Art Therapy through a Continuum of Care in Women's Health: A Program Proposal

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# Art Therapy through a Continuum of Care in Women's Health

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## ABSTRACT

The present study used an integrative literature review methodology to identify the art therapy treatment needs of mothers and families experiencing a high-risk pregnancy within a women's health facility, in order to propose an art therapy treatment model for this population that spans a continuum of care. Three identified stages of a continuum of care included: high-risk hospitalization, neonatal intensive care, and postpartum outpatient services. The results indicated that there are differentiated treatment issues for each stage of care that art therapists can address through individual and group art therapy programming. The present study used these findings to create an integrated program for art therapy across a continuum of care in a woman's hospital. The program's action plan followed the patient and their family through six steps across the care continuum: (1) recruitment and referral, (2) intake evaluations, (3) assessment of needs, (4) treatment planning and recommendations, (5) transitional care, and (6) termination. The researcher developed individual and group art therapy programing to address the treatment issues identified in the literature for each stage of care, with examples of interventions provided for each. Recommendations for future research include implementation of art therapy continuum of care programing in a women's health facility and evaluation of its effectiveness.


*Keywords:* Continuum of care, high-risk, neonatal intensive care unit (NICU), outpatient care, art therapy.

# DEDICATION

I would like to dedicate this capstone to my dad, Stephen David Lugo, who has pushed me in this journey of becoming an Art Therapist. He alone serves with compassion and integrity towards the population of women's health and has inspired me to continue a new line of work that serves women's health in art therapy. Dad, you have made me a better daughter, therapist, and leader as I continue into the world as a professional, and I will be forever grateful for your love and support. I know as I journey through the professional world, we work alongside each other with the same passion and fearlessness in helping others. You helped me recognize how this capstone provides a space in art transformation of the medical population and it has informed me of the importance of providing creative outlets as a method towards healing. Thank you for all that you do and all that you are.

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# CHAPTER I

## INTRODUCTION

High-risk mothers, parents, and families experience the journey of pregnancy within women's health facilities in many different ways. The circumstances of admittance, diagnoses received, and accompanying life events are unique to each family and require personalized care throughout the hospitalization process. There are also many similarities in the needs and patient-faced implications throughout hospitalization and care planning. These similarities and differences are compared to a human's cycle of life; from needing support at birth, through growth and independence later in life. A patient's hospitalized journey can be seen on a continuum, requiring different kinds of care along the way (Smith, Jennings, & Cimino, 2010). Babies grow and have experiences in the womb and then learn to move from a place of life within their mother to a life outside of her. This experience of change may be similar to the experience of high-risk mothers and their families who voyage within the women's hospital and transition back home with their infant. Babies depend on having one reliant structure to see them through to their next experience; ideally a consistent group of parents and family members to assist them in their journey of change. However, for the mother and family experiencing a high-risk pregnancy, the continuation of care through the duration of a hospital stay may span weeks or months (Janighorban, Heidari, Dadkhah, & Mohammadi, 2018). Over this time period, mothers and families don't always experience continuous care from a single healthcare provider and sometimes teams of providers are different from unit to unit (Smith et al., 2010).

In life, people often have friends and family that have been constant through seasons of life that include both times of celebration and mourning. These people provide a sense of comfort, care, and understanding simply because they have been a consistent presence over a

period of time and have shared important life experiences. Thus, for most people, life is not experienced as a journey that has to be taken alone or without consistent supports. In the same way, patients at a women's hospital should have service providers that have the ability to travel with them as they transition to other parts of the hospital for continued care. Patients could benefit greatly from a provider who could be a constant in their journey through high-risk, neonatal intensive care, and postpartum outpatient care. An art therapist can offer support as one consistent provider, bringing care for mothers, parents, and family members through the entire process of hospitalization.

As a current art therapy intern at a women's hospital, I want to study the treatment issues of women and families as they travel through the continuum of services associated with a high-risk pregnancy in order to understand how art therapy may meet patient needs throughout the cycle of care (i.e., from high-risk pregnancy to neonatal intensive care to postpartum and outpatient services) because this will help me to create and provide rationale for an art therapy program across the continuum of care. My research question is: How would implementing a art therapy program that spans the continuum of care provide better support services for high-risk pregnant women and their families? The goal for this study is use support from peer-reviewed literature to create a program that will provide art therapy services across the continuum of care in women's health.

**Operational Definitions**

**Antepartum pregnancy -** refers to women who are pregnant and have yet to deliver a baby. These women are found on the high-risk unit, are typically between 22 and 38 weeks along in their specific pregnancy cycle, and are on doctor-ordered bed-rest (Azevedo, Ferreira, Silvino, & Christovam, 2017; Bauer, Victorson, Rosenbloom, Barocas, & Silver, 2010; Sarid, Cwikel, Czamanski-Cohen, & Huss, 2017).

**Art therapy -** refers to the use of art in a therapeutic setting that provides alleviation of physical or psychological symptoms or as a method of distraction towards an unwanted behavior of personal circumstance or condition. Art therapy may be used as a central or complimentary service in treatment planning that is meant for various health-care outcomes, providing an alternative form of communication (Blomdahl et al., 2016; Kivnick & Erikson, 1983).

**Continuum of care or cycle of care -** demonstrates the ability for a helping professional to continue with patients through transitions to one area of hospitalization to another area of hospitalization for continuation of treatment planning and healthcare outcomes. This cycle of continued care may begin at any point in the patients' treatment plan and continue into discharge or from inpatient to outpatient services (Smith et al., 2010).

**Healing arts -** includes different artistic methods provided to patients that initiate healing through creative methods. These methods encompass art therapy, music therapy, dance and movement therapy, and pet therapy. Each is used to provide additional sources for coping, wellness, and transition (Greenwood, 2011; Kapitan, 2011).

**High-risk hospitalization -** Patients on high-risk units are there due to a threat to the health of the mother, baby, or both. Reasons for admission to high-risk setting include:

premature labor, preeclampsia, high blood pressure, diabetes, or detachment of the placenta (Denis, Michaux, & Callahan, 2012; Holness, 2018).

**Meaning-making -** the use of art materials with personal meaning to understand, communicate and make sense of experiences, life events, and the self. (Baughcum et al., 2017).

**Neonatal Intensive Care Unit (NICU) -** refers to an admission or stay of a newborn child into a hospitalized setting, often following a high-risk or complicated pregnancy. A NICU stay allows growth and development to continue for a newborn child who needs supervision and assisted care (Eliades, 2018; Rasmussen, Raffin-Bouchal, Redlich, & Simon, 2018).

**Nesting -** refers to the physical and psychological period for pregnant mothers during which they begin to ready themselves and their environment for the birth of their baby (Janighorban et al., 2018; Trujillo, Fernandez, Ghafoori, Lok, & Valencia, 2017).

**Postpartum pregnancy -** refers to women who have recently given birth and are no longer physically pregnant. This is a time when the mind and body move back into a non-pregnant state. Changes to hormones, emotions, and the body itself can happen quickly during this time or may last for months (Janighorban, et al., 2018; O'Brien et al., 2013).

**Outpatient care –** provides services that help patients and their families transition from the women's hospital back into everyday living (Jefferies, 2014; O'Brien, Rauf, Alfirevic, & Lavender, 2013).

# CHAPTER II

## METHODOLOGY

The literature for this study was reviewed using an integrative literature review methodology. The role of the researcher using this method is to collect information and organize it as it pertains to the research question and field of study, which leads to greater comprehensive inquiry, inclusive learning, and broadening of ideas (Abelsson, Rystedt, Suserud, Lindwall, 2016). The articles and data from previous research are analyzed to build upon the idea being studied and to provide findings towards new research (Fain, 2016). The goal of the literature review for this study is to better understand and integrate the following topic areas:

1. Needs of women and families effected by hospitalization within a women's health setting.
2. The continuum of care model and continuation of therapeutic services in a medical practice.
3. Art therapy practices currently used with women's health and medical populations.

The results will be used to integrate literature-based treatment needs and art therapy methods into identified areas of care planning along a continuum of care in the women's hospital setting, from high-risk and long-term hospitalization units, to the neonatal intensive care and continuing care units, and finally, in outpatient care.

