holistic outcome. The efficacy of the art assessment in Savazzi et al. (2020) implements a newly designed art intervention called Art, Colors, and Emotions treatment (ACE-t) with individuals with Alzheimer’s disease. A control group is compared with the experimental group using ACE-t to search for the efficacy which results in an increase of quality of life and improvement of behavioral symptoms. Gantt (2011) encourages the creation of informal assessments to support the need for a specific population, but highlights how it requires an effort to standardize and prove validity which will be an ongoing process for art therapists to support through research.

### **Art Interventions with Cancer Patients**

Literature on the singular utilization of art assessments as a scoring measurement with cancer patients appears to be lacking, while literature implementing art interventions and standardized psychological tests conjointly to measure efficacy appears more prominent. For example, Geue et al. (2013) conducted a study on one art intervention for cancer patients in the

ambulant aftercare, consisting of 22 sessions that focused on participants creating a book to express their thoughts and/or experiences. This particular art intervention was implemented as a therapeutic tool and various standardized psychological tests were also included, such as the Hospital Anxiety Scale (HADS), Freiburg Questionnaire on Coping with Illness (FCQI), and Perceived Adjustment to Chronic Illness Scale (PACIS). Radl et al. (2017) review the efficacy of Self-Book, an art therapy intervention implemented to facilitate newly diagnosed breast cancer patients with creating a visual book. Similarly, in order to gauge efficacy, the Distress Thermometer, Perceived Emotional Distress Inventory, Patient-Reported Outcomes Measurement Information System Brief Psychological Well-being test, and the Functional Assessment of Chronic Illness Therapy Spiritual Well-being were implemented.

Bar-Sela et al. (2007) research the efficacy of an art intervention consisting of the creation of three watercolor drawings to express emotions and create movement through the usage of the watercolor medium. As a result of this study, depression and fatigue symptoms were shown to have reduced after the art therapy sessions while there was no significant improvement for anxiety by using HADS and the Brief Fatigue Inventory (BFI) to score after every session. In a meta-analysis of gathering current art therapy research involving cancer patients, Jiang et al. (2020) reveals the benefits in reducing symptoms of anxiety, depression, and fatigue. The study mentions that there is also a positive impact on quality of life. Most studies include the use of standardized measurement tools to measure efficacy of art assessments within research (Jiang et al., 2020; Colette et al., 2021; Geue et al., 2013; Bar-Sela et al., 2007).

This section reflects how literature on the topic of art interventions utilized standardized measurement tools to find efficacy of art therapy interventions when working with cancer patients.

**Conclusion**

In this literature review, the lived experience of cancer, the lived experience of treatment including art therapy, the ways that psychosocial experience of cancer patients has been assessed historically, and non-art therapy and art therapy assessments in research are examined. Taken altogether the ideas emerging from the critical review of the literature support the development of arts based assessments and measurements that take into consideration the lived experiences of cancer patients across the cancer trajectory.

### **Research Approach**

This research project uses qualitative research and in-depth interviews in order to better understand the potential for accurate evaluation of cancer patients' lived experience through using art-based assessments. Although the research is not formally phenomenological or hermeneutic, ideas from both theoretical understandings inform the process. Generally speaking, qualitative research allows for ongoing questioning and investigation, and what Agee (2009) describes is an integral part of understanding the "unfolding lives and perspectives of others" (Agee, 2009, p. 432). Additionally, Leavy (2017) explains how qualitative ontological approaches value and elevate multiple diverse experiences and perspectives on a single topic.

It has been argued that objectivity is challenging when observing human experience, and that the lived experiences and backgrounds of researchers are reflected in the interpretations (Betts & Deaver, 2019, p. 91). Hermeneutic phenomenology infuses the interpreter's experience into the understanding of what is being interpreted, and is leveraged in the present study to explore the lived experience of participants with cancer when clinicians offer art therapy assessments. This "hermeneutic circle" as described by Davis (2010), describes the "iterative and interactive relationship between the clients and the researcher's interpretation of their worldview" (Betts & Deaver, 2019, p. 91).

Data is collected via long form interviews with the clinicians who are offering and facilitating the art based assessments, and who will be dialoguing with the participants about their experiences. Interviews are semi-structured and conversational in nature. Finlay and Evans' (2009), as cited in Betts & Deaver 2019, emphasize the importance of ethics and strong core values when conducting relational research with individual participants. To ensure respect for diversity, maintenance of dignity, and scholarly ethics, the established research relationship between

participants and researchers ought to be one of mutuality and openness (Betts & Deaver, 2019, p. 106). When developing the questions, great consideration must also be made about how the questions will affect participants and clinicians' lives. "Developing qualitative research questions should include careful thought about how the direction of the inquiry will position the researcher in relation to participants and what the implications are for the participants' lives" (Agee, 2009, p. 441).

## Methods

### Definition of Terms

**Art Assessment:** According to Betts (2006), art assessments are used to provide methods of measuring client's level of functioning, understand client's strengths and presenting problems, guide treatment formulation, and create an opportunity to observe client's progress throughout treatment.

**Assessment:** Per Oxford Languages, assessment is defined as the evaluation or estimation of the nature, quality, or ability of someone or something.

**Bird's Nest Drawing (BND):** Per Betts & Deaver (2019), clients should be provided with a set of ten Crayola fine-line markers and an 8" x 12" piece of white paper and directed to "draw a picture of a bird's nest." Clients should be given 15 minutes to complete the drawing and, after that, asked to write a story about the drawing in at least 3-5 sentences" (Betts & Deaver, 2019, p. 172).

**Diagnostic Drawing Series (DDS):** Per Betts & Deaver (2019), the DDS is a three-picture series in which the respondent produces a range of psychological and graphic responses. The drawings are the free picture, the tree-picture, and the feelings picture. Materials must include a 12-color pack Alphacolor or Blick chalk pastels and white (60 or 70 lb.) drawing paper sized 18 x 24 inches (Betts & Deaver , 2019, p. 172).



**Evaluation:** Per the American Evaluation Association (2020), evaluation involves assessing the strengths and weaknesses of programs, policies, personnel, products, and organizations to improve their effectiveness.

**Health Related Quality of Life (HRQoL):** Per the CDC (2018), HRQoL “on the individual level, HRQOL includes physical and mental health perceptions (e.g., energy level, mood) and their correlates—including health risks and conditions, functional status, social support, and socioeconomic status” (para 5).

**Open Studio:** Per Finkel, D., & Bat Or, M. (2020), open studios allows group members to “work at their own pace, regulate their interactions with other participants according to their abilities, and use the group and the space according to their needs.”

**Qualitative Methods:** Per the CDC (2010), qualitative methods are research methods that generate “descriptive information” and “add depth, detail, and meaning” to research (“Determine How the Information Will Be Gathered” section).

**Quantitative Methods:** Per the CDC (2010), quantitative methods are those research methods that produce “numerical data such as frequencies, percentages or rates” and have traditionally been preferred as a means to establish efficacy (“Determine How the Information Will Be Gathered” section).

**Quality of Life (QoL):** Per the CDC (2018), “QoL is a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life” (para 3).

**Lived Experience:** Per Given (2008), “lived experience, as it is explored and understood in qualitative research, is a representation and understanding of a researcher or research subject's human experiences, choices, and options and how those factors influence one's perception of knowledge” (Given, 2008, p. 13).

**Past, Present, and Future Directive:** An art directive designed by an LMFT/ATR-BC clinician to create a symbol to represent when participants were first diagnosed, where they are now, and how they picture the future.

**Person Picking an Apple from a Tree (PPAT):** Per Betts & Deaver (2019), the directive for the PPAT is to “Draw a person picking an apple from a tree.” The materials for PPAT administration include 12” x 18” white drawing paper and a set of “Mr. Sketch” watercolor markers should be used. There is no established time limit on completing the drawing. PPAT drawings are scored with the Formal Elements of Art Therapy Scale (FEATS) rating system (Betts & Deaver, 2019, p. 172).

**Program Evaluation:** Per Rossi (2004), program evaluation is the use of scientific methods to evaluate a program’s design, implementation, improvement, and outcomes (Rossi, 2004).

### **Design of Study**

The study yields the data through the use of in-depth interviews with two licensed Marriage and Family Therapists / Registered Art Therapists who facilitate weekly Art Therapy groups at Cedars-Sinai Medical Cancer Center. Sampling and the gathering of data is discussed in depth below.

## **Sampling**

In this study, researchers work with two clinicians who are licensed Marriage and Family Therapists and registered Art Therapists. Clinicians facilitate art therapy groups through Helen B. Landgarten Clinic at Cedar Sinai Medical Cancer Center. One group is primarily focused on art making in a group setting for the purposes of providing a space for art as therapy, allowing participants a safe space to express themselves and have open discussion with other individuals with similar life experiences. The second group is oriented around both art making and processing of the art. Groups are offered weekly for a ten-week period of time. Participants consist of adult cancer patients who have been diagnosed with different stages and types of cancer. The design of this study is qualitative and includes in-depth interviews. Researchers and clinicians explore potential art based assessments to evaluate their potential efficacy in treatment and in research.

## **Gathering of Data**

For this project, the art based assessments that are proposed during the art therapy groups include: Person Picking an Apple from a Tree (PPAT), Diagnostic Drawing Series (DDS), “Bird’s Nest”, “Past, Present, and Future” (an art directive designed by an LMFT/ATR-BC clinician to create a symbol to represent when participants were first diagnosed, where they are now, and how they picture the future). Four of the researchers have volunteered to observe and participate in studio groups run by the two clinicians in the study, while the fifth researcher has ongoing experience working with cancer patients in a hospital setting this year. The researchers use their experiences to help inform the direction of the literature review and the emerging

questions for the interview, as well as to inform their approach with the clinicians and considerations for the clinical population. As preliminary preparation for data gathering, the researcher and two clinicians engage in the arts-based assessments together as a group to better inform their investigation and questions. The questions are proposed as a structural framework to allow researchers to maintain flexibility and adjust the questions as needed throughout the interview process. Two in-depth interviews with clinicians review the questions and emergent findings to deepen the understanding of how the art assessments were utilized within the groups. The researchers invite the clinicians to create artwork that reflects their thoughts and experiences during the interview and conversation regarding the assessments.

A series of 9 questions offer a framework to guide the interviews between the researchers and clinicians:

1. Can you take a moment to tell us more about how the group is run?
2. How did participants respond to the assessment?
  - a. Did you observe participants more interested in some assessments than others?
3. Were you able to use the assessments in a way that helped you reach your clinical goals and/or clinical intentions for the group?
  - a. Is it your sense that the art assessments were able to encompass and encapsulate the lived experience of patients in an effective and meaningful way?
  - b. Does what was revealed align with the sense you have gathered thus far about the patient's experience?
4. Did you notice any themes emerge from the assessments
  - a. Probe— story telling, nature, use of symbolism?

5. Did you notice that art assessments helped patients engage in the art process
  - a. Clarification: how did you notice that the art assessments were helpful to patients?  
Did it help them engage? Connect?
  - b. Probe: How did being virtual impact this?
6. What was your experience using the art assessments as a clinician?
  - a. Probe: did you feel the relationship you already have with the participants impacted how you felt in offering it? Do you feel the existing relationship changed the way participants engaged with them?
7. Were these assessments sensitive to cultural and socioeconomic experiences of these patients?
  - a. Did/do these assessments have the capacity to cross different cultures?
  - b. What could have been included in the assessment process that would have made them more accessible?
8. Have you continued to adapt/modify the assessments to meet the needs of different cultures, backgrounds, and stages of disease?
9. Can you imagine how the assessments could be helpful in future research?

