Grant Writing for the Development of a
Pediatric Art Therapy Program

A Thesis
Submitted to the Faculty
of
Drexel University
College of Nursing and Health Professions
Creative Arts in Therapy
By
Lisa Marie Rainey
in partial fulfillment of the
requirements for the degree
of
Master of Arts
May 2010
Dedications

“Being healed isn’t the same as being cured. Healing is a process of becoming whole-physically and psychologically… healing takes place even as the body weakens”

- Barbara Graham

This Thesis is dedicated
to
My Dad Ronald Rainey
Who has supported me in ALL of my endeavors,
and has inspired me to follow my dreams,
even if they take me around the world,
and halfway across the country.

Also to
My sister, grandparents, aunts, uncles, cousins, nephew, niece and friends
Whose love and encouragement,
have given me the strength to
take enormous leaps of faith,
without the fear of falling.

And finally to my mom, the late Kathy Brown-Rainey
Her memory continues to keep me company throughout this incredible journey…
Acknowledgements

Betty Hartzell, Ph.D., ATR-BC, LPC, Thesis Chair

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Laura Black Keenan, ATR-BC, LPC Thesis Committee
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Abstract

Grant Writing for the Development of a
Pediatric Art Therapy Program
Lisa Marie Rainey
Betty Hartzell, Ph.D.

The aim of this thesis is to apply to several regional foundations in Indianapolis, Indiana to fund and develop a pediatric art therapy program at Peyton Manning Children’s Hospital. The program is designed to address the negative psychosocial issues related to childhood hospitalization. The purpose of writing the grant proposals will be to secure funding for the pediatric art therapy program, which will provide individual, group, and family art therapy services in the medical setting. The grant proposals submitted to the selected foundations, introduce a pediatric art therapy program designed to serve the patients and family members who receive care at PMCH. This program was designed following this researcher’s graduate internship at a large children’s hospital in Philadelphia, Pennsylvania. Two grant proposals were recently submitted, along with two additional letters of inquiry to the foundations requesting a letter as the initial approach. At this point, the researcher has received approval letters from both foundations. The grants will provide funding for a pediatric art therapy program at Peyton Manning Children’s Hospital. It is the aim of the art therapy program to provide an opportunity for the patients and their family members to express their thoughts and emotions regarding hospitalization.
CHAPTER 1: INTRODUCTION

According to the National Association of Children’s Hospitals and Related Institutions (NACHRI), more than three million children are hospitalized each year in the United States. There are an infinite number of reasons why a hospitalization may occur. Children are principally hospitalized for new diagnoses, chronic illness, emergencies, traumas, pregnancies, and psychological illness. The problems to be addressed are the potentially negative psychosocial implications related to childhood hospitalization. The literature shows that the development of an art therapy program within a children’s hospital would offer additional psychological support to these children as well as to promote socialization, and provide an outlet for emotional expression related to the hospitalization experience (Malchiodi, 1993; Weldt, 2003; Appleton, 1993; Councill, 1993, 2003; Lassetter, 2006; Sundaram, 1995; Wikstrom, 2005; Rode, 1995). While advances and progress in the psychosocial care of these children have been made, research continues to suggest that a child’s emotional well-being may be negatively impacted due to hospitalization (Thompson & Stanford, 1981; Rennick, Johnston, Dougherty, Platt, & Ritchie, 2002; Pao, Ballard, & Rosenstein, 2007; Oremland, 2000; LeBlanc, Goldsmith, & Patel, 2003; Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1990). The on-going documentation that supports a lack of efficacy regarding the psychosocial care of hospitalized children supports the need to investigate and implement additional interventions, such as art therapy.

The purpose of this thesis is to write a grant proposal, which will address the need for additional psychosocial care by developing a pediatric art therapy program at a Children’s
Hospital in Indianapolis, Indiana. The grant writing process begins with identifying a specific need or problem. The central need for this grant was determined during this researcher’s, nine-month internship at a children’s hospital in Philadelphia, upon realization that the chosen hospital does not currently have an art therapy program. The specific hospital referred to in this thesis is one of only two hospitals in Indianapolis, Indiana entirely dedicated to children. However, the other children’s hospital in Indianapolis, offers creative arts therapy (music therapy) in their medical treatment and recovery.