# CHAPTER III

# LITERATURE REVIEW

The following review of the literature introduces the continuum of care as applied to women's health, with an emphasis on hospitalized systems, mental health, and the roles and functions of care teams. The literature on women's health during hospitalization encompasses three major systems which are reviewed: high-risk hospitalization, neonatal intensive care for families and caregivers, and an outpatient care service. The implications of each system, or hospitalized unit, is shown in relation to the experiences that hospitalized individuals face over the continuum of their care. The literature reviewed also highlights further needs, recommended areas for improvement, and new ways to approach treatment planning. Further, the literature on art therapy in women's health and other medical settings is reviewed in relation to the implications of each system. This provides a glimpse of what art therapy might contribute toward a more unified healthcare experience along a new type of continuum in care with use of art therapy.

## A Continuum of Care at the Women's Hospital

Hospitalization admission, regardless of the details or cause, may lead to stressors and anxieties that the patient or patient's family was not expecting. Upon admission, patients and family members find themselves in an unfamiliar place and without much control. Additionally, the separate units and entities within the hospital may seem complex and confusing to navigate. High-risk antepartum care, neonatal intensive unit for families and caregivers, and outpatient postpartum care involving baby and mother make up a continuum that most women and families must go through once they are admitted to the women's hospital (Arnold, 2019). The ability to see a patient through transitions from one setting to another and then, even further into outpatient

services or check-ins may provide hospitalized individuals with higher quality of care, feelings of being understood, and even greater healthcare services (Smith et al., 2010, p. 207). Providers often cycle patients from one provider to the next, with each provider being like one spoke in the wheel needed to keep moving the patient forward. In a continuum of care, one health professional is able to essentially be the wheel itself and travel with the patient and family as they move through an entire hospitalization process (Smith et al., 2010, p. 208).

Inpatient care encompasses many stages and units of care, each staffed by different medical team members. When transitioning to outpatient care in particular, the patient does not see the care providers that journeyed with them through their hospitalization. Arnold (2019) addressed the importance of provider mobility to standardize decision-making, communication, and safety toward patients and patient families. When providers can move with patients through each additional step in their care and physically from unit to unit, patient and patient families may experience less stressful outcomes, for example communication appears to be stronger and more well-rounded (Smith et al., 2010). This finding supports Ward (2001) who found that patients appreciate assurances and honest answers to their questions within their healthcare treatment, which also facilitates the best possible outcomes.

**High-Risk Hospitalization**

Within a continuum of care, high-risk pregnancy is often the first hospital unit in the cycle of transitional care. Antepartum pregnant women admitted to the high-risk unit at the women's hospital are often in the beginning stages of hospitalization. The high-risk unit comes with a specific set of rules and complications. Patients often find themselves outside of their homes for day, weeks, or months depending on the severity of their admission diagnosis and without any sort of notice (Janighorban et al., 2018). This leaves patients feeling unable to nest;

having little notice to arrange for household care, baby sitters, or give notice to their employer, they have been unable to 'tie things up' before hospitalization (Nakahara Melo, Vasconselos Amorim, Salimena de Oliveira, Simoes Cardoso de Melo, & Oliveira Souza, 2016). On top of an often-unpredicted admission, women face the ending weeks or months of their pregnancy more isolated and away from home. This means that antepartum women are less likely to see family on a regular basis. Some families may live far away in which travel becomes a barrier. This further leads mothers feeling at a loss of control with their admission and alone during this peak life event (Oliveira & Teixeira Mandu, 2015). These factors lead to more adverse implications that additionally affect mother and baby as the pregnancy progresses. Holness (2018) highlighted aspects that go along with labeling a pregnancy as high risk. For example, mothers may develop negative emotions, with feelings of vulnerability and mental stress due to feeling 'sick' or 'inadequate' in their health. The high-risk label may lead to additional anxieties which and may result in a sense of loss of control over the pregnancy. In addition, increased fear and anxiety regarding pregnancy and birth may develop (p. 246). Further psychological and emotional themes that play into high-risk thinking patterns include: "desire to have a child, acknowledging the existing health problem, overcoming the initial shock of a newborn with health problems, and coping with the intense feelings associated with having a sick newborn while experiencing frustrations, desires, and surmounting problems associated with the pregnancy" (Holness, 2018, p. 247).

Patients may not view their personal risk as severe as their healthcare providers view them and because of this, problems may arise in communication. Holness (2018) stated, "The statistical aspect to high-risk assessment is based on how likely it is that the event will occur, whereas the psychological portion hinges on how the woman views her risk" (p. 247). There

may also be dissatisfaction in care and a failure to use necessary health care resources when the pregnancy is labeled as high risk (Holness, 2018). Bauer et al. (2010) found that women who consciously observed their own personal hospitalization process of care during high-risk pregnancies and childbirths better communicated and understood staff and medical team operations. When staff and team members listen to patients and answer their questions thoughtfully, patients feel they are treated in a meaningful and way. However, when staff and team members show only technical points of view and subjectivity, patients often verbalize feeling stress and misunderstandings (Azevedo et al., 2017). Further, patient experience and psychological coping are negatively impacted by healthcare providers and interactions that come across as impersonal, distant, and aggressive (Nakahara Melo et al., 2016). Patients suffer psychologically on the high-risk unit due to a lack of attention in an isolating space, feelings of a lack of guidance and control, and further misunderstanding about pregnancy risk factors (Azevedo et al., 2017). Patients should be provided with a greater understanding of what the patient and staff relationship should look like, for short- and long-term patient care. The idea of treatment and treatment plans are something to be largely rethought as it pertains to a healthcare team and patient relationship (Nakahara Melo et al., 2016). Women have many needs in high-risk scenarios including physical, psychological, emotional, social, and educational. However, medical professionals tend to focus on only physical needs and curable actions (Oliveira & Teixeira Mandu, 2015).

**High-risk Treatment Issues**. Understanding the needs of women in a high-risk setting is important when it comes to treatment planning and quality individualized healthcare. "Antepartum hospitalization implications have been associated with increased levels of psychosocial distress, including anxiety, depression, stress, boredom, loneliness, feelings of loss

of control, and powerlessness" (Bauer et al., 2010, p. 523). Bauer et al. (2010) also reported a relationship between antepartum-related distress and adverse events in pregnancy towards labor and delivery. Four main categories of needs were found by Sarid et al. (2017) for high-risk women: (1) psychosocial support, (2) support for family, (3) support for childcare, and (4) comprehensive support for coping with these issues collectively. High-risk women and their family members often experience prolonged grief and other adverse effects once they become aware of doctor ordered bed-rest (Janighorban et al., 2018). In addition, "bedrest has devastating physiological effects including muscular dysfunction, weight loss, bone loss, thrombosis, fatigue, and sleep disorders" (Janighorban et al., 2018, p. 1328). Related to psychological needs, Oliveira & Teixeira Mandu (2015) stated that "the suffering of women is higher when they have no space in the service to talk, express themselves and better understand what the diagnosis means" (p. 97).

Motherhood is often associated with happy feelings and thoughts, while also being a common experience of the human population. Because of this, it seems that unhappiness during pregnancy is often not accepted or understood unless it is the pain of birth itself. Imbalances and intra-psychic changes are common occurrences during a high-risk pregnancy which often lead to behaviors that a mother might not typically display (Dornelas, Ferrand, Stepnowski, Barbagallo, & McCullough, 2010). Quality prenatal healthcare through a psychotherapeutic approach is shown to be a successful strategy when intervening high-risk situations. This is where emotional and psychological response can determine how mothers continue to progress through their maternal state (Azevedo et al., 2017). Literature further expresses that high-risk women experience several biological and behavioral events that uncover unmet personal needs within their personal, family, and social lives. Without carefully addressing these, the health of the

mothers and how they care for themselves could ultimately lead to complications during antepartum state or with the baby (Oliveira & Teixeira Mandu, 2015).