### **Analysis of Data**

Qualitative data collected by researchers includes transcripts from the in-depth interviews with clinicians, recordings of these interviews, and notes taken during interviews. Researchers identify, cluster, and discuss themes from the interviews to find what was meaningful or useful for participants. Researchers each individually read over notes while listening to transcripts, as to ensure each researcher is offering an unbiased and distinct voice when assessing themes. During

this process, researchers identify the language used in transcripts and the nonverbal processes observed during interviews. After conducting this process individually, researchers together analyze transcripts and notes taken during focus groups to distill key themes, highlight differences among participants, and understand the general reactions participants had surrounding assessments. The analysis is additionally informed by the researchers experiences and recollections participating and observing patients and clinicians engaged in the open studio process.

## Results

### Presentation of Data

The data collected for this research project was gathered from two interviews with clinicians who run weekly art therapy groups with women who are undergoing or who have survived breast cancer treatment. These 10 week modules were organized by Cedar Sinai Medical Center for and structured as “open groups” with optional attendance, such that participants were welcomed to come for any portion of each group meeting throughout the 10 weeks. Within both groups, a total of 7 participants engaged in the PPAT, 2 participants engaged in the Past, Present and Future assessment, and 5 participants engaged in the Bird’s Nest. No participants opted to engage in the Diagnostic Drawing Series.

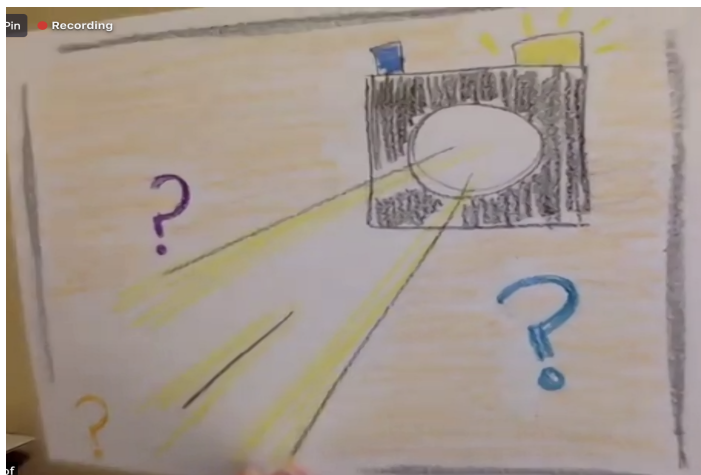
Each clinician was interviewed separately by the researchers and asked a series of questions about how they offered the four assessments to participants, how participants responded to the invitation to engage in assessments, how they reflected on patients’ experiences of the assessments, and offered thoughts on how they imagined the assessments could be clinically useful and/or potentially valuable for research (to measure efficacy of art therapy interventions). Each clinician was invited to create a piece of art to reflect on their process at the end of the interview. The conversations and themes surrounding the artwork are discussed in research findings.

The qualitative data derived from these interviews and the art were recorded and transcribed, and is presented below in table 1. For the purpose of continuity the researchers asked the clinicians the same series of open ended questions. Researchers offered additional clarification or follow-up questions to ensure that each question was answered over the course of

the interview. Due to the conversational nature of the questions, researchers remained flexible about the order of the questions to allow space for conversation to unfold and for questions to be explored organically.

### ***Module 1 Interview:***

For the first module of the interview, Nicole Imhof was invited to join researchers for a 1-hour zoom interview, including 9 questions and 10 minutes to engage in response art. Nicole appeared engaged and was open to sharing verbal responses to questions and art making. Prior to conducting this interview, Nicole was sent a form to document her consent to being interviewed. Nicole was asked a series of nine questions presented below in Table 1. Figure 1 below shows Nicole's art response.



**Figure 1.**

### ***Module 2 Interview:***

Researchers decided to keep the format and directive the same to ensure consistency from



group to group. Prior to the second module interview, Jillian Luz was provided a form to obtain consent and then engaged in a similarly structured 1-hour zoom interview with researchers.

Jillian appeared engaged and eager to share her experiences and insights.

Jillian was asked a series of nine questions as seen in Table 1. Figure 2 below shows Jillian's art response.



**Figure 2.**

**Table 1**

Question	Purpose	Jillian Interview	Nicole Interview
<p>1. Can you take a moment to tell us more about how the group is run?</p>	<ul style="list-style-type: none"> <li>● Identify group structure</li> <li>● Identify clinician style</li> </ul>	<ul style="list-style-type: none"> <li>● She offered assessments to open studio group, and *maybe* closed studio group (couldn't remember for sure)</li> <li>● Open studio group— 2-4x per month for last few months, 2 hours each, drop in and out, casual, via zoom</li> <li>● Participants invited to make whatever they wanted to unless they were offered assessments</li> <li>● Will occasionally ask a question—such as: what makes you most relaxed...how will you care for yourself over holidays... what's your favorite way to unwind</li> <li>● “I was pretty candid with what they are and why we are doing it. Purely to see if it is interesting to you. Not evaluating the content. It was fine, it was good, I was curious to see what they would do with it.”</li> <li>○ “Some of them were like ‘yeah no i don't want to do that’ which is fine”</li> </ul>	<ul style="list-style-type: none"> <li>● Up to four participants, sometimes 1 or 2. Usually 2 per session</li> <li>● Format is they come in and once were ready to start we do a check in for the week (how things have been going, anything they want to share), some sort of mindfulness/self compassion/guided imagery to help regroup and prepare for art making, art making (in this process nicole will sometimes have a directive, an assessment or two, and then an option to do whatever they want “whatever is on their heart” or whatever they need”. Try to give ~45 min to create and then option to share art at the end, closing ritual.</li> <li>● Considerations of having had Cancer:             <ul style="list-style-type: none"> <li>a. Emotional poking and prodding— and we don't want to poke and prod for no reason.</li> <li>b. My experience impacts doing the assessments and my treatment</li> <li>c. Art is very beneficial in my treatment and journey but I need to take care of myself so I'm not overly triggered in groups.</li> <li>d. Assessments— trying to be purposeful and respecting them as a human and not</li> </ul> </li> </ul>

			just a patient
<p>2. How did participants respond to the assessments?</p>	<ul style="list-style-type: none"> <li>● Explore how assessments were offered</li> <li>● Understand how participants reacted to invitation to engage with assessments</li> </ul>	<ul style="list-style-type: none"> <li>● “Pretty well”</li> <li>● 5 people for birds nest                         <ul style="list-style-type: none"> <li>a. “Idk, it kind of has a cozy quality. A lot of participants are older females, it's winter time, I gave it in the middle of jan, kind of hunkering down, maybe it's seasonal?...something about it with an inherent narrative they are drawn to.”</li> <li>b. One woman had a coffee mug with a bird nest on it</li> </ul> </li> <li>● 5 people for PPAT                         <ul style="list-style-type: none"> <li>a. Somebody “loved it” and created a narrative and story they shared, one person “sort of liked it” and didn’t elaborate</li> </ul> </li> <li>● 0 people did DDS</li> <li>● 2 people in past present future                         <ul style="list-style-type: none"> <li>a. Jillian attributes this to “where they were at that day” and “what was happening in their lives.” A helpful launching pad for some, but for others they are self sufficient and don't really need to.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● First Nicole offered it and explained the purpose of it and the research. History of written assessments from last year was provided</li> <li>● Two participants were there who said they were “Eventually open to trying” but their first responses were “well what is it? What's the process? What do I have to do?” She said “you draw, i share and report what that experience was like.”</li> <li>● They ended up not trying it that session (PPAT) but the following week, 3 were offered and 2 tried PPAT</li> <li>● Participants wanted to understand results, meaning of what they made                         <ul style="list-style-type: none"> <li>a. what it “means”...”if i do this...what am i communicating”</li> </ul> </li> <li>● “when you mention an assessment there comes concern of ‘do i really want to do this and share this because i’m not sure what’s going to come out in it””</li> <li>● Nicole speculates: cancer patients have a lot of physical tests done on them, this is a bit of an emotional vulnerability test</li> <li>●</li> </ul>
<p>3. Were you able to use the assessments in a way that helped you</p>	<ul style="list-style-type: none"> <li>● Understand whether clinicians</li> </ul>	<ul style="list-style-type: none"> <li>● I wasn't analyzing the content of assessment to discern any info but yeah, to help them engage, let go of other life</li> </ul>	<ul style="list-style-type: none"> <li>● “That was trickier for me— when I see them as assessments, it's hard to make a clinical connection. There was some</li> </ul>

<p>reach your clinical goals and/or clinical intentions for the group?</p>	<p>found assessments useful for clinical goals</p> <ul style="list-style-type: none"> <li>● Understand whether clinicians believed assessments mirrored their understandings of participants lived experiences and contributions to group thus far</li> </ul>	<p>responsibilities, and focus on the creative process mindfully. Felt helpful.</p>	<p>hesitation for me to put them out there because i wanted them to be clinically appropriate and I wanted to get information for you all”</p> <ul style="list-style-type: none"> <li>● Even when the clients did it, they didn’t really have a connection to it.</li> <li>● It was never “oh this means something to me” but more “you’re saying to do this so i’m going to try it.” I don’t think they were able to find meaning in doing it, at least from what they expressed.</li> <li>● Themes in Cancer (lived experience):             <ol style="list-style-type: none"> <li>a. How people respond when they find out you have cancer— who steps closer and further</li> <li>b. Some participants currently in treatment, but all have regular dr visits— when life feels “typical” between treatments and then you’re brought back to reality...even as treatment is “done,” its not</li> <li>c. Difficulties with treatment—how it impacts body, some would discuss and validate each others experience even when not the same</li> <li>d. A lot of joy and happiness—especially with larger groups— they’d have fun</li> <li>e. Themes of recurrence —</li> </ol> </li> </ul>
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			<p>underlying — people would reflect on how much fear of recurrence they had prior ot group but fear had gone down with groups</p> <p>f. Advocating for self needs and treatment—empowering self</p>
<p>4. Did you notice any themes emerge from the assessments</p>	<ul style="list-style-type: none"> <li>● Explore how participants responded to particular assessments</li> </ul>	<ul style="list-style-type: none"> <li>● Birds nest— noticed big, full, protective nests. Really protective of eggs</li> <li>● Therapeutic rapport existed in groups— they are comfortable with each other.</li> <li>● PPAT             <ul style="list-style-type: none"> <li>a. One person's PPAT had tons and tons of apples and person was very small</li> </ul> </li> <li>● Past present future             <ul style="list-style-type: none"> <li>a. Seemed to elicit a lot of emotion, maybe more than they were expecting. I was surprised they had done it because they were going through some medical stuff at the time. A lot of emotion and had become tearful for first time (sees them 2x a month since september)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Two people did a bird's nest— nature was something they could connect to. Nature often comes up as a way people find self care</li> <li>● One person did PPAT and called it “apple tree” and it didn’t have a person in it and she used a scribble drawing from a warm up</li> <li>● Offered the “cancer one” and really worked on trusting the strength in my clients— that they had that and could handle it— to one patient. She’s already doing something to visually tell her story so she decided not to do it.</li> <li>● One person said “I've never drawn a nest before” so that was something new to try. “I didn't know I could draw it.”</li> <li>● No major feelings came up or seemed to be attached to assessments</li> </ul>
<p>5. Did you notice that art assessments helped patients engage in the art process</p>	<ul style="list-style-type: none"> <li>● Understand extent to which assessments enabled</li> </ul>	<ul style="list-style-type: none"> <li>● “Many of them are no longer in treatment. Some are processing experiences from years ago and some are processing current treatment and in</li> </ul>	<ul style="list-style-type: none"> <li>● Its hard to know because we presented them as “assessments” whereas our usual directives connect to what were talking about or themes about cancer...theres a</li> </ul>