The child who experiences a long-term hospital stay is subjected to many challenges. He/she not only face changes in their physical health, but also faces changes in the physical environment of the hospital, the educational setting, and their family life. Children are forced to adapt their coping style to accommodate these changes. With over three million pediatric hospitalizations occurring annually much research has been conducted to study those children affected. Research continues to conclude that there are significant psychosocial implications stemming from these hospitalizations. (Thompson & Stanford, 1981; Rennick, et al., 2002; Pao, et al., 2007; Oremland, 2000; LeBlanc, et al., 1990). It seems relevant that hospitals serving these children find and utilize new approaches to help minimize the psychosocial implications that may occur during and after a hospitalization.

According to Cathy Malchiodi, providing art therapy to hospitalized children has the potential to alleviate feelings of helplessness and lack of control often associated with physical debilitation and hospitalization. (1993). Participating in art therapy provides the patient with an opportunity to actively participate in their medical treatment. Allowing children to play an active role in communicating their experience to the treatment team may provide them with the opportunity to regain a sense of power and control related to their
hospitalization (1993). As research continues to find significant psychosocial implications stemming from these hospitalizations, it may help that hospitals serving these children find and utilize new approaches to help minimize the psychosocial implications that may occur during and after a hospitalization. It is believed that the addition of art therapy services at Peyton Manning’s Children’s Hospital will be of great benefit to the psychosocial well-being of the children and families that are served.

Countless psychosocial concerns may arise during a pediatric hospitalization, but the most common issues that appear in relevant literature include; separation from parents and possible relocation; loss of autonomy and control; and the fear of bodily harm or death (1993). The intention of this research is to write and submit a grant to provide the rationale for the development of a medical art therapy program at a Children’s Hospital in Indianapolis, Indiana. The grant will provide a detailed description of the implementation of a pediatric art therapy program. A literature review of art therapy, medical art therapy, and hospitalized children will be included. The thesis will include two fully completed grant proposals, which will provide the framework for the additional proposals. The individual grant proposals will follow the guidelines of the chosen funding sources, and will include all of their required submissions. It will be submitted to several funding sources, which will be selected from the preliminary findings.

This researcher aims to apply to several regional foundations for grants to fund the aforementioned program. If funded, the program will offer art therapy services to all referred patients. The art therapy services will include individual art therapy, including bedside sessions, group art therapy (unit specific and/or waiting room), as well as family/sibling art therapy. The program will operate primarily within the existing child-life department of the
hospital, but will also aim to be part of the clinical team (medical, nursing, social work, and psychology) in an effort to promote the targeted hospitals multidisciplinary approach to offering a comprehensive treatment team approach. Child Life programs have been developed in response to the research and literature that suggests the negative psychosocial impact of a pediatric hospitalization (Thompson & Sanford, 1981). The earliest play program for children began in 1922, at Mott’s Children’s Hospital in Michigan, and have since grown and expanded to become what is now known as Child Life Programs (1981).

Medical art therapy is quickly becoming an expected service in pediatric hospitals. US News and World Report (2008) ranks the top 30 Children’s hospitals on their website, and 23 out of those 30, or nearly 77% of the hospitals listed offers some sort of creative arts therapies (either art or music therapy) to their patients. The only other exclusively pediatric hospital in Indianapolis, offers creative arts therapy to their patients in the form of music therapy. In 2005, the Indianapolis area hospital formed a partnership with a second pediatric hospital in Ohio, where art therapy is also offered. The creation of an art therapy program would also support the targeted hospital’s mission to creativity through courageous innovation.