**Newborn Intensive Care Unit Hospitalization with Families**

Within a continuum of care, Neonatal Intensive Care Unit admission (NICU) is often the second stage of the cycle. Often times a women's high-risk pregnancy will directly correlate with the baby being admitted to the NICU, at least for a small amount of time (Morton & Forsey, 2013). Postpartum mothers and parents are often in what is considered the middle stages of admission, which means that they are already somewhat familiar with the quality of care, the systems, and environment of the hospital (Trujillo et al., 2017). In this stage, women and families begin to settle into what they can expect of their hospital admission; although in moving to a separate unit, and being passed on to other healthcare providers, women and families experience some frustration. While their physical needs may be addressed when they are passed from one care team to another, their psychosocial and emotional needs are often not (Rasmussen et al., 2018). Women and families may experience disconnection with their medical team and feelings of not being understood, which may also increase anxiety and stress for the parents and caregivers of the newly admitted patients (Barr, 2017). Patient families often find themselves traveling to the neonatal intensive care unit from a distance multiple times a week for weeks or months depending on the severity of the baby's admission diagnosis; and they are often not given a timeline of care (Welch et al., 2013). Patients are less likely to see family on a regular basis and are affected financially in terms of loss of income and job placement as well as the need for external care providers for other children or family they may have at home (Rasmussen et al., 2018). Many of these factors lead to increased stress and anxiety for parents who are trying to juggle a high-risk newborn and their personal lives. This stress affects the parent's

ability to cope and be present for their child in the hospital during an important time for baby growth and development (Silva, Linhares, & Gaspardo, 2018).

**Neonatal Intensive Care Unit treatment issues.** At the women's hospital, women, parents, and caregivers of NICU children face many of the same emotional implications due to hospitalization. Ward (200) studied Midwestern United States families and their particular needs related to neonatal intensive unit care and how these needs affect their perceived care overall (Ward, 2001). Statements of needs were ranked and broken down into the following subcategories: support, assurance, information, comfort, and proximity to the NICU location. Findings suggested that assurance statements were ranked most highly as having the greatest importance to parents in their experiences with staff and other healthcare providers on the unit (Ward, 2001). Examples of assurance statements included: "assurances on the expected outcome of the infant," "assurances in the best possible care being given to the infant," and "to have assurance that questions about the infant are answered honestly" (Ward, 2001, p. 281). These statements show that parents need to have both assurance and direct, honest information about their baby's treatment plan. Coping with chaotic emotions is a largely evaluated outcome by parent experience in the NICU. Chaotic emotions appear as parents experience the busyness of staff in the NICU environment, not being able to fill the parent role, and fear in dealing with a still developing newborn; due to these emotions, parents often verbalize feeling a loss of control (Hagan, Iverson, & Svindseth, 2016, p. 4). Feeling a loss of control contributes to heightened anxiety and stress levels which may also be attributed to a lack of personal parental self-care and coping (Silva et al., 2018). Parents often "felt as if they were part of an audience looking through a window at the situation from an almost out-sider position" and "witnessing something that you should not witness as a parent" (Hagan et al., 2016, p. 5). Individual processing as

mother and father figures as well as coping as a couple in relation to their newborn are equally important aspects of psychological healing during the experience of having a child in the NICU (Shoemark, 2018). According to Hagan et al. (2016):

> Rituals of bonding and natural processes are disrupted in premature births. The picture in the parents' minds are often disordered, as reality is quite different from their expectations. Parents are afraid of harming their baby and are torn between emotions like attraction versus fear, sometimes even disgust and always helplessness. (p. 4-5)

Parents are often told by practitioners that they will only bond with their baby when they are emotionally and individually ready to do so (Mouradian, DeGrace, & Thompson, 2013). Because of the need for parents with an infant in the NICU to take care of their own health and receive emotional support, it is important to assist them by recognizing their strengths and abilities and teach them how to access services that can provide such support (Hagan et al., 2016).

**Outpatient Center**

Within a continuum of care, the outpatient center is often the third and last stage in the cycle of transitional care. This last stage involves a discharge of mother and baby and a required follow-up appointment anywhere from one to six weeks later, depending on discharge status. The primary care center handles postpartum and outpatient appointments for prior patients. The outpatient facility ties up the ends of patient care. As patients and patient families travel home, they may find themselves in yet another transitional state, moving from a hospitalized setting to a previously familiar home setting. Their home setting may be familiar, but it has less regulations, follow-ups, check-ins, and also no care center team for the baby; this is a big change for those

patients previously on 24-hour assistance and care (Friedman, Friedman, Collin, & Martin, 2018).

Even though going home is typically a time of joy, it may also be a very intimidating and anxiety-ridden experience; parents face new challenges of being on their own in addition to concerns about their own bodies and sometimes with the body of their newborn (Jefferies, 2014). With this transition comes increased levels of uncertainty as family members move into stages of life that they anticipated but had little time to prepare for. During follow-up appointments, healthcare providers check-in on physical care abilities, transition to home, and medical care needs of the mother and child (Morton & Forsey, 2013). As the continuum of care within the hospital setting ends, the care does not have to; instead services can be given to previous patients and patient caregivers as part of the transition from inpatient to outpatient. A provider who has built rapport and carried patients through the healthcare setting is in the best position to provide further resources and care to these individuals as they transition into a newly formed life and routine (Arnold, 2019).

An important part of this care would be psychosocial support. However, there is scant literature on services that address psychosocial implications and the emotional transition from hospitalization to home. A provider who has been able to follow the patient and their family through the continuum of care would be in the best position to determine needs of the patient and their family prior and during discharge (Arnold, 2019). At this time, outpatient services may be given to the patient and patient families in order to support their transition. Based on rapport and trust having already been built and psychosocial support previously given, patients may be inclined to share more of their emotional thoughts and feelings, including important postpartum experiences such as depression (Morton & Forsey, 2013). If this stage is considered as part of a

continuum of care, patients can be given the opportunity to continue services on an outpatient basis if needed or properly terminate services (Smith et al., 2010).

**Outpatient treatment issues.** The literature shows that it is important to give mothers and their infants the opportunity to continue care from inpatient to outpatient with the goal of integrating physical and psychosocial support and connections outside of hospitalization (Hou, Zhao, Feng, Cui, & Wang, 2014). Related to mental health needs, Holness (2018) stated:

> High-risk pregnancies result in higher postpartum anxiety and depression rates (9%-12%) when compared with women with low-risk pregnancies. Contributing factors include maternal age, gravidity, number of abortions, interval between pregnancies, and the desirability of pregnancy. Although postpartum depression is common, in women with high-risk pregnancies, emotions of 'guilt, inadequacy, and uneasiness' may result in higher levels of depression, bonding troubles, and readiness anxieties. (p. 247)

Psychosocial needs related to care-giving are also important to address. Morton (2013) stated, "although parents assume full responsibility for their infant's care following discharge, many do not feel fully prepared for this role when they take their baby home...as well as providing basic infant care" (p. 695). At the women's hospital, twenty-four-hour care is provided to patients and parents can rely on staff and healthcare providers when in doubt or in a high-risk situation (Friedman et al., 2018).

Despite the issues identified above, there is a lack of literature on the treatment needs of patients and families after discharge. Therefore, it seems that further research is needed to determine mental health and psychosocial implications for this stage of a continuum of care. Though there is not literature to draw on, it may be assumed that patients are often outsourced or

find community mental health associations when discharged and do not continue with hospital healthcare staff for mental health needs.

**Art Therapy within Women's Health Continuum of Care**

**High risk.** Studies report the needs of pregnant women with high-risk pregnancies as psychosocial support, improved environment, help for mental compatibility, and acceptance of resting or long-term hospitalization (Janighorban et al., 2018). Art therapy can help to meet these needs by helping the patient to develop healthy coping skills on an individual or group basis during hospitalization. "Creative Arts in a women's health hospitalization setting involves providing the patient with creative outlets for self-expression and relaxation. Patients can participate in such activities as journal writing, poetry writing, listening to music, and independent craft activities" (Bauer et al., 2010, p. 525). Oliveira & Teixeira Mandu (2015) explored the elements that strengthen women and how this could be incorporated creatively into their prenatal needs through individual and collective strategies. Art used as a form of healing may bring forth artwork that serves to promote personal reflection and even inspiration as patients move through the treatment process (Blomdahl et al., 2016). By allowing a patient's personal expression to become meaningful through their own conversation and conceptualization, art-making can help to alleviate unwanted psychological symptoms and provide a source of personal support (Kivnick & Erikson, 1983).