	<p>engagement with art process, reflection, or sharing</p> <ul style="list-style-type: none"> <li>● Explore whether art assessments stimulated thought or provocative movement in groups.</li> </ul>	<p>stage 4”</p> <ul style="list-style-type: none"> <li>● In setting it felt not much on lived experience could be explored.</li> <li>● Virtual: Do they feel safer because they’re home?</li> <li>● Can be difficult when they want to show the art, if it has fine detail or light colors, or textures</li> <li>● They don’t know what other people are working on...could they be influenced if they saw other people?</li> <li>● People may choose certain assessments based on how they are feeling that day “depending on what was happening in their lives at the moment”</li> <li>● Assessments were a “launching pad” for some clients</li> </ul>	<p>purpose to why im doing them, im not just pulling them out of a hat. Purpose here was “to get information for you all.” “I wonder if it would have meant something different to them if they didnt know it was an assessment and just thought it was a directive.”</p> <ul style="list-style-type: none"> <li>● They've had more emotional connections to things, maybe not always communicable with words, than with assessment</li> <li>● Being virtual: for clinician yes because gauging client needs, for participants no.</li> </ul>
<p>6. What was your experience using the art assessments as a clinician?</p>	<ul style="list-style-type: none"> <li>● Understand how clinicians viewed assessments in helping or hindering relationship with participants</li> </ul>	<ul style="list-style-type: none"> <li>● I was pretty candid with what they are and why we are doing it. Purely to see if it is interesting to you. Not evaluating the content. It was fine, it was good, I was curious to see what they would do with it.</li> <li>● Some of them were like “yeah no i don't want to do that” which is fine</li> <li>● Probe: did you feel the relationship you already have with the participants impacted how you felt in offering it? Do you feel the existing relationship</li> </ul>	<ul style="list-style-type: none"> <li>● It's been hard to know when it is clinically appropriate to offer during a group. I can see it being done pre or post to assess change or.... But it was hard for me to tie it into the group and the themes that came up in the group. They may have felt my hesitation of “oh is this clinically appropriate right now             <ul style="list-style-type: none"> <li>a. “It was hard to make the clinical connection, I think, and so there were some hesitation for me, and, you know, sharing them, or like putting them out there, because I</li> </ul> </li> </ul>

		<p>changed the way participants engaged with them?</p> <ul style="list-style-type: none"> <li>○ Transparency in general when clinically appropriate is important to me as a clinician</li> <li>○ Don't like hiding things from clients</li> <li>○ Not a rorschach, not a “what do you see”</li> <li>○ Agency was important— it wasn't like they had to do it, as would maybe be the case with a psych assessment. People may be more apt to take option when there is no pressure to or nothing to be lost **</li> </ul>	<p>wanted it to be clinically appropriate”</p> <ul style="list-style-type: none"> <li>● Didn't want to put pressure on me or the clients but also wanted to get you guys research material. I don't usually have something that i have to do for the groups, we don't have a curriculum or anything like tha</li> <li>● “It didn't feel a clinical connection in I mean I think there always is when you do art in general But they weren't able to find meaning in it in doing it at least what they expressed in which 2 assessments did they choose to do so?.”</li> <li>● “The bird's nest drawing was the the most popular that 2 of the participants did that.And yeah, they, the people that did that one. They liked it because it had like nature, and that that was really something they could connect to. So that piece they liked”</li> <li>● “Actually nature is a theme that comes up in the groups, just because that's a way that people find self-care and like taking care of themselves going out in nature. So that one I think you know it had a nature theme, so that was I think why they were drawn to it, or that's what they said.”</li> <li>● Probe: did you feel the relationship you already have with the participants</li> </ul>
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			<p>impacted how you felt in offering it?-- yes in the sense that i knew what themes were coming up and what was going on for them...which made it harder for me to see if something was clinically appropriate...which would be different for sure if i was an outsider coming in...</p>
<p>7. Were these assessments sensitive to cultural and socioeconomic experiences of these patients?</p>	<ul style="list-style-type: none"> <li>● Identify cultural considerations and opportunities for further competencies</li> </ul>	<ul style="list-style-type: none"> <li>● What could have been included in the assessment process that would have made them more accessible?</li> <li>● “I don't know if i'm the right person to say whether something is culturally appropriate, as a white female” “i didn't hear anything come up that they were not supportive” “i didn't hear anything that made me think it was culturally sensitive and inappropriate but i'm not sure im the best judge”</li> </ul>	<ul style="list-style-type: none"> <li>● I feel like they are... they felt okay...most would know what a bird's nest is...PPAT okay and culturally informed... cancer one i think so as well... DDS i didnt do- i felt like i was running out of time but it was the last one i was going to try with the group but bc there are so many stages i felt it was harder to monitor and sometimes with too much information things can get jumbled— there's chemo brain...even with PPAT, when she did that, she just called it the apple tree and went on her own way of what she understood it to mean at that point in time **             <ul style="list-style-type: none"> <li>a. Nice to have things clear and concise, considering the treatments and exhaustion of cancer</li> </ul> </li> <li>● What could have been included in the assessment process that would have made them more accessible?</li> </ul>
<p>8. Have you continued</p>	<ul style="list-style-type: none"> <li>● Understand</li> </ul>	<ul style="list-style-type: none"> <li>● As a white female identifying person</li> </ul>	<ul style="list-style-type: none"> <li>● Knowing what's going on for them, i did</li> </ul>



<p>to adapt/modify the assessments to meet the needs of different cultures, backgrounds, and stages of disease?</p>	<p>how clinicians offer adaptations</p>	<p>who has not had cancer is my culture...Nicole had fears about the one I developed being emotionally evocative and she had fears around whether it was an emotionally safe assessment.</p> <ul style="list-style-type: none"> <li>● If there is an opportunity for me to offer these assessments again through this research, bc idk if i would without this research component, i may experiment a bit more with how i present them— perhaps the more emotionally evocative ones later in our time together...</li> <li>● I know she has her own countertransference....so that's another consideration...should a clinician offer.</li> </ul>	<p>have a little more hesitation of “is this going to work, is this going to fit”</p> <ul style="list-style-type: none"> <li>● Having clear and concise directions— like for the DDS, maybe one panel not 3.</li> <li>● The cancer journey one...depending on knowing that somebody is stage 4, talking about “what do you see for the future” is hard bc the future isn’t necessarily so big, a day can be big, it's all relative **</li> </ul> <p>a. Re: exploring @ diagnosis: I don’t think many people understand the whole “ you can use lines, shapes, colors to describe that, you don’t need pics” ...i don't think people get that. t</p> <p>b. I think a bridge drawing could help— could touch on cancer journey without hitting on it directly. Our groups are about people who had cancer but it's about people's lives, cancer isn't the only thing in people's lives and we want to help them realize that. Something that could touch ON the cancer journey without saying that “your whole life is about cancer”</p> <p>c.</p>
<p>9. Can you imagine how the assessments</p>	<ul style="list-style-type: none"> <li>● Probe potential clinical utility</li> </ul>	<ul style="list-style-type: none"> <li>● Could be helpful as a pre and post</li> <li>● Could be helpful for grant money</li> </ul>	<ul style="list-style-type: none"> <li>● I think they could be helpful with pre and post— when I think of bird's nest I think</li> </ul>

<p>could be helpful in future research?</p>	<ul style="list-style-type: none"> <li>● Deepen understanding of research process</li> </ul>	<ul style="list-style-type: none"> <li>● Assessments can be adapted and used in this pre/post capacity</li> <li>● Could be used individual settings to introduce art</li> <li>● Could be used in closed group settings to kind of analyze content and evaluate own art more. Valuable clinical tool to client and clinician</li> </ul>	<p>of attachments and relationships— I'd be interested in seeing any shift or change as they've connected with other participants. Some group participants do know each other from other groups but most dont...some old, some young, some higher SES, some lower. I think it'd be neat to see if the relationships they form shift their birds' nests—it's still a season in their lives they've felt seen and heard and connected to people with similar experiences in some way or another.</p> <ul style="list-style-type: none"> <li>● PPAT is about resources if i'm not mistaken.... If I remember correctly, that'd also be interesting to see a pre and post— to see if they developed more resources or see if there's a shift or not.</li> <li>● We practice coping skills and strategies (like drawing) each week...they are building connections. Wondering if that would shift</li> <li>● Individual pre and post would be beneficial bc you could dig into meaning a little more without making them even more vulnerable in group.             <ul style="list-style-type: none"> <li>○ “Oh that's what that means, uh oh!” “oh shit i just showed everybody this?!”...”if its an individual session i think some participants would be interested</li> </ul> </li> </ul>
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			<p>in that and maybe not have those concerns”</p> <ul style="list-style-type: none"><li>○ *note currently they do not meet individually before or after</li></ul>
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## **Analysis of Data**

### ***Qualitative Analysis***

The present research consisted of two clinicians and because of this small sample size, researchers began analysis by taking detailed notes during both interviews and engaging in dialogue around themes that were emerging immediately after each group, respectively. After establishing a cursory understanding of each clinician's experience and the ways in which their experiences seemed to relate and differ, researchers engaged in a second and more detailed analysis of the interviews. Researchers independently revisited the recorded Zoom interviews, transcripts, and interview notes by question, to gain a more nuanced view of how the clinicians answered each question during the interview process. This step of the analysis resulted in the creation of table 2, shown below, that included notes from the interviews in which researchers examined commonalities, differences, and observations gathered from both clinicians. After the table was organized by question and populated with data from the interviews, researchers collaborated together as a group to identify key themes that emerged from the content and language. Researchers then reexamined each clinician's art response including their verbal explanations about their process and imagery to better inform the researcher's understanding of clinicians' experience facilitating groups and offering assessments. Anecdotes from the art making process are embedded in the themes that emerged. Finally, after identifying and clustering core themes from interviews, art, and analysis process, researchers condensed themes down to the five that become the organizing substructure of the analysis. Throughout the analysis process, researchers remained informed by their experiences of clinically observing and/or

working with cancer patients and applied their deepened understanding gained from these experiences to help categorize the emergent themes.