A preliminary plan to measure the benefits of the proposed pediatric art therapy program has been designed, and includes:

- A detailed program evaluation, which will consist of a patient and/or caretaker questionnaire. The patient/caretaker questionnaire will be designed to collect information related to patient satisfaction as well as their perceived benefit(s) of art therapy during hospitalization. The exact questionnaire will be developed and approved in collaboration with the hospital.
Surveys completed by members of the treatment team. The exact survey will be developed and approved in collaboration with the hospital. The surveys to be completed by the treatment team (including physicians, nurses, and child life staff) will request them to provide information related to their perception of the art therapy program. Records will be maintained throughout the award year, in order to document the number of children and/or family members who receive art therapy services. These records will also track the number of sessions that each patient received, as well as the number of children and/or family members who attended art therapy groups throughout the year.

All of this information will be synthesized and presented to supporting Foundations, in report format, at the conclusion of the award year. With patient and family member consent, reproductions of artwork will also be included to illustrate specific case examples. The consent form will be developed and approved in collaboration with the hospital.

The objective is to write a pediatric art therapy grant for a children’s hospital. Upon completion of the grant, it will be submitted to several foundations in an attempt to fund the proposed program at the Indianapolis children’s hospital. The ultimate objective is to obtain funding to develop the pediatric art therapy program, in an attempt to provide comprehensive psychosocial support to hospitalized children, as well as to continue the hospital’s mission of ensuring that they provide holistic care – mind, body and spirit – for every child who enters their health care ministry. The hospital’s brochure states that they are, “looking for ways to ensure that no child’s need is left unmet, that no family needs to look elsewhere for the highest-quality medical care”. Implementing a pediatric art therapy program at this hospital would support their goal of providing, “a comprehensive and completely different continuum
of pediatric services,” in Indianapolis. This thesis is delimited to grant writing for the development of a Pediatric Art Therapy program at a specific children’s hospital in Indianapolis, Indiana, and is delimited in scope to a proposed Pediatric Art Therapy Program at Peyton Manning Children’s Hospital.
CHAPTER 2: LITERATURE REVIEW

Various considerations were included in the writing of this thesis, and consist of: an investigation into the current literature and research regarding; pediatric hospitalization, the psychosocial implications of hospitalization, art therapy, medical art therapy, pediatric art therapy, and child life programming, while writing the grant proposals and developing a pilot art therapy program at Peyton Manning Children’s Hospital.

Pediatric Hospitalization- Demographics

The National Association for Children’s Hospitals and Related Institutions (NACHRI) (2008) estimates that more than 3 million children are hospitalized each year in the United States. About one third of these children are hospitalized at freestanding children’s hospitals. The most frequent conditions that children are hospitalized for are: respiratory (16.8 percent), gastrointestinal (11.9 percent), neonates (11.9 percent), neurological (9.8 percent), and orthopedic (6.7 percent). NACHRI also states that, “one in every 10 children has a chronic (long lasting) illness that needs ongoing medical care” (2008). While medical technology and treatment continue to improve and progress, serious illness and injury are always going to require childhood hospitalizations.

Psychosocial Implications of Pediatric Hospitalization

Countless psychosocial concerns may arise during a pediatric hospitalization, but the most common issues that appear in relevant literature include; separation from parents and possible relocation to another state/city if there is not a children’s hospital that provides treatment for the child’s specific condition, loss of autonomy and control; and the fear of
bodily harm or death (O’Malley, McNamara, 1993, Malchiodi, 1995, Councill, 1993).
Thompson and Stanford (1981) discuss the many behavioral changes that may be seen in pediatric hospitalized patients. The variety of reactions include; active responses (e.g. crying, yelling, physical aggression) passive responses; (e.g. excessive sleeping, withdrawal, bedwetting), and psychological upset. They also discuss specific elements, which are related to the degree of psychological upset in pediatric patients and include; unfamiliarity of the hospital setting; separation from parents; age, and pre-hospital personality (1981). The authors present the prevalence of psychological upset resulting from hospitalization through the review of several studies and found that, “A significant proportion of all children who enter the hospital suffer some form of psychological upset” (1981). The studies also suggest that even with a preparation program, a significant number of children still exhibit signs of psychological upset.