Dornelas et al. (2010) indicated that psychotherapy should be a first-line treatment and is recommended over pharmacological solutions for pregnant women with a first occurrence of major depression. As a non-pharmacological psychotherapeutic intervention, art therapy could be used to address the psychological and physical needs of mother and child in a high-risk setting (Bauer, Victorson, Rosenbloom, Barocas, & Silver, 2010). Kivnick & Erikson (1983) found that

art therapy is able to give high-risk mothers control and a sense of self-expression, providing an outlet for building positive coping mechanisms that also decrease symptoms of depression through creativity. Further, art therapy provides an outlet for communication both verbally and non-verbally that allow these women to further express and understand their thoughts, feelings, and depressive symptoms (Blomdahl et al., 2016, p. 532).

**Neonatal Intensive Care Unit.** Art therapy has many treatment applications for families and parents during the high-stress and grieving process involved in the NICU care setting. Different types of art making could occur from nesting with the baby in the NICU, stress and anxiety relief, as well as legacy making with parents after an infant has died (Xeros-Constantinides, Boland, & Bishop, 2017). Mouradian, DeGrace, & Thompson (2013) found that art experientials provided greater anxiety relief than other non-artistic tasks. Scrapbooking in particular has been effective with both parents and families who have experienced a long hospital journey or lost a child (Villinskas, 2019). This activity involves all members related to the birth or death and provides a way to make meaning of the circumstance and combat high levels of stress and anxiety (Mouradian et al., 2013, p. 693). The scrap booking materials used include pictures, ultrasound photographs, hand or foot prints, writing, markers, colored paper, a small book and glue. By giving parents a book to work on that takes time, they are able to focus and devote time, previously spent in a stressful state, into a more positive directive that provides absorption and relief (Lichtenthal, Currier, Neimeyer, & Keesee, 2010). The ability to relax and have a hope for the future outside of the NICU is a common theme mentioned among those who participated in scrapbooking as meaning making; this activity contributed to their hope for a future and encouraged personal identity building (Mouradian et al., 2013).

Legacy building, described as commemorating and keeping alive the memory of life through art making, is another process that is provided using art in the NICU (Kohut, 2011). Accordion scrapbooks are used in legacy making as a way to continue meaning making and address grief after infant or fetal death. As parents redefine their expected roles for anticipated parenthood, scrapbooks provide a sense of self-expression, ownership, and encouragement of freedom by allowing participants to engage with the books as they please (Kohut, 2011). Diverse populations are able to participate in this experiential as the meaning making is determined by the individual (Lichtenthal et al., 2010). Writing adds another element to the books; parents are able to depict thoughts and feelings had at the time of death and then be able to look back on the writings to see how they have progressed in the future (Brelsford & Doheny, 2016). The legacy building form of art allows adults to grieve on paper and then physically move forward to the next page (Kohut, 2011). Parents are encouraged to share scrapbooks with others in a therapeutic group setting, allowing connection regarding similar grief and pain (Kohut, 2011). Art experientials such as these provide meaning-making and are adaptable for a group setting that can additionally provide community and discourage isolation. As parents grieve in art and within a group setting, they are better able to recognize that they are not alone and are not the only ones who have lost a child (Baughcum et al., 2017).

**Outpatient Center.** There is no current literature about art therapy for outpatient care in a women's health hospital setting. Some literature exists related to addiction and cancer outpatient treatment; however, nothing yet related directly to women, family and infant health. The review of this literature yielded no results that attribute directly to this populations within the continuum of care model.

# CHAPTER IV

# RESULTS

An integrative literature review was conducted to better understand and integrate three topic areas in order to create art therapy programming to be provided to women and families located within women's health medical facilities across a continuum of care. The topic areas reviewed were:

1. Needs of women and families effected by hospitalization within a women's health setting.
2. The continuum of care model and continuation of therapeutic services in a medical practice.
3. Art therapy practices currently used with women's health and medical populations.

The results of the review were analyzed by creating thematic matrices that identify the care issues that women, families, patients and caregivers face as they undergo and move through the hospitalization process. The literature confirmed that there are three key areas of care within the continuum at the women's hospital setting: (1) high-risk and long-term hospitalization units, (2) neonatal intensive care and continuing care units (NICU), and (3) outpatient care. Literature for each area of care was analyzed separately to identify the issues unique to that area, as well as existing gaps within treatment planning and care programming. The results are shown in the tables below, in order of the continuum of care. Finally, art therapy methods and interventions found in the literature related to women's health and medical settings were mapped to the treatment issues identified for each area of care. These are included below each table. Additionally, for areas where literature was absent for art therapy methods and interventions,

examples are provided based on observations of art therapists practicing in women's health during my internship, as well as from my own practice in this setting.

**High Risk Treatment Issues**

Treatment issues shown in the literature for the high-risk population, the first area in the continuum of care, is shown in *Table 1*. The issues stated most frequently among articles are as follows: anxiety, depression, isolation, support, loss of control, pain, nesting, and self-esteem. These needs are shown by article name, author and year, and within the context of which they were most mentioned.

Table 1. *High-Risk Treatment Issues*

| Article title, Author (Year) | Anxiety | Depression | Isolation & Supports | Loss of Control | Pain | Nesting | Self-Esteem |
|---|---|---|---|---|---|---|---|
| Profile of high-risk pregnant women hospitalized in maternity hospital. Azevedo et al. (2017) | | | X | | X | | X |
| Alleviating distress during antepartum hospitalization. Bauer et al. (2010) | X | X | X | X | | | |
| Art therapy for patients with depression. Blomdahl et al (2016) | | X | | | | X | |
| Factors implicated in moderating the risk for depression and anxiety in high-risk pregnancy. Denis et al. (2012) | X | X | | | | | |
| A pilot study of affect-focused psychotherapy for antepartum depression. | | X | | X | | | |

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|---|---|---|---|---|---|---|---|
| Dornelas et al. (2010) | | | | | | | |
| High-risk pregnancy. Holness (2018) | X | | | | X | | X |
| Women's needs on bed rest during high-risk pregnancy and postpartum period. Janighorban et al. (2018) | X | | X | X | | | |
| Hospital care of women who experienced a high-risk pregnancy. Nakahara et al. (2016) | | | | X | | X | X |
| Women with high-risk pregnancy: experiences and perceptions of needs and care. Oliveira et al. (2015) | | | X | X | | | X |
| The relationship between grief adjustment and continuing bonds for parents who have lost a child. Ronen et al. (2010) | | X | | | | | |
| Treating women with perinatal mood and anxiety disorders with cognitive behavioral and art therapy treatment. Sarid et al. (2017) | X | | X | | | | X |
| The effect of inpatient group art therapy on anxiety. Villinskas et al (2019) | X | X | | | | X | |

**Art Therapy methods and interventions related to high-risk treatment issues.**

***Anxiety.*** Art making provides self-expression and relaxation through journal writing, poetry, and music which may alleviate anxiety and provide control through externalization

(Bauer et al., 2010). Art therapist Joani Rothenberg (personal communication, March 2019) uses felting or drawn mandalas to center an individual providing them a sense of flow or alleviation of energy.

***Depression.*** Art therapist, Kaitlin Knapp (personal communication, January 2019) advises use of acetate paper and markers to create window hangings that look like stained glass in order to alleviate symptoms of depression. These window hangings encourage the patient to keep window blinds open in order to let light in and reflect different colors around the room engaging perceptual and affective components that positively stimulate the mind and regulate emotions.

***Isolation and support systems.*** Psychosocial needs are shown to be the most important to women hospitalized while pregnant for extended periods of time. Mothers show concern for needing support from significant others or other family members alongside their journey (Janighorban et al., 2018). Including family and other caregivers in the experience of artmaking on the high-risk unit allows the patient to feel supported and take control in sharing their experience while also becoming relatable to others outside of hospitalization (Kivnick & Erikson, 1983). In my personal practice, I have seen that when families have the ability to contribute collectively to a larger piece, such as a painting, scrapbook and journaling process, or weaving that shows collaboration and completion by multiple hands, they create a bond with other members involved.