**Table 2**

Questions	Jillian Interview	Nicole Interview	Themes (observations, commonalities, differences)
<ul style="list-style-type: none"> <li>• Can you take a moment to tell us more about how the group is run?</li> </ul>	<ul style="list-style-type: none"> <li>• She offered assessments to open studio group, and *maybe* closed studio group (couldn't remember for sure)</li> <li>• Open studio group— 2-4x per month for last few months, 2 hours each, drop in and out, casual, via zoom</li> <li>• Participants invited to make whatever they wanted to unless they were offered assessments</li> <li>• Will occasionally ask a question—such as: what makes you most relaxed...how will you care for yourself over holidays... what's your favorite way to unwind</li> <li>• I was pretty candid with what they are and why we are doing it. Purely to see if it is interesting to you. Not evaluating the content. It was fine, it was good, I was curious to see what they</li> </ul>	<ul style="list-style-type: none"> <li>• Up to four participants, sometimes 1 or 2. Usually 2 per session</li> <li>• Format is they come in and once were ready to start we do a check in for the week (how things have been going, anything they want to share), some sort of mindfulness/self compassion/guided imagery to help regroup and prepare for art making, art making (in this process nicole will sometimes have a directive, an assessment or two, and then an option to do whatever they want “whatever is on their heart” or whatever they need”. Try to give ~45 min to create and then option to share art at the end, closing ritual.</li> <li>• Considerations of having had Cancer:             <ul style="list-style-type: none"> <li>a. Emotional poking and prodding— and we don't want to poke and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Open structure:</b> both Nicole and Jillian offer “open groups.” It seems most people come at the beginning and experience some level of structure. Nicole begins with guided imagery and an invitation to make art about “what is on your heart” or “in your mind” with an invitation to share at the end. Jillian will occasionally offer a prompt to guide art making. Both clinicians were offering assessments</li> <li>• <b>Clinician differences in style and experience:</b> Nicole as a survivor of cancer and mindful not to “poke and prod for no reason” and to “respect them as humans not just patients.”             <ul style="list-style-type: none"> <li>a. Could reference art here</li> <li>b. Could reference professional background and personal experiences</li> </ul> </li> <li>• <b>Importance of transparency and choice</b></li> </ul>

	<p>would do with it.</p> <ul style="list-style-type: none"> <li>○ Some of them were like “yeah no i don't want to do that” which is fine</li> </ul>	<p>prod for no reason.</p> <ul style="list-style-type: none"> <li>b. My experience impacts doing the assessments and my treatment</li> <li>c. Art is very beneficial in my treatment and journey but I need to take care of myself so I'm not overly triggered in groups.</li> <li>d. Assessments— trying to be purposeful and respecting them as a human and not just a patient</li> </ul>	<ul style="list-style-type: none"> <li>a. Jillian: I was pretty candid with what they are and why we are doing it. Purely to see if it is interesting to you. Not evaluating the content. It was fine, it was good, I was curious to see what they would do with it.</li> <li>b. Nicole: Two participants were there who said they were “Eventually open to trying” but their first responses were “well what is it? What's the process? What do I have to do?” She said “you draw, i share and report what that experience was like.”</li> </ul>
<p>2. How did participants respond to the assessments?</p>	<ul style="list-style-type: none"> <li>● “Pretty well”</li> <li>● 5 people for birds nest             <ul style="list-style-type: none"> <li>a. “Idk, it kind of has a cozy quality. A lot of participants are older females, it's winter time, I gave it in the middle of jan, kind of hunkering down, maybe it's seasonal?...something about it with an</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● First Nicole offered it and explained the purpose of it and the research. History of written assessments from last year was provided</li> <li>● Two participants were there who said they were “Eventually open to trying” but their first responses were “well what is it? What's the process? What do I have to do?” She said “you draw, i</li> </ul>	<ul style="list-style-type: none"> <li>● <b>Importance of transparency and choice</b></li> <li>● Apprehensiveness about the idea of an “assessment” and vulnerability when engaging in them.             <ul style="list-style-type: none"> <li>○ “when you mention an assessment there comes concern of ‘do i really want to do this and share this because i'm not sure what’s going to come out</li> </ul> </li> </ul>

	<p>inherent narrative they are drawn to.”</p> <p>b. One woman had a coffee mug with a bird nest on it</p> <ul style="list-style-type: none"> <li>● 5 people for PPAT             <ul style="list-style-type: none"> <li>a. Somebody “loved it” and created a narrative and story they shared, one person “sort of liked it” and didn’t elaborate</li> </ul> </li> <li>● 0 people did DDS</li> <li>● 2 people in past present future             <ul style="list-style-type: none"> <li>a. Jillian attributes this to “where they were at that day” and “what was happening in their lives.” A helpful launching pad for some, but for others they are self sufficient and don't really need to.</li> </ul> </li> </ul>	<p>share and report what that experience was like.”</p> <ul style="list-style-type: none"> <li>● They ended up not trying it that session (PPAT) but the following week, 3 were offered and 2 tried PPAT</li> <li>● Participants wanted to understand results, meaning of what they made             <ul style="list-style-type: none"> <li>a. what it “means”...”if i do this...what am i communicating”</li> </ul> </li> <li>● “when you mention an assessment there comes concern of ‘do i really want to do this and share this because i'm not sure what’s going to come out in it””</li> <li>● Nicole speculates: cancer patients have a lot of physical tests done on them, this is a bit of an emotional vulnerability test</li> </ul>	<p>in it””</p> <ul style="list-style-type: none"> <li>● Curiosity of what it “would say about them”             <ul style="list-style-type: none"> <li>○ Participants wanted to understand results, meaning of what they made...what it “means”...”if i do this...what am i communicating”</li> <li>○ Cancer patients may be particularly positioned to want more clarity about assessments as they are used to being prodded and surveyed/assessed.</li> </ul> </li> </ul>
<p>3. Were you able to use the assessments in a way that helped you reach your clinical goals</p>	<ul style="list-style-type: none"> <li>● I wasn't analyzing the content of assessment to discern any info but yeah, to help them engage, let go of other life responsibilities, and focus on the creative process</li> </ul>	<ul style="list-style-type: none"> <li>● “That was trickier for me—when I see them as assessments, it's hard to make a clinical connection. There was some hesitation for me to put them out there because i</li> </ul>	<ul style="list-style-type: none"> <li>● Advocating for self needs and treatment—empowering self.</li> <li>● Themes specific to cancer experience seemed to help clinicians make sense of patient’s experiences with</li> </ul>



<p>and/or clinical intentions for the group?</p>	<p>mindfully. Felt helpful.</p>	<p>wanted them to be clinically appropriate and I wanted to get information for you all”</p> <ul style="list-style-type: none"> <li>● Even when the clients did it, they didn’t really have a connection to it.</li> <li>● It was never “oh this means something to me” but more “you’re saying to do this so i’m going to try it.” I don’t think they were able to find meaning in doing it, at least from what they expressed.</li> <li>● Themes in Cancer (lived experience):             <ul style="list-style-type: none"> <li>a. How people respond when they find out you have cancer— who steps closer and further</li> <li>b. Some participants currently in treatment, but all have regular dr visits— when life feels “typical” between treatments and then you’re brought back to reality....even as treatment is “done,” its not</li> <li>c. Difficulties with treatment—how it</li> </ul> </li> </ul>	<p>assessments.</p>
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		<p>impacts body, some would discuss and validate each others experience even when not the same</p> <p>d. A lot of joy and happiness—especially with larger groups—they’d have fun</p> <p>e. Themes of recurrence — underlying — people would reflect on how much fear of recurrence they had prior ot group but fear had gone down with groups</p>	
<p>4. Did you notice any themes emerge from the assessments</p>	<ul style="list-style-type: none"> <li>● Birds nest— noticed big, full, protective nests. Really protective of eggs</li> <li>● Therapeutic rapport existed in groups— they are comfortable with each other.</li> <li>● PPAT             <ul style="list-style-type: none"> <li>a. One person's PPAT had tons and tons of apples and person was very small</li> </ul> </li> <li>● Past present future             <ul style="list-style-type: none"> <li>a. Seemed to elicit a lot of</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Two people did a bird's nest— nature was something they could connect to. Nature often comes up as a way people find self care</li> <li>● One person did PPAT and called it “apple tree” and it didn’t have a person in it and she used a scribble drawing from a warm up</li> <li>● Offered the “cancer one” and really worked on trusting the strength in my clients— that</li> </ul>	<ul style="list-style-type: none"> <li>● Nicole explains nature as a theme that clients connected with during the groups.</li> <li>● Past, present, and future elicited emotions for a participant from Jillian’s group compared to other assessments offered.</li> <li>● Clients seem to gravitate towards Bird’s nest assessment more than the other assessments.</li> </ul>

	<p>emotion, maybe more than they were expecting. I was surprised they had done it because they were going through some medical stuff at the time. A lot of emotion and had become tearful for first time (sees them 2x a month since september)</p>	<p>they had that and could handle it— to one patient. She’s already doing something to visually tell her story so she decided not to do it.</p> <ul style="list-style-type: none"> <li>● One person said “I’ve never drawn a nest before” so that was something new to try. “I didn’t know I could draw it.”</li> <li>● No major feelings came up or seemed to be attached to assessments</li> </ul>	
<p>5. Did you notice that art assessments helped patients engage in the art process</p>	<ul style="list-style-type: none"> <li>● “Many of them are no longer in treatment. Some are processing experiences from years ago and some are processing current treatment and in stage 4”</li> <li>● In setting it felt not much on lived experience could be explored.</li> <li>● Virtual: Do they feel safer because they’re home?</li> <li>● Can be difficult when they want to show the art, if it has fine detail or light colors, or textures</li> <li>● They don’t know what other people are working on...could they be influenced</li> </ul>	<ul style="list-style-type: none"> <li>● It’s hard to know because we presented them as “assessments’ ’ whereas our usual directives connect to what we’re talking about or themes about cancer...there’s a purpose to why I’m doing them, I’m not just pulling them out of a hat. Purpose here was “to get information for you all.” “I wonder if it would have meant something different to them if they didn’t know it was an assessment and just thought it was a directive.”</li> <li>● They’ve had more emotional connections to things, maybe not always communicable with</li> </ul>	<ul style="list-style-type: none"> <li>● Being virtual seems to allow for more control for clients, but less for clinicians (e.g. gauging client’s needs, observing details of their art).</li> <li>● Clients seemed to choose the art assessment/directive that interested them in session during both groups.</li> <li>● Participants may connect more to some assessments than others depending on circumstances happening in their lives.</li> </ul>

	<p>if they saw other people?</p> <ul style="list-style-type: none"> <li>● People may choose certain assessments based on how they are feeling that day “depending on what was happening in their lives at the moment”</li> <li>● Assessments were a “launching pad” for some clients</li> </ul>	<p>words, than with assessment</p> <ul style="list-style-type: none"> <li>● Being virtual: for clinician yes because gauging client needs, for participants no.</li> </ul>	
<p>6. What was your experience using the art assessments as a clinician?</p>	<ul style="list-style-type: none"> <li>● I was pretty candid with what they are and why we are doing it. Purely to see if it is interesting to you. Not evaluating the content. It was fine, it was good, I was curious to see what they would do with it.</li> <li>● Some of them were like “yeah no i don't want to do that” which is fine</li> <li>● Probe: did you feel the relationship you already have with the participants impacted how you felt in offering it? Do you feel the existing relationship changed the way participants engaged with them?</li> </ul>	<ul style="list-style-type: none"> <li>● It's been hard to know when it is clinically appropriate to offer during a group. I can see it being done pre or post to assess change or.... But it was hard for me to tie it into the group and the themes that came up in the group. They may have felt my hesitation of “oh is this clinically appropriate right now             <ul style="list-style-type: none"> <li>a. “It was hard to make the clinical connection, I think, and so there were some hesitation for me, and, you know, sharing them, or like putting them out there, because I wanted it to be clinically</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>● Providing more psychoeducation seemed to be helpful for the participants and potentially influenced the way they engaged with assessments.</li> <li>● Transparency was important for both clinicians offering assessments and for participants engaging with them.</li> <li>● Agency for participants was a core consideration by clinicians in conjunction with offering assessments.</li> </ul>