According to Kaplan and Sadock (2003):

Adjustment disorders are one of the most common psychiatric diagnoses for disorders of patients hospitalized for medical and surgical problems. In one study, 5 percent of persons admitted to a hospital over a 3-year period were classified as having an adjustment disorder. Up to 50 percent of persons with specific medical problems or stressors have been diagnosed with adjustment disorders. According to the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (American Psychiatric Association, 2000), an adjustment disorder, is a psychological response to an identifiable stressor or stressors [hospitalization] that results in the development of clinically significant emotional or behavioral symptoms. (2000).
Literature and research conducted as early as the 1960s revealed findings that suggest psychosocial stress, as well as a prolonged psychological impact associated with hospitalization (Haller, Talbert, & Dombro. 1967). The authors of these studies also suggested the need for additional emotional care of children during hospitalization (Haller, et al., 1967, Petrillo & Sanger, 1972, Thompson & Stanford, 1981, Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1990, Malchiodi, 1999, Oremland, 2000, Pao, Ballard, & Rosenstein, 2007). Many research studies report statistics regarding psychosocial complications during and after a hospital stay. In 2002, Rennick, et al. conducted a phenomenological study with 120 children, to determine the psychological effects of a PICU hospitalization, and their findings indicated that there was not a significant difference between the responses of children who were hospitalized in the PICU compared to those on a hospital ward. Their study did find that, “children, particularly young children, who have been severely ill and exposed too many invasive procedures may be significantly traumatized by their hospital experience and continue to demonstrate psychological difficulties six months post-discharge”. They also found that, “hospital programs geared toward providing psychological support to these children are particularly important” (2002).

As soon as a child arrives at the hospital, the potential for negative emotional impact begins. In many cases, the hospital is a completely new experience for the child as well as their parents. The environment, including sights, sounds, and staff, may be unfamiliar and frightening. A child not only deals with their own insecurities about their illness/injury, but also experiences the impact and anxiety of their parents or caretakers (Bossert, and Martinson, 1990). In a five year, longitudinal study of 40 families, conducted by Bossert and Martinson (1990), to determine the child’s perception of the family’s attitudes and emotions
(regarding their diagnosis of cancer), “findings indicated that all of the subjects perceived a negative change in family attitudes and emotions over time, although the magnitude of the change varied with the type of cancer and the child’s health status.” They are also forced to adapt their coping style to accommodate these changes. Individuals with chronic illness frequently suffer from depression, and feelings of worthlessness, self-dislike, loss of gratification, hopelessness, loss of motivation, guilt, indecisiveness, psychomotor retardation, and delusions about being unworthy. (LeBlanc, Goldsmith, & Patel, 2003).

During a hospitalization a child not only has to master the hospital experience and their illness, but they also have to attempt to continue to master their normal developmental stage. Continuing to progress through the normal developmental stage can be hindered in the hospital (Rode, 1995, Thompson and Sanford, 1981, Pao, Ballard, and Rosenstein, 2007). Diane Rode conducted a literature review and discovered: over 500 articles and studies examining children’s psychological responses to hospitalization.

The literature describes how the experiences of illness and hospitalization can be disruptive and have the potential to negatively influence a child’s future psychosocial development. The literature also focuses on the importance of providing developmentally based interventions to prevent or mitigate undue distress (1995).