***Loss of control.*** Patients are able to engage in decision-making when it comes to art materials and art making. Active engagement through sessions on content drawn or words chosen through music making or poetry allow the patient to feel in control of their environment in a place that leads for little voice or control (Bauer, 2010). Control may be given in group or

individual sessions that allow the patient to complete a directive with multiple options. For example, creating accordion books, scrapbooking, or art-making that involves many different papers, utensils, and outcomes often engage the patient to make choices and become active in their environment rather than remain stationary while hospitalized (Kivnick, 1983).

***Pain.*** Spontaneity through art making provides distraction and increased concentration for patients, which assists in alleviating pain or other stressors (Kivnick & Erikson, 1983). The goal is that the task is both engaging and challenging, which will vary from patient to patient. Particular art making tasks will need to be determined between therapist and client based on their comfortability and strengths (Blomdahl et al., 2016). In personal practice, I have used clay or sculpted material to create resistance and pressure on a different part of the body than the one being impacted by pain.

***Nesting.*** Personalized art-making and materials allow patients to find personal comforts in unfamiliar environments (Kivnick & Erikson, 1983). Art therapist Anne Collins (personal communication, April 2019) provided insight towards nesting techniques that have been used to personalize and make early memories of the preparation process towards birthing. These include personalizing painted canvases for the high-risk or NICU rooms, making a dip-dyed swaddling cloth, and altered books made from ultra sound pictures and journaling.

***Self-esteem.*** Personal exploration of strengths through creative incorporation into their prenatal needs allows patients to express themselves and build confidence in high-risk circumstances (Oliveira & Teixeira Mandu, 2015). Materials such as clay allow for manipulation and grounding as patients are able to formulate, destroy, and reconfigure the material multiple times before engaging in a finished outcome (Nakahara Melo et al., 2016).

**NICU Treatment Issues**

Treatment issues shown in the literature for the NICU, the second area of the continuum of care, are shown in *Table 2.* The issues stated most frequently among articles are as follows: anxiety, need to be given assurances and support, bonding, nesting, coping, grief and bereavement, isolation, and loss of control. These needs are shown by article name, author and year, and within the context of which they were most mentioned.

Table 2. *NICU Caregiver Treatment Issues*

| Article title, Author (Year) | Anxiety | Assurances & Support | Bonding & Nesting | Coping | Grief & Bereavement | Isolation | Loss of Control |
|---|---|---|---|---|---|---|---|
| Perspectives from bereaved parents on improving end of life care in the NICU. Baughcum et al (2017) | | | X | | X | | |
| Compassion fatigue and compassion satisfaction in neonatal intensive care unit: relationships with work stress and perceived social support. Barr et al. (2017) | X | | X | | | | |
| Religious and spiritual journeys: brief reflections from mothers and fathers in the NICU. Bresford et al. (2016) | | X | X | | | | X |
| Mitigating infant medical trauma in the NICU. Eliades (2018) | | | X | | | X | |
| Differences and similarities between mothers and fathers of | | | | X | | | X |

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|---|---|---|---|---|---|---|---|
| premature children: coping experiences in the NICU. Hagan et al. (2016) | | | | | | | |
| Making art from memories: honoring deceased loved ones through bereavement group. Kohut (2011) | | | X | X | X | | |
| Art-based occupation group reduces parent anxiety in the NICU. Mouradian et al (2013) | X | | X | X | X | | |
| Patient and family experiences of advance care planning conversations help prior to intensive care unit admission. Rasmussen et al (2018) | X | X | X | | | X | X |
| Time together: a feasible program to promote parent-infant interaction in the NICU. Shoemark (2018) | | | X | X | | | |
| Development care approaches for mitigating stress in preterm neonates in the NICU. Silva et al. (2018) | X | | | X | | | X |
| Interdisciplinary family conferences to improve patient experience in the NICU. Trujillo et al. (2017) | | X | | | | | X |
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|---|---|---|---|---|---|---|---|
| Perceived needs of parents critically ill infants in a NICU. Ward (2001) | | X | X | X | | X | |
| Family nurture intervention in the NICU: assessments of length of stay, feasability, and safety. Welch et al. (2013) | | | X | | | X | X |
| Journeying to connect: promoting post-natal healing and relationship formation through connection group art-therapy program. Xeros-Costantinides et al (2017) | | | | | X | X | |

**Art therapy methods and interventions related to NICU issues.**

***Anxiety.*** Studies show journaling, image collection, or scrapbooking have alleviated parent anxiety while experiencing the feelings of having an infant in the NICU (Mouradian et al., 2013). Process-style art-making provides caregivers the opportunity to externalize and reflect over a long period of time and also allows visitation to older entries in order to gain insight in effective coping methods.

***Assurances and support.*** By giving parents an altered book to work on that takes time, they are able to focus and devote time previously spent in a stressful state into a more positive directive that provides absolute absorption and relief (Lichtenthal, Currier, Neimeyer, & Keesee, 2010). This allows parents to work cohesively on the same book, providing each other with multiple outcomes and changes along the way, which is often similar to the NICU experience day-to-day.

***Bonding, nesting, and isolation.*** "Milestone beads" allow parents to take part together in their personal journey with their infant. In a primarily isolating time, parents and caregivers share milestones such as first feedings, overcoming surgeries, and breathing on their own as milestone accomplishments that may be represented with handmade beads (Xeros-Constantinides, Boland, & Bishop, 2017, p. 5). As infants are moving through their own journey to grow and survive, caregivers make efforts to bond and nest with their infant. This is also an important time for parents to cope and externalize through physical representation of accomplishments they have been through collectively (Hagan, et al., 2016).

***Coping.*** Nurses have observed that caregivers feel more easily acclimated to the NICU when they are able to participate in the customization of their infant's space. This includes personalizing areas with the infant's name, infant colors, and family associations, such as favorite items of comfort like blankets or initialed canvases to engage a space (Friedman et al., 2018). In my personal practice, I have observed that coping methods present differently for each caregiver and should be prepared individually for works best for them.

***Grief and bereavement.*** Scrapbooking provides a sense of ownership and freedom to engage with artmaking as families and individuals desire. Writing adds an element to depict thoughts; once a page is filled it can be turned, which is a literal representation of moving forward (Brelsford & Doheny, 2016). These scrapbooks work well with individuals or families as they make better understanding of their life with the infant and the journey they have taken together (Kohut, 2011). In my personal practice, I have used memory boxes including clothing, prints, images, and journaling to commemorate the time that parents or caregivers have spent with their child. These may be carried and opened at later times to keep memories alive and

remember times they were with their baby. These boxes may be added to over the years as the grief may never pass, but the journey to move forward will continue.

***Loss of control.*** Sand mandalas provide a way of externalizing and processing what it feels like to not have control. Art therapist Eileen Misluk (personal communication, December 2019) uses sand as a way to visualize what it is like to not feel in control and how you cope with it. Sand allows patients to manipulate the material then start over or change approach at any time. This process also provides insight into how we try to continually take control of situations that are out of our reach.

**Outpatient Treatment Issues**

Treatment issues shown in the literature for the outpatient population, the final area in the continuum of care, is shown in *Table 3*. The issues stated most frequently among the articles are as follows: anxiety, depression, bonding, grief and bereavement, loss of control, support and transition or readiness for home. These needs are shown by article name, author and year, and within the context of which they were most mentioned.