	<ul style="list-style-type: none"> <li>○ Transparency in general when clinically appropriate is important to me as a clinician</li> <li>○ Don't like hiding things from clients</li> <li>○ Not a rorschach, not a “what do you see”</li> <li>○ Agency was important— it wasn't like they had to do it, as would maybe be the case with a psych assessment. People may be more apt to take option when there is no pressure to or nothing to be lost **</li> </ul>	<p style="text-align: center;">appropriate”</p> <ul style="list-style-type: none"> <li>● Didn't want to put pressure on me or the clients but also wanted to get you guys research material. I don't usually have something that i have to do for the groups, we don't have a curriculum or anything like tha</li> <li>● “It didn't feel a clinical connection...I mean I think there always is when you do art in general But they weren't able to find meaning in it in doing it at least what they expressed in which 2 assessments did they choose to do so?.”</li> <li>● “The bird's nest drawing was the most popular that 2 of the participants did that.And yeah, they, the people that did that one. They liked it because it had like nature, and that that was really something they could connect to. So that piece they liked”</li> <li>● “Actually nature is a theme that comes up in the groups, just because that's a way that people find self-care and like</li> </ul>	
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		<p>taking care of themselves by going out in nature. So that one I think you know it had a nature theme, so that was I think why they were drawn to it, or that's what they said.”</p> <ul style="list-style-type: none"> <li>● Probe: did you feel the relationship you already have with the participants impacted how you felt in offering it?-- yes in the sense that i knew what themes were coming up and what was going on for them...which made it harder for me to see if something was clinically appropriate...which would be different for sure if i was an outsider coming in...</li> </ul>	
<p>7. Were these assessments sensitive to cultural and socioeconomic experiences of these patients?</p>	<ul style="list-style-type: none"> <li>● What could have been included in the assessment process that would have made them more accessible?</li> <li>● “I don't know if i'm the right person to say whether something is culturally appropriate, as a white female” “i didn't hear anything come up that they were not supportive” “i</li> </ul>	<ul style="list-style-type: none"> <li>● I feel like they are... they felt okay...most would know what a bird's nest is...PPAT okay and culturally informed... cancer one i think so as well... DDS i didnt do- i felt like i was running out of time but it was the last one i was going to try with the group but bc there are so many stages i felt it was harder to monitor and sometimes with too much</li> </ul>	<ul style="list-style-type: none"> <li>● Clarity and concise phrasing of assessments have an impact on accessibility for patients.</li> <li>● Consideration for cultural experiences appeared woven throughout group experience.</li> </ul>

	<p>didn't hear anything that made me think it was culturally sensitive and inappropriate but i'm not sure im the best judge"</p>	<p>information things can get jumbled— there's chemo brain...even with PPAT, when she did that, she just called it the apple tree and went on her own way of what she understood it to mean at that point in time **</p> <ul style="list-style-type: none"> <li>a. Nice to have things clear and concise, considering the treatments and exhaustion of cancer</li> <li>● What could have been included in the assessment process that would have made them more accessible?</li> </ul>	
<p>8. Have you continued to adapt/modify the assessments to meet the needs of different cultures, backgrounds, and stages of disease?</p>	<ul style="list-style-type: none"> <li>● As a white female identifying person who has not had cancer is my culture...Nicole had fears about the one I developed being emotionally evocative and she had fears around whether it was an emotionally safe assessment.</li> <li>● If there is an opportunity for me to offer these assessments again through this research, bc idk if i would without this</li> </ul>	<ul style="list-style-type: none"> <li>● Knowing what's going on for them, i did have a little more hesitation of "is this going to work, is this going to fit"</li> <li>● Having clear and concise directions— like for the DDS, maybe one panel not 3.</li> <li>● The cancer journey one...depending on knowing that somebody is stage 4, talking about "what do you see for the future" is hard bc the future isn't necessarily so big,</li> </ul>	<ul style="list-style-type: none"> <li>● Both clinicians recognize ways the assessments could be adapted. Each clinician comes from a different background and has different suggestions on ways they would/could adapt the assessments.</li> <li>● Assessments can be adapted to meet the needs of different cultures, backgrounds, and stages of disease. Both clinicians would make adaptations if presenting assessments again.</li> </ul>

	<p>research component, i may experiment a bit more with how i present them— perhaps the more emotionally evocative ones later in our time together...</p> <ul style="list-style-type: none"> <li>● I know she has her own countertransference....so that's another consideration...should a clinician offer.</li> </ul>	<p>a day can be big, it's all relative **</p> <p>a. Re: exploring @ diagnosis: I don't think many people understand the whole “ you can use lines, shapes, colors to describe that, you don't need pics” ...i don't think people get that. t</p> <p>b. I think a bridge drawing could help— could touch on cancer journey without hitting on it directly. Our groups are about people who had cancer but it's about people's lives, cancer isn't the only thing in people's lives and we want to help them realize that. Something that could touch ON the cancer journey without saying that “your whole life is about cancer”</p> <p>c.</p>	
<p>9. Can you imagine how the assessments</p>	<ul style="list-style-type: none"> <li>● Could be helpful as a pre and post</li> </ul>	<ul style="list-style-type: none"> <li>● I think they could be helpful with pre and post— when I think of bird's nest I think of</li> </ul>	<ul style="list-style-type: none"> <li>● Pre and Post: The clinical utility of these assessments would be to offer them pre and post</li> </ul>



<p>could be helpful in future research?</p>	<ul style="list-style-type: none"> <li>● Could be helpful for grant money</li> <li>● Assessments can be adapted and used in this pre/post capacity</li> <li>● Could be used individual settings to introduce art</li> <li>● Could be used in closed group settings to kind of analyze content and evaluate own art more. Valuable clinical tool for client and clinician</li> </ul>	<p>attachments and relationships— I'd be interested in seeing any shift or change as they've connected with other participants. Some group participants do know each other from other groups but most dont...some old, some young, some higher SES, some lower. I think it'd be neat to see if the relationships they form shift their birds' nests—it's still a season in their lives they've felt seen and heard and connected to people with similar experiences in some way or another.</p> <ul style="list-style-type: none"> <li>● PPAT is about resources if i'm not mistaken.... If I remember correctly, that'd also be interesting to see a pre and post— to see if they developed more resources or see if there's a shift or not.</li> <li>● We practice coping skills and strategies (like drawing) each week...they are building connections. Wondering if that would shift</li> <li>● Individual pre and post would be beneficial bc you could dig</li> </ul>	<p>treatment/participation according to both clinicians.</p> <ul style="list-style-type: none"> <li>○ Can pre and post assessments reflect shifts in experience of participants?</li> <li>● Utility could be to offer assessments in closed groups or individually so there is more space for transparent sharing and reflection.</li> </ul>
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		<p>into meaning a little more without making them even more vulnerable in group.</p> <ul style="list-style-type: none"> <li>○ “Oh that's what that means, uh oh!” “oh shit i just showed everybody this?!”...”if its an individual session i think some participants would be interested in that and maybe not have those concerns”</li> <li>○ *note currently they do not meet individually before or after</li> </ul>	
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The following section explores themes initially identified in Table 2 and subsequent discussion identifies how the themes were fully developed and categorized by the researchers.

### **Clinician Approach.**

The first theme that emerged from careful analysis of data was the care with which the clinicians understood the use of arts based assessments as an overall part of their clinical approach and posture. Each participant conveyed considerations that highlighted the sensitive nature of offering assessments to group members. For example, as Nicole described, there is considerable “poking and prodding” that cancer patients undergo, and she mentions feeling an additional mindfulness and caution not “poke and prod for no reason.” Nicole went on to explain that she is careful to make sure assessments are purposeful, as to “respect them [patients] as humans, not just patients.” In addition to Nicole’s considerations as a clinician, the conversation also suggests an additional layer of consideration due to her personal experience as a cancer survivor, alluding to the human elements of offering arts assessments and the possibility that it affects the administering, or in this case offering, of the assessments. This was echoed in Nicole’s art, as she narrated the theme of questioning, empowerment, and transparency through the depiction of a camera and a series of question marks.

Alongside clinician level of comfortability with assessments playing a role in how they chose to offer them, there seemed to be a theme in which clinicians noticed that providing psychoeducation about the assessments, and being transparent about the purpose of the assessments, influenced participation. Jillian remarked that she “was pretty candid with what they [the assessments] are and why we [the researchers] are doing it,” describing that the intent was “purely to see if it is interesting to you, not evaluating the content.” Nicole expressed a similar focus on being transparent about the offering, highlighting how many of the participants

had questions about what the assessments were going to be assessing, and what their possible responses could mean or say about them. Nicole explained that some participants were “eventually open to trying, but their first responses were ‘well what is it?’ ‘What's the process?’ ‘What do I have to do?’” to which Nicole describes feeling a clinical and ethical obligation to explain the purpose.

Both clinicians seemed to naturally assume the responsibility of offering psychoeducation. While this transparency and psychoeducation seems standard to how these clinicians run their open studio groups, there seemed to have been a greater focus on psychoeducation due to the way participants responded to being *offered* assessments. Nicole observed “when you mention an assessment there comes concern of ‘do i really want to do this and share this because i'm not sure what's going to come out in it,’” and Jillian echoed this sentiment and highlighted that questions arose about the assessments, specifically what they were for and what they could mean. Ultimately, it seems these questions led clinicians to be more transparent about the goal of the assessment and to emphasize that they were optional.

### **Patient Consideration.**

The second theme that emerged from the careful analysis of the data was the importance of the clinical consideration about patient needs and experience taken by the therapist as they introduced the different assessments.

When examining Nicole’s interview she shared that participants demonstrated a gradual openness to participating in the assessments after explaining the purpose and the process. Although nobody chose to participate in assessments in the first session, two of three participants did so in the 2nd session. From Nicole’s interaction, it appeared that participants displayed agency by asking probing questions related to the assessments; “What’s the process? What do I

have to do? What is the meaning of the product?...” When they chose to participate in the assessment, participants appeared to feel safe enough to inquire about its significance. Some of the participants believed that their result possibly represented something specific about themselves. Nicole shared her observation that the participants, all cancer patients, may have made a connection between having someone “read” their art assessments similar to how they read the physical tests associated with their cancer diagnosis. This possibility could play a role in a participant's openness to participating in assessments. Another thing that came up with Nicole's group was the theme that nature played in the lives of the participants. She described how nature seemed to help participants feel open about the process since nature has been closely associated with their self-care. Nicole wondered if the assessments would have been received differently if they were introduced as directives.

During Jillian's group, participants seemed open to some of the assessments and demonstrated agency in the decision making related to participation. She stated, “I think having the ability to choose to do this or not is important... Having the option to do it is important. Taking the pressure off by having options helps to release the pressure associated with the term *assessment*.” Jillian goes on to mention that client participation appeared to be “dependent on where they were on that day,” indicating additional openness for choice in the process. When discussing assessments, the stage of the group's therapeutic experience and comfort in their setting (most participants know each other and are familiar with one another) may have contributed to a fuller, more-detailed creative experience. This may indicate that the group dynamic and the stage of therapy plays a significant role in the observable openness towards assessments. Additionally, Jillian reported that the Past, Present and Future assessment seemed

to elicit more emotional responses than the others. This may have been an unexpected response from participants, to the point where there was some “tearfulness” in the group.

The discussion about virtual verses “in- person,” could also affect one’s openness in terms of access to the experience. Some participants may not have access to in-person experiences because of their medical concerns, virtual therapy opens the process up to these people and allows them the choice to be involved in a group experience. Another factor that may affect openness in the process associated with virtual interaction is the lack of being able to see and borrow artistic ideas from other participants in the art process. Jillian explicitly shared background with her clients that the content of the assessments would not be evaluated.

Both therapists make references to how the use of the word *assessment* can create a shift in the participants' openness to the experience.

### **Potential Clinical Utility.**

The third theme that emerged from careful analysis of data was the potential clinical utility of the arts based assessments could be offering them pre treatment and post treatment to participants. Jillian stated how Quality of Life surveys are traditionally offered to participants at the beginning and end of programs, and suggested the benefit of offering assessments might be to similarly implement them pre treatment and then post treatment to participants at the exit of a group to assess “what their experience of that group was,” and to “evaluate” the clinical usefulness and impact of group programs. Jillian also shared that offering the assessments within a closed group structure that integrates more reflective sharing, rather than open studio structured groups, could potentially allow participants to “start to develop a relationship with art therapy” and “ help them start analyzing their own artwork” by reflecting on their choices, process and personal meanings they find within their art making.

Nicole similarly identified the potential utility of offering assessments pre and post treatment, suggesting that certain assessments could possibly capture or reflect participants' social and relational experiences within the art therapy studio groups during a period of time in their lives when participants feel “heard, understood, and connected” with other group members who share “similar experiences in some way or another.” Nicole emphasized how offering assessments individually to participants could deepen opportunities to process and explore meaning in the assessments, rather than causing participants to feel forced exposure by sharing in front of others when they are “already (feeling) vulnerable enough being in a group with other people who have experienced cancer.”

During both interviews, an overarching connection appears to be the possibility of assessments having an empowering component that allows for participants to feel a sense of agency when engaging in them. Both clinician’s seem to suggest overall significance and clinical value in offering assessments that have relevance to participant’s lived experiences, with potential opportunities for capturing meaningful exploration, connections and changes.

### **Cultural Considerations.**

The fourth theme that emerged from careful analysis of data was the ability for arts based assessments to be culturally sensitive. In the interviews, both clinicians expressed that the assessments have the capacity to cross cultures and that they [assessments] are sensitive to the cultural experiences of the group. As mentioned earlier, both clinicians took caution to be transparent with the participants in presenting assessments, openly engaging in conversation with them, and answering any questions they [participants] had. Both clinicians allowed participants autonomy in providing them transparency, psychoeducation, and the choice of whether or not to participate in the assessment, signifying the importance of patient participation in decision

making.

Nicole has experienced cancer, and that experience could have influenced how she presented the assessments. Nicole emphasized the importance of knowing what is going on for the clients when offering the assessments, expressing hesitation about whether or not the assessments would fit with the current stages of participants and the group. Nicole informed the researchers that she did not present the DDS, stating, "it was the last one I was going to try with the group, but because there are so many stages, I felt it was harder to monitor, and sometimes with too much information, things can get jumbled— there's chemo brain." Nicole also emphasized the importance of presenting assessments clearly and concisely, taking into consideration the treatments and exhaustion that cancer may cause. In reference to Jillian's assessment [Past, Present, Future], Nicole expressed hesitation in presenting the assessment and referenced how depending on the participant's stage of cancer, the assessment could prove emotionally difficult for the participant. She stated "knowing that somebody is stage 4, talking about "what do you see for the future" is hard because the future isn't necessarily so big, a day can be big, it's all relative". Nicole also shared that "I don't think many people understand the whole "you can use lines, shapes, colors to describe that, you don't need pictures". Nicole suggested the use of the bridge drawing as an assessment tool, expressing that it could touch on the cancer journey without singularly targeting the participant's cancer experiences. With consideration for participant's lived experiences, Nicole stated "our groups are about people who had cancer, but it's about people's lives, cancer isn't the only thing in people's lives and we want to help them realize that."

Jillian does not have a cancer history which could impact how assessments were provided in her group. However, in responding to the researchers' questions about the assessments'



abilities to cross cultures and their sensitivity, Jillian responded, "I don't know if I'm the right person to say whether something is culturally appropriate, as a white female". In addition, Jillian responded, "I didn't hear anything come up that they [participants] were not supportive...that made me think it was culturally insensitive and inappropriate, but I'm not sure I'm the best judge". Finally, Jillian shared, "If there is an opportunity for me to offer these assessments again through this research, because I don't know if I would without this research component, I may experiment a bit more with how I present them— perhaps the more emotionally evocative ones later in our time together".

Both clinicians seem to agree overall that the assessments presented in their open studio groups have the capacity to cross cultures and that they [assessments] are sensitive to the cultural experiences of the group.

### **Potential Scholarly Value.**

The fifth theme that emerged from careful analysis of data was the potential scholarly value of using art assessments to observe changes from the beginning of treatment to the end of treatment. The use of art assessments can be explored through the lens of how they were offered and utilized, and the ways patients and clinicians engaged with them.

### ***Presentation of the Art Assessments.***

In the open studio groups, the art assessments are presented to the participants as optional art directives which differ from the standardized instructions and scoring scales used for the PPAT, Bird's Nest Drawing, and the DDS. Both clinicians express that the art assessments are alternative suggestions that are offered. Jillian discusses with the group that they will not be analyzing the assessments to discern any results, but to use it as a "creative and mindful

process”. Nicole also explains to the group that the results will not be scored and some participants respond with “concern and curiosity” of the results’ outcome. The partial adjustments in how the art assessments are presented and utilized seem to form naturally for the open studio groups. Providing the assessments as options and adjusting the instructions to the group members’ needs seem to allow the participants to engage more freely.

*Art Assessment Impact on Participants.*

In the first group, Jillian mentions that it seems like the choice of the assessments are dependent on “where the member is at that day and that the members responded well”. Jillian says, “One participant loved it because she was able to create a narrative using the PPAT.” Jillian continues to explain that the assessments seem to provide a guideline and is a “launching pad” for some clients since they usually work on whatever project they want to engage in. Jillian states that the Bird’s Nest assessment drawings seem to have a “cozy” quality which may have a correlation to gender being that participants are mostly older females and that the weather being winter may also have made an impact. Jillian mentions that most of the nests seem “very full” and that this may be connected to their therapeutic rapport within the group members and feeling comfortable amongst each other. Jillian comments that “one participant created the art directive about the past, present, future with cancer diagnosis and it elicited more emotions than the participant had expected and that this was the only time this member became teary”. These observations were made by this clinician when using the art assessments with adjustments from the original standardized instructions indicating that despite the different approach, the clinicians were able to gain understanding of the participant’s experience and needs during the open studio group sessions.

In the second group, Nicole reflects that it seems like the participants did not have an emotional connection to the art assessments when discussing their art work. Nicole states that art directives she provides in the open group sessions are usually tied to the themes that are brought up within the group whereas the assessments seemed “random”, but also wonders if the art assessments were not presented with the context of research if the participants would have approached it differently. Nicole mentions that participants that engaged in the Bird’s Nest Drawing may have connected to the theme of nature and how that theme was common for their group sessions. Another participant worked on the PPAT and adjusted the instructions and created just an apple tree without the person. Similarly to the first group, the participant connected with what the art assessments in ways that it was appropriate and comfortable for the participant. Providing the art assessment in an informal way and adjusting to the participant’s desire, led to gaining unique observations and discussions regarding the participant’s needs in the moment.

*Art Assessments Impact on the Clinicians.*

Jillian states that art assessments could be a useful tool for research by learning and adjusting the assessments or surveys to better provide for future research participants. Both clinicians discuss the usefulness of using the art assessments for a pre and post data collection to observe changes from the beginning and the end of treatment. For future research, depending on the theme of the different art assessments, utilizing art assessments may be useful to compare the shift in change from beginning to the end of treatment. This may provide further knowledge of understanding if the assessments help measure the participant’s experience in the art therapy groups and incorporate their lived experiences.

The value of quantitatively analyzing the data, although the sample size was small in numbers, was to explore whether art therapy assessments could stimulate thought or provocative movement in therapy. By taking the assessment out of the standardized format and typical assessment structure (where it is used to measure changes after interventions), researchers assessed whether there are opportunities for art therapy assessments to better address the lived experience of individuals who experience cancer. From this preliminary study, researchers connected qualitative data to existing and future research, ultimately priming opportunities for art therapy assessments to serve as more efficacious, gentle, and relevant assessment tools.

### **Findings or Meanings**

The following section revisits the key findings from qualitative data analysis and draws connections between themes and the literature and scholarly discussion surrounding the topic.

### ***Psychoeducation/Agency of Participants***

As explored in the literature review, the qualitative data points to the importance of sensitivity in regard to the unique lived experience of a cancer diagnosis, and the significance of offering control and transparency whenever possible. As mentioned in the research, diagnoses and related treatment often contribute to significant uncertainty, lack of control, and negative changes in self-esteem (Arora et al., 2007, Williams, F., & Jeanetta, S.C. 2015). Additionally, research surrounding lived experience of cancer patients illustrates the importance of access to information in mediating the loss of security and increasing sense of control (Lilliehorn et al. (2010). This research coupled with the preliminary findings from the qualitative data of the present study highlight the importance of empowering patients throughout treatment phases,

including the moments in which they are being assessed. In other words, as clinicians observed and experienced the groups, offering psychoeducation and hyper-transparency about the purpose, process, and possible outcomes of the assessments offered, they attuned to the needs and agency of the participants in the moment. Future research should consider how the individual personalities and clinical styles can be clinically relevant and function as an intervention with potential to influence self esteem, efficacy, and meaning.

### ***Relational Qualities of Clinician***

Radl et al. (2018) highlights the importance of the relationship between therapist and patient, specifically alluding to the combination of creative expression and storytelling in propelling individuals towards a more positive sense of identity. The present research further corroborates the importance of this relationship and extends the dyadic or group dynamic to what could be possible in all clinical settings, including assessment settings which historically lack consideration of relational and subjective factors. Furthermore, echoing what García-Rueda et al. (2016) emphasizes around living with diagnosis as “a unique process for each person,” the present research removed assessments from their traditional and “standardized” context and adapted them to honor the unique experience of each individual. Clinicians felt empowered to intuit participants' needs based on clinical insight and present moment observations, and offered adaptations that aligned with individual and group needs.

### ***Cultural Considerations***

The literature indicates shared changes experienced by individuals in different stages of cancer, such as the need to access and assimilate information about the trajectory of the disease

and the importance of patient participation in decision making. Meyer and Grober (2006) highlight the role of information in advanced breast cancer diagnoses and how access to information is an adaptive way for patients to maintain a sense of control in coping with advanced disease (Liliehorn et al. 2010; Mayer and Grober, 2006, p.15). The research process reflects these considerations, as the clinicians centered the participants' experiences including their current stage of cancer, prognosis, level of treatment and recency of diagnosis. As concerns for the future can frequently be accompanied by the fear of a cancer recurrence and worry about how this diagnosis will affect relationships, existential distress may be prominent for patients. Additionally, patients may be confronted by a loss of control that impacts their wellbeing adjustment to illness as they seek ways to cope following diagnosis. The research reflects considerations about these fears, specifically in the manner that clinicians chose to present the assessments and which assessments they selected. Nicole specifically took care to take into consideration the participants' experience, consciously choosing to not present Jillian's Past, Present, Future assessment in honor of respecting the participants emotional safety within the group.

### *Use of Art therapy Assessments*

The findings indicate that art assessments may be helpful for future research when clinicians hold consideration for the participants' lived experiences when offering the assessments. In the literature review, the process of administering standardized art assessments with the utilization of scoring measurements to find efficacy of the art therapy assessments was mentioned by Jiang et al.(2020), Colette et al. ( 2021), Geue et al. ( 2013), Bar-Sela et al. (2007). In the research, without the use of a scoring measurement and by adapting the art assessments to

the participant's needs, the findings still indicate that the use of art based assessments could be a useful method in future research. Rather than focusing on the standardized instructions for the assessments, the clinicians intentionally led discussions regarding the participant's experience with the art assessments to gather more accurate data of the participant's experiences during the therapy session.

Applying this consideration when offering assessments may provide an opportunity to gain responses that capture participants' lived experiences. This finding echoes Betts (2016) statement that integrative interviews with the use of formal art assessments seem to be a necessary and informed perspective included in assessing efficacy of art assessments in research. Clinicians typically present these art assessments pre and post intervention to measure change, a methodology that could be potentially useful also in deepening the understanding of how the art therapy assessments could be used in future research with cancer patients.