Table 3. *Outpatient Treatment Issues*

| Article title, Author (Year) | Anxiety & Depression | Bonding | Grief & Bereavement | Loss of Control & Supports | Transition & Readiness |
|---|---|---|---|---|---|
| Safe patient mobilization across the continuum of care. Arnold (2019) | | X | | X | X |
| Mitigating infant medical trauma in the NICU: skin to skin contact as trauma-informed. Eliades (2018) | | X | | | X |
| Staff perceptions of challenging parents: staff interactions and beneficial strategies in the NICU. Friedman et al. (2018) | | X | | X | X |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| High-risk pregnancy. Holness (2018) | X | X | X | X | |
| Women's needs on bed rest during high-risk pregnancy and postpartum period. Janighorban et al (20 (2018) | X | | | X | X |
| Going home: facilitating discharge of preterm infants. Jefferies (2014) | | X | | X | X |
| Sense and significance: meaning making after the loss of one's child. Lichtenthal et al. (2010) | | X | X | X | X |
| My time, my space (an arts-based group for women with postnatal depression). Morton et al. (2013) | X | | | | |
| The relationship between grief adjustment and continuing bonds for parents who have lost a child. Ronen et al. (2010) | X | | X | | |

**Art therapy methods and interventions mapped to outpatient issues.**

***Anxiety and depression.*** Images that specifically direct the mother to show personalized view of self, personalized view of infant, and how these work together becomes important in screening for depressive symptoms or feelings regarding loss of control. Interactions or lack of creative connections may show that the new mother or infant are not interacting in a way that feels comfortable (Hogan, Sheffield, & Woodward, 2010).

***Bonding and nesting.*** Music played in the high-risk and NICU settings are shown to alleviate symptoms during hospitalization (Bauer et al., 2010). Cassandra Haines (personal communication, March 2020), a music therapist, describes that this very same music, whether created personally from scratch or implemented into a playlist, allows patients and families to transition from hospitalized care into a more personalized home setting more easily. When

caregivers are emotionally involved in a hospitalized setting, they may engage with sensory experiences and then engage again during the transition home as a way to re-orient and transition themselves home in less-heightened times.

***Grief and bereavement.*** Weaving has been introduced to outpatient mothers or caregivers as a way to commemorate and spend time processing the life and death of their infant. As caregivers begin to weave, different colored yarns or materials may be used to represent different moments or meaningful periods that they shared with their baby. This method has shown to be a collection of highs and lows bringing joy and grief, and also encompasses the relationship as a whole rather than internalized pieces or thoughts (Hogan et al., 2010).

***Support systems.*** Social support in the first six weeks is mentioned to be the most important time for postnatal mothers to gain support, as the body and mind go through a type of personalized trauma all their own (Baer, et al., 2010). A pathway depicting the mother's journey from hospitalization to home may be able to indicate where the mother feels she has properly transitioned to psychologically (Hogan et al., 2010).

***Transition and readiness (education).*** Art therapist Kaitlin Knapp (personal communication, March 2020) describes that patients are often unprepared for the transition home and do not understand the way that their body is changing and the rebalancing of hormones. Teaching methods to externalize feelings in a productive way, and using methods such as creative-making to cope when feeling often misunderstood, can help educate the patient about self-care.

# CHAPTER V

# DISCUSSION

## Overview of Results

This study used an integrative literature review methodology to identify the art therapy treatment needs of mothers and families experiencing a high-risk pregnancy within a women's health facility, in order to propose an art therapy treatment model for this population that spans a continuum of care. The results indicate that there are differentiated treatment issues for each stage of care that art therapists can address through individual and group art therapy programming. These findings were used to create an integrated program for art therapy, presented below. The program's plan follows the patient and their family through six action steps across the care continuum: (1) recruitment and referral, (2) intake evaluations, (3) assessment of needs, (4) treatment planning and recommendations, (5) transitional care, and (6) termination. These steps provide connection with the patient or caregiver and carries them through a step-by-step process of introducing services through art therapy programming and further into closure of provided services. Individual, family, and group art therapy programing was developed to address the treatment issues identified in the literature for each stage of care, with examples of interventions provided for each. Examples of documentation forms needed to support this model are also included.

## Art Therapy Through a Continuum of Care Programming

Women and their families experiencing a high-risk pregnancy may be less inclined to provide information about their experience through hospitalization and transition into home care due to the lack of patient provider rapport and the emotional toil it takes to relay a very personal experience. However, if a patient has built trustworthy rapport with an art therapist or other

healthcare provider, they may be more inclined to share personal experiences and life concerns that can inform all aspects of care. Traveling with a high-risk mother after delivery from one unit of hospitalized care into the next unit of care would provide consistent support and therapeutic services towards meeting overall patient goals, from admission to discharge. The value of emotional support given by consistent providers is important to recognize, considering that currently no single provider is able to carry patient care through the entirety of the hospitalized journey. Art therapy programming through the continuum of care may offer a new way to address patient emotional needs and provide a smoother transition through hospitalization and outpatient treatment.

**Programming Action Plan**

The continuum of care addressed in this model encompasses three stages—high-risk, neonatal intensive care unit, and outpatient care services—which need a process plan to implement with patients. The six action steps for art therapy programming are: (1) recruitment and referral, (2) intake evaluations, (3) assessment of needs (4) treatment planning and recommendations, (5) transitional care and (6) termination.

**Recruitment and referrals.** Recruitment process involves fliers, word of mouth, hospital staff meetings, in-services, and in email. These processes are typically executed during already scheduled staff meetings in order to engage all different healthcare professionals. Since art therapy referral and art therapy process is dependent on education of treatment, it is important that proper training related to patient goals and outcomes are described during the recruitment and referral process. In-services are used to inform healthcare professionals of the benefits and outcomes of art therapy. These in-services may be used in the form of an informative presentation, or more directly with staff members as they are able to participate in their own

experience of art therapy, such as art therapist-facilitated wellness experiences. Some professionals learn best with hands on experience as it pertains to their personal experiences and may better understand the patient needs and benefits from an art-based workshop. Recruitment and referrals will be documented through the medical treatment team. Referral information will be examined and evaluated by the art therapist for intake and in furthering the therapeutic relationship with the patient.

**Intake.** Intakes are the first point of contact with the patient that the therapist initiates after receiving a referral. These sessions will typically occur at bedside with patient and/or patient family, lasting anywhere from twenty minutes to one hour. Intake sessions evaluate appropriateness for art therapy services, and identify needs and develop goals that the patient may benefit from. These intakes also identify general background information, patient concerns, impact of concern, and support systems. *Appendix A* shows general notes for intake and provides additional information towards the first contact for services with the patient.

**Assessment.** Following intake, the art therapist conducts a more formal assessment based on the needs identified from intake and to further develop goals to achieve during time of hospitalization. Evaluating coping mechanisms, identifying treatment issues, and exploring patient-verbalized goals are all part of this session. Both counseling and art-making approaches will be used to identify patient needs and desired outcomes during hospitalization. *Appendix B* shows assessment procedures that include an initial recommended treatment plan that fits patients' needs and art-making goals. Further notes may be made to address impression of the patient's mood and affect during the session. During assessment, the therapist may further record the appropriateness of services, use of time, comfortability with art materials, and proposed initial benefit for the patient.

**Treatment.** Following the initial assessment procedure, the art therapist continues with treatment planning which assesses previous sessions outcomes and creates new or continued goals for future sessions. *Appendix C* provides a document that serves as informative review of the integrated counseling and art-making session to determine how the patient was affected. Outcomes from art therapy are recorded, frequency of services are determined, and future plan of care is measured. These assessment and treatment notes are continually used through services until a transition to another unit of care or discharge happens. With continued treatment planning, the therapist will conduct progress reviews through art therapy sessions, and will create goals in agreement of patient and therapist together.

**Transitional care.** Transitional care will take place at time of discharge from one stage towards another stage or unit of care along the continuum. Patients will be asked to fill out documentation at this time to proceed and continue services or officially terminate services. This process is a key part of the continuum of care model as it proposes the continuation of services with patients and following through to the next stage of care. Upon continuation of services, the therapist will complete the transitional care form (*Appendix D).* This form helps to document benefits of therapeutic services provided during the current stage or hospitalization, desire to continue services to the next stage or unit, as well as continued needs and general information regarding where the patient is transitioning from where they will transition to. This documentation will be provided by the art therapist at time of discharge from the current unit of care. Transitional care documentation is crucial to evaluating current and continuing treatment issues, which will be assessed multiple times across the continuum of care. Patients and families using art therapy services may terminate in different stages of care. As art therapy services are participated in at-will, the termination or transition process follows this same procedure. This

means that a patient may use art therapy services in high-risk and discontinue when moving into the NICU or could continue them into the NICU and have another choice to continue or discontinue services once reaching outpatient care. Reassessment of needs and addressing reoccurring and new needs happens each time patients transitions to another care unit. This phase is the cornerstone of the continuum of care treatment model.

**Termination.** Following patients through many units of care will inevitably lead to moments of transitional closure and, finally, completion of services. The patient and therapist together decide appropriateness of continued out-patient or community services, continuation of goals, and how to further integrate counseling and art-making tools into everyday life. While it is assumed that continuing care in each stage across the continuum of care will be ongoing until the patient or family members decide that termination is needed, therapeutic services are at-will for this population and provided on as-needed basis. Termination provides closure to the therapist and patient together.

## High-Risk Programming

**Group programming.** Group programming is provided to offer support to patients and families through a therapeutic environment where the other group members have similar experiences. Group programming in this stage of care addresses treatment issues including anxiety, depression, isolation, support, pain, and nesting. This high-risk group will be available to high-risk unit patients and their families twice a week in a space located on the unit. An art therapy studio space will be most appropriate and ideal for women and their families to participate in art therapy. Studio times will be scheduled during times when monitoring and regular procedure check-ins are not occurring, in order to make groups accessible and available to most patients. The studio space will be mostly an open studio concept; a therapeutic directive

may be planned, however, patients may also use this time to work on something more personal or meaningful to them. This space provides a physical area for patients to leave their rooms that many of them are often confined and to meet other individuals on the unit in a neutral space. Studio space will be open to patients at all times for working on artistic projects and some supplies will be left out for patient enjoyment.

**Individual programming.** Many treatment issues on high-risk and extended stays involve psychological and physical antepartum complications. Individual programming is available to offer one-on-one care with a focus on coping and addressing treatment issues such as anxiety, depression, delirium, loss of control, pain, nesting, and self-esteem. Individual sessions are available on an as-needed basis to patients as determined during intake and assessment. Re-occurring visits will be determined by patients and therapist together as goals are created and obtained. These sessions will take place primarily at bed side with the patient and whomever the patient has in the room, as decided by the patient. Sessions are able to take place in studio space during times where groups are not taking place. Materials for the patient are provided during the session and at times will be left in the room at bedside so they may complete or continue to work on art-making in spare time. The use of art-making to achieve goals and assist with coping as a personal tool will be addressed and encouraged.

**Interventions.** Specific interventions are compiled and listed within the results section above, see *Table 1*. The treatment issues found include anxiety, depression, isolation, support, loss of control, pain, nesting, and self-esteem. The listed interventions may change and vary depending on the patient's needs, ability level, and appropriateness for either group or individual work. As interventions listed were pulled from literature, some practices were mentioned from observations of other art therapists in my internship. Most interventions may be used in both

group and individual therapy where others are best fit for only one. More specifically, group needs will focus on areas such as isolation and support where it is best fit and individual needs may focus more on pain management and coping on a patient to patient level. All other treatment needs are met as the patient-therapist relationship sees fit and determined by what best suits individualized treatment goals. Not all art therapy interventions are listed above, but those included provide a snapshot into what art therapy looks like in practice and in meeting the treatment issues found in literature.

## NICU Programming

**Group programming.** NICU programming offers a bi-monthly group consisting of different art experientials and counseling techniques geared towards parents and caregivers. This group offers the caregivers for infants a chance to learn coping skills, enhance personal expression, and communicate with families in similar circumstances as themselves. Specific treatment needs that group programming addresses for caregivers are assurances, support, nesting, grief and bereavement, coping, and isolation. Groups will be held outside of the neonatal intensive care unit and located within the same building for easy access. Art therapy group services are scheduled and relayed to families each week. This scheduling meets family needs through availability on nights and weekends, times where scheduling is often more obtainable for families and allows NICU patients a time to rest. This also provides caregivers and families a space to leave the NICU and focus on the importance of themselves, their emotions, and the need for self-care that goes into caring day-to-day for a child in the NICU. In efforts to provide a closed space, caregivers and families will be reminded of confidentiality and be given the option to use the time and space in a way that they determine best fit for them. Pre-made art

interventions will be available to families to participate in and counseling will address needs and treatment issues found in the literature to guide initial discussion.

**Individual programming.** Individual session within the NICU will focus on treatment issues that include anxiety, support, bonding, nesting, coping, and loss of control. The need for support and assurances are essential for caregivers who are seemingly unsure of length of stays, diagnosis, and healing process. Complications are more prevalent in families whom have infants that were born weeks-to-months earlier than expected. Coping mechanisms and need for support within the NICU remain heavily present as friends and family outside of the immediate experience lack visitation rights and the knowledge about the true implications both baby and caregiver face. Individual sessions are available on an as-needed basis and are determined by therapist and caregiver together during intake and assessment. Re-occurring visits will be determined by patients and therapist together as goals are created and obtained. These sessions will take place at the NICU bed or a close by family lounge, wherever the caregiver feels most comfortable. Materials will be provided to the caregivers and families as a way to pass time, build coping skills, encourage family building, and achieve other personal goals.

**Interventions.** Specific interventions are compiled and listed within the results section above, see *Table 2*. Treatment issues found in the literature include anxiety, need to be given assurances and support, bonding, nesting, coping, grief and bereavement, isolation, and loss of control. The listed interventions may change and vary depending on the patient's needs, ability level, and appropriateness for either group or individual work. As several interventions listed were selected from the literature, other practices came from observations of art therapists in my internship. Most interventions may be used in both group and individual therapy where others are best fit for only one. More specifically, group needs will focus on areas such as assurances

and support and individual needs may focus more on loss of control and coping on a patient-to-patient basis. All other issues are addressed by the patient-therapist relationship based on what best suits individualized treatment goals. Not all art therapy interventions are listed above, but instead provide a snapshot into what art therapy looks like in practice and in meeting the treatment issues found in literature.

**Outpatient Programming**

**Group programming.** Group sessions will be available in an outpatient setting primarily for those who have experienced loss during hospitalization. This loss includes antepartum, postpartum, and NICU loss as families, and caregivers navigate through the life event of losing a child. Treatment issues for this specific group will address anxiety, depression, grief, bereavement, loss of control, support, and transition. Groups are available to patients, parents, and caregivers upon discharge in which they may join or attend group at any time after leaving the facility. Beginning or termination of services are up to the individual(s) seeking therapy based on how they perceive their specific need of support. Groups allow members to participate in art-making and counseling provides supportive conversations about grief and allows for personal expression and storytelling. Confidentiality for the group gives group members a chance to participate in relationships and conversations that enable self-reflection and understanding of how grief and bereavement change over time.

**Individual programming.** Individual sessions are available in efforts to assess postpartum state and transition to home. These sessions coincide with aftercare and check-ups that evaluate physical needs of mother and baby that were discharged from hospitalization. Individual sessions will be scheduled during discharge or at any time that the discharged patient would like to receive services post-care. Outpatient treatment issues that are supported through

individual programming are anxiety, depression, bonding, loss of control, support, transition, and readiness. Parents, families, and caregivers are able to schedule individual sessions on an as-needed basis. Art therapy can provide education as individuals move through life transitions and cope with being home and caring for a newborn. Education and coping practices are part of individual programming to support mothers as they tackle new understandings of how their body is coping with the postpartum state, familiarizing the home and self with having an infant in the environment, and coping with new implications that arise from a departure to home. Art materials will be provided to mothers and families during these times as a way to build coping skills, encourage family building, and achieve personal goals.

**Interventions.** Specific interventions are compiled and listed within the results section above, see *Table 3*. The treatment issues found include anxiety, depression, bonding, grief and bereavement, loss of control, support, and transition or readiness for home. The listed interventions may change and vary depending on the patient's needs, ability level, and appropriateness for either group or individual work. As interventions listed were pulled from literature, some practices were mentioned from observations of art therapists in my internship. Most interventions may be used in both group and individual therapy where others are best fit for only one. More specifically, group needs will focus on areas such as transition and support and individual needs may focus more on bonding and readiness. All other treatment issues are met as the patient and therapist see fit and what best suits individualized treatment goals. Not all art therapy interventions are listed above, but instead provide a snapshot into what art therapy looks like in practice and in meeting the treatment issues found in literature.