### **Conclusion**

The present research investigated the integration of art assessments in the clinical work as a way to determine if they could be of value to potential scholarship. Utilizing art based assessments in a more open-ended fashion, rather than typical use where they are relegated to research protocols, researchers investigated their clinical use and consequently their appropriateness for more patient centered studies of art therapy efficacy. In doing so, five main themes were revealed. First, the relationship between clinician and patient seemed to play a central role in surfacing meaningful conversations about the assessments, and clinicians emphasized the significance of being transparent and honest about the process to patients. This finding underscores the importance of considering who is administering an assessment, the relationship between clinician and patient, and the space offered to ask questions and process the invitation. Second, in examining the importance of clinical considerations about patient needs, experience by the clinicians as they introduce the different assessments is important. Third, this research found the potential clinical utility of the art assessments could be to offer assessments pre and post treatment to participants as a way to capture experience and impact. The research also revealed the significance of utilizing art assessments in a manner that allows participants to feel a sense of agency when engaging in them. Fourth, this research explored the assessments' capacity to cross cultures and examine if the assessments were sensitive to the cultural experiences of the participants. Both clinicians seem to agree overall that the assessments presented in their open studio groups have the capacity to cross cultures and are sensitive to the cultural experiences of the group. The fifth theme explores the scholarly value through the use of art assessments and how they were offered and presented, and the ways patients and clinicians



engaged with them. These findings suggest that if assessments were reintroduced in a more traditional context, such as before and after an intervention to measure change, and presented alongside clinicians who are attuned to the needs and impact on patients, there could be further opportunities for exploring the clinically efficaciousness alongside cultural and contextual sensitivity. Throughout the research process the researchers' experiences of clinically observing and working with cancer patients remained embedded in the considerations for the clinicians and participants' experiences of the assessments, the development of themes, and the connections made to future scholarly research.

### References

- Arora, N.K., Rutten, L.J., Gustafon, D.H., Moser, R., & Hawkins, R.P. (2007). Perceived helpfulness and impact of social support provided by family, friends, and health care providers to women newly diagnosed with breast cancer. *Psycho-Oncology, 16*, 474-486. <https://doi.org/10.1002/pon.1084>
- Barofsky I. (2012). Can quality or quality-of-life be defined?. *Quality of life research : an international journal of quality of life aspects of treatment, care and rehabilitation, 21*(4), 625–631. <https://doi.org/10.1007/s11136-011-9961-0>
- Bar-Sela, G., Atid, L., Danos, S., Gabay, N., & Epelbaum, R. (2007). Art therapy improved depression and influenced fatigue levels in cancer patients on chemotherapy. *Psycho-Oncology, 16*(11), 980–984. <https://doi.org/10.1002/pon.1175>
- Betts, D. J. (2006). Art therapy assessments and rating instruments: Do they measure up? *The Arts in Psychotherapy, 33*(5), 422–434. <https://doi.org/10.1016/j.aip.2006.08.001>
- Betts, D. J., & Deaver, S. P. (2019). *Art therapy research: A practical guide*. Routledge.
- Björneklett, H.G., Rosenblad, A., Lindemalm, C., Ojutkangas, M., Letocha, H., Strang, P., & Bergkvist, L. (2013). Long-term follow-up of a randomized study of support group intervention in women with primary breast cancer. *Journal of Psychosomatic Research, 74*, 346-353. <https://doi.org/10.1016/j.jpsychores.2012.11.005>
- Darewych, O. H., Newton, N. J., & Farrugie, K. W. (2018). Investigating Imagination in Adults with Autism Spectrum Disorder with Art-Based Assessments. *Journal on Developmental Disabilities, 23*(2).

- Dickerson, S.S., Alqaissi, N., Underhill M., & Lally, R.M. (2011). Surviving the wait: defining support while awaiting breast cancer surgery. *Journal of Advanced Nursing*, 67(7), 1468–1479. <https://doi.org/10.1111/j.1365-2648.2011.05612.x>
- Fann, J. R., Thomas-Rich, A. M., Katon, W. J., Cowley, D., Pepping, M., McGregor, B. A., & Gralow, J. (2008). Major depression after breast cancer: a review of epidemiology and treatment. *General Hospital Psychiatry*, 30(2), 112–126. <https://doi.org/10.1016/j.genhosppsy.2007.10.008>
- Ferrans, C. E. (2005). Definitions and conceptual models of quality of life. In J. Lipscomb, C. C. Gotay, & C. Synder (Eds.), *Outcomes assessment in cancer* (pp. 14–30). NY: Cambridge University Press.
- Finkel, D., & Bat Or, M. (2020). The Open Studio Approach to Art Therapy: A Systematic Scoping Review. *Frontiers in Psychology*, 11. <https://doi.org/10.3389/fpsyg.2020.568042>
- Forzoni, S., Perez, M., Martignetti, A., & Crispino, S. (2010). Art therapy with cancer patients during chemotherapy sessions: An analysis of the patients' perception of helpfulness. *Palliative and Supportive Care*, 8(1), 41–48. <https://doi.org/10.1017/s1478951509990691>
- Frick, E., Riedner, C., Fegg, M., Hauf, S., & Borasio, G.D. (2006). *European Journal of Cancer Care*, 15, 238–243 A clinical interview assessing cancer patients' spiritual needs and preferences
- Fryback, D. G., Palta, M., Cherepanov, D., Bolt, D., et al. (2009). Comparison of 5 health-related quality of life indexes using item response theory analysis. *Medical Decision Making*. doi:10.1177/0272989X09347016.
- Fuhrer, M.J. (2000). Subjectifying quality of life as a medical rehabilitation outcome. *Disabil*

- Rehabil*, 22, p. 481–489.
- Elkinton J. R. (1966). Medicine and the quality of life. *Annals of internal medicine*, 64(3), 711–714. <https://doi.org/10.7326/0003-4819-64-3-711>
- Gantt, L. (2004). The case for formal art therapy assessments. *Art Therapy*, 21(1), 18–29. <https://doi.org/10.1080/07421656.2004.10129322>
- García-Rueda, N., Valcárcel, A.C., Saracíbar-Razquin, M., & Solabarrieta, M.A. (2016). The experience of living with advanced-stage cancer: a thematic synthesis of the literature. *European Journal of Cancer Care*, 25, 551-569. <https://doi.org/10.1111/ecc.12523>
- Geue, K., Richter, R., Buttstädt, M., Brähler, E., & Singer, S. (2013). An art therapy intervention for cancer patients in the Ambulant Aftercare - results from a non-randomised controlled study. *European Journal of Cancer Care*, 22(3), 345–352. <https://doi.org/10.1111/ecc.12037>
- Gilroy, A., Tipple, R., & Brown, C. (2012). *Assessment in art therapy*. Routledge.
- Granek, L., Nakash, O., Ben-David, M., Shapira, S., & Ariad, S. (2018). Oncologists' Treatment Responses to Mental Health Distress in Their Cancer Patients. *Qualitative Health Research*, 28(11), 1735–1745. <https://doi.org/10.1177/1049732318786479>
- Grassi, L., Gritti, P., Rigatelli, M., & Gala, C. (2000). Psychosocial problems secondary to cancer: an italian multicentre survey of consultation-liaison psychiatry in oncology. *European Journal of Cancer*, 36(5), 579–585. [https://doi.org/10.1016/s0959-8049\(99\)00285-3](https://doi.org/10.1016/s0959-8049(99)00285-3)
- Grassi, L., Sabato, S., Rossi, E., Biancosino, B., & Marmai, L. (2005). Use of the diagnostic

- criteria for psychosomatic research in oncology. *Psychotherapy and psychosomatics*, 74(2), 100–107. <https://doi.org/10.1159/000083168>
- Gregurek, R., Bras, M., Dordevic, V., Ratkovic, A., & Brajkovic, L. (2010). Psychological problems of patients with cancer. *Psychiatria Danubina*, 22(2).
- Gripsrud, B. H., Brassil, K. J., Summers, B., Søiland, H., Kronowitz, S., & Lode, K. (2016). Capturing the Experience. *Cancer Nursing*, 39(4), E51–E60. <https://doi.org/10.1097/ncc.0000000000000300>
- Guité-Verret, A., & Vachon, M. (2021). The incurable metastatic breast cancer experience through metaphors: the fight and the unveiling. *International Journal of Qualitative Studies on Health and Well-being*, 16(1). 1-11. <https://doi.org/10.1080/17482631.2021.1971597>
- Halkett, G.K.B., Arbon, P., Scutter, S.D., & Borg, M. (2007). The phenomenon of making decisions during the experience of early breast cancer. *European Journal of Cancer Care*, 16(4), 322-330. <https://doi-org.electra.lmu.edu/10.1111/j.1365-2354.2007.00778.x>
- Horgan, O., Holcombe, C., & Salmon, P. (2011). Experiencing positive change after a diagnosis of breast cancer: A grounded theory analysis. *Psycho-Oncology*, 20(10), 1116–1125. <https://doi-org.electra.lmu.edu/10.1002/pon.1825>
- Hunter, J. L. (2005). Emelda's story: Applying ethnographic insights to cultural assessment and Cervical Cancer Control. *Journal of Transcultural Nursing*, 16(4), 322–330. <https://doi.org/10.1177/1043659605278939>

- Jiang, X. H., Chen, X. J., Xie, Q. Q., Feng, Y. S., Chen, S., & Peng, J. S. (2020). Effects of art therapy in cancer care: A systematic review and meta-analysis. *European Journal of Cancer Care, 29*(5). <https://doi.org/10.1111/ecc.13277>
- Joyce, C. R. B. (1988). Quality of life: The state of the art in clinical assessment. In S. W. Walker & R. M. Rosser (Eds.), *Quality of life assessment and application* (pp. 119–169). Lancaster, PA: MTP Press.
- Kristiansen, M., Tjørnhøj-Thomsen, T., & Krasnik, A. (2010). The benefit of meeting a stranger: Experiences with emotional support provided by nurses among Danish-born and migrant cancer patients. *European Journal of Oncology Nursing, 14*(3), 244–252. <https://doi.org/10.1016/j.ejon.2010.01.028>
- La Cour, K., Ledderer, L., & Hansen, H. P. (2016). Storytelling as part of cancer rehabilitation to support cancer patients and their relatives. *Journal of Psychosocial Oncology, 34*(6), 460–476. <https://doi.org/10.1080/07347332.2016.1217964>
- Lewis, S., Willis, K., Yee, J., & Kilbreath, S. (2016). Living well? Strategies used by women living with metastatic breast cancer. *Qualitative Health Research, 26*(9), 1167–1179. <https://doi-org.electra.lmu.edu/10.1177/1049732315591787>
- Martino, L.M., & Freda, M.F. (2016). Meaning-making process related to temporality during breast cancer traumatic experience: The clinical use of narrative to promote a new continuity of life. *Europe's Journal of Psychology, 12*(4), 622-634. doi:10.5964/ejop.v12i4.1150
- Martino, M. L., Gargiulo, A., Lemmo, D., & Margherita, G. (2019). Cancer Blog Narratives: The

- Experience of Under-Fifty Women with Breast Cancer during Different Times after Diagnosis. *The Qualitative Report*. Published.  
<https://doi.org/10.46743/2160-3715/2019.3646>
- Mayer, M., & Grober, S.E. (2006). *Silent voices: Advanced breast cancer needs assessment survey report*. Living Beyond Breast Cancer.
- MN, A., B, B., M, Z., M, S. A., WL, C., & R, D. (2020). The Efficacy of Art Therapy on Mental Health Outcomes Among Breast Cancer Patients: The Current State of Evidence Based on Randomised Controlled Trials. *IJUM Medical Journal Malaysia*, 17(2).  
<https://doi.org/10.31436/imjm.v17i2.274>
- Newton, J. C., O'Connor, M., Saunders, C., Moorin, R., Ali, S., Nowak, A. K., & Halkett, G. K. B. (2020). The role of psychosocial support in the experiences of people living with advanced cancer: A qualitative exploration of patients' perspectives. *Psycho-Oncology*, 30(3), 287–295. <https://doi.org/10.1002/pon.5569>
- Oster, G. D., & Crone, P. G. (2004). Chapter 2 Beginning Assessment and Treatment. In *Using drawings in assessment therapy: A guide for mental health professionals* (pp. 30–51). essay, Brunner-Routledge.
- Payne, D.K., Hoffman, R.G., Theodulou, M., Dosik, M., Massie, M.J. (1999). Screening for anxiety and depression in women with breast cancer. *Psychosomatics*, 40, 64–69.
- Pénzes, I., van Hooren, S., Dokter, D., Smeijsters, H., & Hutschemaekers, G. (2014). Material interaction and art product in art therapy assessment in Adult Mental Health. *Arts & Health*, 8(3), 213–228. <https://doi.org/10.1080/17533015.2015.1088557>
- Post M. W. (2014). Definitions of quality of life: what has happened and how to move on. *Topics in spinal cord injury rehabilitation*, 20(3), 167–180. <https://doi.org/10.1310/sci2003-167>