**Limitations**

Limitations for this study include not having a cohesive body of literature across the continuum of care to from which to gain results. Some stages of care and treatment issues were heavily covered, while others lacked mentioning or were only prominent in a specialized area of the literature. The literature used for research was also published over the course of many years and in many locations across the United States. Further, some of the peer-reviewed journals may show truer results to rural or urban settings. These may indicate and lead to a less accurate result pool as healthcare treatments continually increase and expand due to advancements in healthcare. Time limitations of the researcher should also be noted, which limited the scope of this study and the time needed to understand, integrate, and present the results and to develop the program.

**Implications**

Because such a program would reach a greater number of individuals with longer admissions, I hypothesize that art therapy services that span a continuum of care will shorten stays, increase psychosocial well-being, and reduce negative implications of long-term hospitalization. An art therapy program that spans the continuum of care offers support to address the potentially adverse psychosocial implications of long-term and high-risk hospitalizations by offering patients a new form of coping, opportunities to communicate their experiences verbally and non-verbally, and continued support. Art therapy may be offered individually, in groups, with couples, and with family and siblings. This variety allows for personalized services that support patients as well as the staff members who provide other aspects of care.

In addition, art therapists are able to act as non-medical professionals that provide a more relatable style of communication than doctors or nurses. For example, art therapists in the

medical setting do not use medical language and are not seeking a specific diagnosis or outcome. This provides patients an opportunity to be more vulnerable. The patient, the patient's family, and the therapist are able to develop a therapeutic relationship to address psychosocial implications outside of the hierarchy of medical professionals. This type of interaction supports both parents and staff members as art therapists are able to act as a translator to provide knowledge of the medical diagnosis without use of medical language as it is not needed for the therapeutic relationship. Art therapists can provide patients a special style of support and vulnerability, in which the patient, the patient's family, and the therapist are able to tackle the psychosocial implications together outside of the medical hierarchy.

Over time, a program evaluation will be necessary to gauge the success of the continuum of care, where it is not working, and how treating individuals over many stages of care benefits the patients and other healthcare providers alike.

**Challenges**

The success of this program depends on levels of buy-in and on-going education to gain support for an art therapy programming across a continuum of care. It will be critical to educate non-creative-therapy healthcare professionals on the purpose and need for art therapy services used in a hospitalized setting. Art therapy is likely to be less valued than other tiered healthcare treatments as it is less frequently seen in medical settings and might be looked at as unconventional. The longevity of art therapy programming depends greatly on the ability to build rapport with other healthcare professionals, self-advocate, and integrate treatment planning with other disciplines.

Further, enabling other practitioners to see or experience art interventions in practice may best convince them of the value of art therapy as a successful treatment modality. However, there

is a concern related to patient confidentiality as well as time required for ongoing educational in-services or workshops. Concerns for constant education also arise due to employee turn-over and changes in hospital policies, which are expected in the medical field. These challenges also impact the continuum of care; art therapy treatment may be encouraged by some healthcare professionals and rejected by others. These dynamics may impact the patient's view toward receiving art therapy services.

A related challenge is educating patients and their families of the personal and emotional concepts brought up through art-making and how those experiences may be personal and kept to themselves instead of shared with an entire healthcare team. This way, the therapeutic relationship may be kept more confidential and less impacted by the opinions of those who might not understand the creative therapeutic process.

# CHAPTER VI

# CONCLUSION AND RECCOMNEDATIONS

The present study examined the needs and treatment issues of women and families along a continuum of care within women's health. Programming was developed and specifically designed to meet the needs of these populations using literature-based art therapy interventions and observed art therapy practices. I developed a model that frames the art therapy continuum of care using six action steps which include (1) recruitment and referral, (2) intake evaluations, (3) assessment of needs (4) treatment planning and recommendations, (5) transitional care and (6) termination. This program identifies the specific populations addressed and stages of the continuum, recruitment and referrals for the population, individual and group programming for the different stages of the continuum, documentation processes of intake and assessment, and transitional documentation to follow up with care planning. This research is intended to be used for program building with women's health and to mirror opportunities for continuums of care to be implemented within other hospitalized populations.

## Recommendations

I recommend using this research to implement an art therapy programming into women's health facilities with a targeted plan to treat women, families, caregivers, and patients using art-based therapeutic methods. Furthering research about successful hospitalized programs that follow a continuum of care as well as art therapy programs based in medical setting will provide better insight towards establishment and sustainability of permanent programming. I also recommend furthering research with outpatient populations, referring to continued treatment planning, art interventions, and continued care into group and individualized settings regarding hospitalized treatment issues. Expectations of cost and accessibility to travel, art therapy

materials, and therapeutic expectations should be considered for patients both admitted and discharged as the relationship of the patient and therapist continue through multifaceted affiliations.

Additionally, since hospitalization affects more than just women's health and individuals directly impacted by these facilities, expanding this research to reach populations outside of women's health but still within medical treatment would also be suitable. Future research like this present study should consider and evaluate nuances and changes between women's facilities that impact the continuum of care and transferring of services outside of the appointed therapeutic relationship.

A continuation of this research should address a formal needs assessment within the scope of this population as using found literature only provides a small window into treatment needs. Future research built from this study will require direct patient contact, IRB approval, and an evaluation tool of its workings and sustainability. As art therapy practices move forward, it is my hopes that programming such like this becomes more common and available to inpatient facilities and their families. Populations undergoing similar stressors, life events, and traumatic events are susceptible to treatment issues that resulted from this study, and can also be better supported in receiving services along a continuum of care.

# CHAPTER VII

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# APPENDIX A

## Creative Arts Therapy Intake Note

Creative Arts Therapy Intake Note
Therapist name, credentials, contact information:

**General Session Information**
Referred by:

Reason for visit:
- Referral Received
- Introduced services to patient or family
- Attempted to see patient or family but currently unavailable
- Contact information left at bedside
- Follow-up
- Other -

Services were attempted; however, the patient was not able to participate due to:
- Medical status or illness
- Patient deferred services at this time
- Patient off unit for procedure
- Patient sleeping
- Patient not available at time of attempt
- Other-

Interest or non-interest expressed (include follow-up time):

Background information and support system(s):

Appropriateness for individual and group services:

Additional comments:

# APPENDIX B

## Creative Arts Therapy Assessment Note

Creative Arts Therapy Assessment Note
Therapist name, credentials, contact information:

**Assessment**
Presenting problem:

Treatment issues found:

Patient stated concern(s) and impact of concern(s):

Interest in art materials:

Previous art and therapeutic experience:

**Impression**
Mood and behaviors during session:

Presentation:

Additional comments:

# APPENDIX C

## Creative Arts Therapy Treatment Session Note

Creative Arts Therapy Treatment Session Note
Therapist name, credentials, contact information:

**Session details/ outcomes**
Therapeutic goals:

Session description including important patient verbalizations:

Therapeutic outcomes:

Additional notes:

**Plan of Care**
- Will continue to follow patient and address therapeutic goals
- Provided materials to patient room
- Provide termination and closure
- Patient currently not appropriate for services
- Will reassess
- Referred to appropriate interdisciplinary team member for consultation
- Other

Frequency:
- Daily
- 2-3 times a week
- 1-2 times a week
- Other -

# APPENDIX D

## Transitional Care Creative Arts Therapy Note

Transitional Care Creative Arts Therapy Note

Patient Name:
Date of Transition:

**Discharge from:**
- High-Risk
- Neonatal Intensive Care Unit
- Outpatient
- Other

**Transition to:**
- High-Risk
- Neonatal Intensive Care Unit
- Outpatient
- Other

Have you (patient) or as a family member received Creative Art Therapy services?
- Yes
- No
- Other -

Would you wish to continue Creative Art Therapy Services? Why or why not?

What do you think you need most, that you are not receiving from hospital resources?

Other questions, comments, or concerns you wish to have addressed as you transition?