- Puetz, T. W., Morley, C. A., & Herring, M. P. (2013). Effects of Creative Arts Therapies Psychological Symptoms and Quality of Life in Patients With Cancer. *JAMA Internal Medicine*, 173(11), 960. <https://doi.org/10.1001/jamainternmed.2013.836>
- Radl, D., Vita, M., Gerber, N., Gracely, E. J., & Bradt, J. (2018). The effects of Self-Book© art therapy on cancer-related distress in female cancer patients during active treatment: A randomized controlled trial. *Psycho-Oncology*, 27(9), 2087–2095. <https://doi.org/10.1002/pon.4758>
- Reilly, R., Lee, V., Laux, K., & Robitaille, A. (2021). Creating doorways: finding meaning and growth through art therapy in the face of life-threatening illness. *Public Health*, 198, 245–251. <https://doi.org/10.1016/j.puhe.2021.07.004>
- Ricoeur, P., McLaughlin, K., & Pellauer, D. (1990). *Time and Narrative, Volume 1 (Time & Narrative)* (1st ed.). University of Chicago Press.
- Ricouer, P. (1983). *Time and narrative*. University of Chicago Press.
- Rothrock, N., Peterman, A. H., & Cella, D. (n.d.). *Evaluation of health-related quality of life (HRQL) in patients with a serious life-threatening illness*. UpToDate. Retrieved October 28, 2021, from <https://www.uptodate.com/contents/evaluation-of-health-related-quality-of-life-hrql-in-patients-with-a-serious-life-threatening-illness>.
- Ruta, D. A., Garratt, A. M., Leng, M., Russell, I. T., et al. (1994). A new approach to the measurement of quality of life: The patient generated inventory (PGI). *Medical Care*, 32, 149–166.
- Sabo, B., Singh, M., Snelgrove-Clarke, E., & Maimets, I. (2016). Benefits and challenges in the



- use of art as an intervention for making sense of the cancer experience. *JBI Database of Systematic Reviews and Implementation Reports*, 14(4), 76–84.  
<https://doi.org/10.11124/jbisrir-2016-2479>
- Savazzi, F., Isernia, S., Farina, E., Fioravanti, R., D’Amico, A., Saibene, F. L., Rabuffetti, M., Gilli, G., Alberoni, M., Nemni, R., & Baglio, F. (2020). “art, colors, and emotions” treatment (ACE-T): A pilot study on the efficacy of an art-based intervention for people with alzheimer’s disease. *Frontiers in Psychology*, 11.  
<https://doi.org/10.3389/fpsyg.2020.01467>
- Shapiro, J. P., McCue, K., Heyman, E. N., Dey, T., & Haller, H. S. (2010). A Naturalistic Evaluation of Psychosocial Interventions for Cancer Patients in a Community Setting. *Journal of Psychosocial Oncology*, 28(1), 23–42.  
<https://doi.org/10.1080/07347330903438891>
- Smit, A., Coetzee, B.J., Roomany, R., Bradshaw, M., & Swartz, L. (2019). Women's stories of living with breast cancer: A systematic review and metasynthesis of qualitative evidence. *Social Science and Medicine*, 222, 231-245.  
<https://doi.org/10.1016/j.socscimed.2019.01.020>
- Tabrizi, F.M., Radfar, M., & Taei, Z. (2016). Effects of supportive-expressive discussion groups on loneliness, hope and quality of life in breast cancer survivors: a randomized control trial. *Psycho-Oncology*, 25, 1067-1063. <https://doi.org/10.1002/pon.4169>
- Tripp, T. (2019). More than an image: Revisiting the Ulman Personality Assessment procedure. *Art Therapy*, 36(3), 133–140. <https://doi.org/10.1080/07421656.2019.1649546>

- Vilhauer, R.P. (2011). 'Them and 'us:' The experiences of women with metastatic disease in mixed-stage versus stage specific breast cancer support groups. *Psychology and Health, 26*(6), 781-797. <https://doi-org.electra.lmu.edu/10.1080/08870446.2010.496853>
- Wasteson, E., Brenne, E., Higginson, I. J., Hotopf, M., Lloyd-Williams, M., Kaasa, S., Loge, J. H., & European Palliative Care Research Collaborative (EPCRC) (2009). Depression assessment and classification in palliative cancer patients: a systematic literature review. *Palliative medicine, 23*(8), 739–753. <https://doi.org/10.1177/0269216309106978>
- Wilkinson, A., Vasudevan, V., Honn, S., Spitz, M., & Chamberlain, R. (2009). Sociodemographic characteristics, health beliefs, and the accuracy of cancer knowledge. *Journal of Cancer Education, 24*(1), 58–64. <https://doi.org/10.1080/08858190802664834>
- Williams, F., & Jeanetta, S.C. (2015). Lived experiences of breast cancer survivors after diagnosis, treatment and beyond: Qualitative Study. *Health Expectation, 19*, 631-642. <https://doi.org/10.1111/hex.12372>
- Williams, L. A., Agarwal, S., Bodurka, D. C., Saleeba, A. K., Sun, C. C., & Cleeland, C. S. (2013). Capturing the patient's experience: Using qualitative methods to develop a measure of patient-reported symptom burden: An example from ovarian cancer. *Journal of Pain and Symptom Management, 46*(6), 837–845. <https://doi.org/10.1016/j.jpainsymman.2013.02.007>
- Williams, S., & Dale, J. (2006). The effectiveness of treatment for depression/depressive symptoms in adults with cancer: a systematic review. *British Journal of Cancer, 94*(3), 372–390. <https://doi.org/10.1038/sj.bjc.6602949>

Wood, M. J. M., Molassiotis, A., & Payne, S. (2011). What research evidence is there for the use of art therapy in the management of symptoms in adults with cancer? A systematic review. *Psycho-Oncology*, *20*(2), 135–145. <https://doi.org/10.1002/pon.1722>

World Health Organization. (n.d.). *Constitution of the World Health Organization*. World Health Organization. Retrieved October 28, 2021, from <https://www.who.int/about/governance/constitution>.

Zabora, J., Brintzenhofe-Szoc, K., Jacobsen, P., Curbow, B., Piantadosi, S., Hooker, C., Owens, A., & Derogatis, L. (2001). A new psychosocial screening instrument for use with cancer patients. *Psychosomatics*, *42*, 241–246.

**Appendix A: Informed Consent**  
**Loyola Marymount University**  
**Informed Consent Form**

- TITLE:** Evaluating Art Therapy Assessments with Cancer Survivors
- INVESTIGATOR:** Debra Linesch, Graduate Department of Marital and Family Therapy, 310-338-7674, [Debra.Linesch@lmu.edu](mailto:Debra.Linesch@lmu.edu)
- PURPOSE:** You are being asked to participate in a research project that seeks to investigate the clinical and scholarly usefulness of arts-based assessments with cancer patients engaged in an art therapy group intervention. You will be asked to complete an interview process exploring your observations about the inclusion of the three identified assessments and the experiences the patients had with the tasks.
- RISKS:** Possible risks involved with this process are the heightened concerns you have about the potential integration between clinical and research tools with vulnerable populations.
- BENEFITS:** Potential benefits are a deeper understanding of the ways that clinical work and research can be complimentary.
- INCENTIVES:** You will receive no gifts/incentives for this study.
- CONFIDENTIALITY:** Your name will never be used in any public dissemination of these data (publications, presentations, etc.). When the research study ends, any identifying information will be removed from the data, or it will be destroyed.
- RIGHT TO WITHDRAW:** Your participation in this study is *voluntary*. You may withdraw your consent to participate at any time without penalty. Your withdrawal will not influence any other services to which you may be otherwise entitled, your class standing or relationship with Loyola Marymount University.
- SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you.
- VOLUNTARY CONSENT:** I have read the above statements and understand what is being asked of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason, without penalty. If the study design or use of the information is changed I will be informed and my consent reobtained. On these terms, I certify that I am willing to participate in this research project.

I understand that if I have any further questions, comments or concerns about the study or the informed consent process, I may contact Dr. David Moffet, Chair, Institutional Review Board, Loyola Marymount University by email at [David.Moffet@lmu.edu](mailto:David.Moffet@lmu.edu).

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 Participant's Signature

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 Date

## Appendix B: IRB Approval

**From:** Paterson, Julie <[Julianne.Paterson@lmu.edu](mailto:Julianne.Paterson@lmu.edu)>  
**Date:** Thursday, September 3, 2020 at 8:31 AM  
**To:** Linesch, Debra <[Debra.Linesch@lmu.edu](mailto:Debra.Linesch@lmu.edu)>  
**Cc:** Moffet, David <[David.Moffet@lmu.edu](mailto:David.Moffet@lmu.edu)>, Paterson, Julie <[Julianne.Paterson@lmu.edu](mailto:Julianne.Paterson@lmu.edu)>  
**Subject:** IRB Approval/Linesch

Dear Professor Linesch,

Thank you for submitting your IRB application for your protocol titled *Evaluating Art Therapy Assessments with Cancer Survivors*. 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 **September 3, 2020**. Please note that if there are any changes to your protocol, you are required to submit an addendum application to the IRB.

For any further communication regarding your approved study, please reference your **new IRB protocol number: LMU IRB 2020 FA 01 R**

Best wishes for a successful research project.

Sincerely,

Julie Paterson

.

**Julianne Paterson**

Research Compliance Specialist

1 LMU Drive, University Hall, Suite #1878

Los Angeles, CA 90045

Telephone: (310) 258-5465

Email: [Julianne.Paterson@lmu.edu](mailto:Julianne.Paterson@lmu.edu)



## Appendix C: IRB Addendum Approval

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**From:** Paterson, Julie <[Julianne.Paterson@lmu.edu](mailto:Julianne.Paterson@lmu.edu)>  
**Date:** Wednesday, January 12, 2022 at 9:19 AM  
**To:** Linesch, Debra <[Debra.Linesch@lmu.edu](mailto:Debra.Linesch@lmu.edu)>  
**Cc:** Moffet, David <[David.Moffet@lmu.edu](mailto:David.Moffet@lmu.edu)>, Paterson, Julie <[Julianne.Paterson@lmu.edu](mailto:Julianne.Paterson@lmu.edu)>  
**Subject:** IRB Approval/Linesch

Dear Professor Linesch,

Thank you for submitting your IRB request for addendum for your protocol titled **Evaluating Art Therapy Assessments with Cancer Survivors**. All documents have been received and reviewed, and I am pleased to inform you that your request for addendum has been approved.

Your IRB approval number remains the same. If there are any additional changes to your protocol, you are required to submit an additional addendum application.

Best wishes for a successful research project.

Sincerely,

Julie Paterson

**Julianne Paterson**

Research Compliance Specialist  
1 LMU Drive, University Hall, Suite #1878  
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