Providing developmentally based and age appropriate interventions are important because children conceptualize their illness/injury differently based on their age and developmental stage (Sundaram, 1995). Table 1., Illustrates a child’s understanding of illness according to Piagetian stage.
<table>
<thead>
<tr>
<th>Typical Age</th>
<th>Piagetian stage</th>
<th>Response to “Why do children get sick?”</th>
<th>Implications for patient education</th>
</tr>
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<tbody>
<tr>
<td>4 to 6</td>
<td>Preoperational</td>
<td>Responses are typically circular, magical, or global, and define illness solely by associations with external events or sensory phenomenon. Child fails to specify the causal link between an experienced event and his/her illness. Example responses: “You just do” or “By catching a disease”</td>
<td>Child learns from concrete evidence provided in the form of engaging visual aids and demonstrations. Because of limited perspective-taking abilities, explanations should focus on the illness from the child’s perspective only and center on only one dimension of an event. Select the most pertinent information and make it relevant to the child’s life. Look for any formulation of fictitious causal relationships and dispel any resulting misconceptions.</td>
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<td>6 to 8</td>
<td>Concrete operational</td>
<td>Responses characterized by the naming of symptoms, actions, or situations associated with illness or repeating concrete rules and common parental prohibitions commonly associated with the illness (i.e. external causes) without evidence of understanding them. Child sees himself as a vulnerable victim of illness. Example responses: “By going out without a coat” or “By eating too much junk food”</td>
<td>Education should focus on dispelling common myths and assuring the child that his/her behavior did not bring about illness (e.g. not wearing your coat in cold weather doesn’t cause asthma). Education in this direction should not confirm child’s belief that s/he is a passive participant in the process, and, is therefore, vulnerable to the illness. Instead, educations should begin to focus on the impact that the child’s behavior may have on the current manifestation of the illness.</td>
</tr>
<tr>
<td>8 to 11</td>
<td>Concrete operational</td>
<td>Responses specify causal agent of illness and demonstrate limited internalization of the agent. Responses demonstrate understanding of the process of getting sick, and describe illness as within the body. Example response: “The germs just don’t belong there”</td>
<td>Child often believes that s/he has become contaminated by physically engaging in a harmful action. Educators should use the child’s increasingly logical abilities to offer accurate interpretations of the cause of his or her illness. The child is not yet developmentally ready to comprehend these interpretations in the abstract; s/he still relies on personal experiences and concrete situations/events to understand his/her illness.</td>
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<td>11 to 13</td>
<td>Late concrete operational</td>
<td>Responses reflect a beginning comprehension of role as an active host to the illness as well as an agent in causing illness. Responses often include “…makes you…”, although they don’t explain the relationship. Example response: “The germs just don’t agree with your body so I guess our own body makes you sick.”</td>
<td>Education should make use of the child’s ability to (1) recognize and identify a problem, (2) consider many possibilities for a given condition, (3) comprehend abstract explanations, (4) have a long-term perspective and plan ahead, and (5) solve complex and hypothetical problems by stating several alternative hypotheses, executing procedures to collect information, and testing the hypotheses.</td>
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<td>14 and older</td>
<td>Formal operational</td>
<td>Responses are characteristically abstract, describing a coherent mechanism operating within the body resulting in illness/recovery. Child describes illness in terms of internal body organs or systems. Example response: “Germs get into your body; too many at one time so the body can’t fight them all off and they change the way all the parts of your body work”</td>
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Table 2. Erikson’s Developmental Stages of Childhood, with Regards to Hospitalization

<table>
<thead>
<tr>
<th>Age</th>
<th>Psychosocial Stage</th>
<th>Hospitalization Issues</th>
<th>Possible Troublesome Responses</th>
<th>Interventions</th>
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</thead>
<tbody>
<tr>
<td>0-18m</td>
<td>Basic trust vs. Mistrust</td>
<td>Separation</td>
<td>Lack of Stimulation Pain</td>
<td>Failure to bond</td>
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<td></td>
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<td>Distrust</td>
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<td>Anxiety</td>
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<td>Delayed skills development</td>
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<td>18m-3y</td>
<td>Autonomy vs. Shame and Doubt</td>
<td>Separation</td>
<td>Fear of bodily injury</td>
<td>Regression (including loss of newly learned skills</td>
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<td></td>
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<td></td>
<td>Frightening fantasies</td>
<td>Uncooperativeness</td>
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<td>Immobility/restriction</td>
<td>Protest (verbal/physical)</td>
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<td>Forced Regression</td>
<td>Despair</td>
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<td>Loss of Routine/Rituals</td>
<td>Negativism</td>
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<td></td>
<td>Temper tantrums</td>
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<td>Resistance</td>
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<tr>
<td>3y-6y</td>
<td>Initiative vs. Guilt</td>
<td>Separation</td>
<td>Fear of loss of Control</td>
<td>Regression</td>
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<td></td>
<td></td>
<td></td>
<td>Sense of own power</td>
<td>Anger toward primary caregiver</td>
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<td></td>
<td>Fear of body mutilation or penetration by surgery/injections, castration</td>
<td>Acting out</td>
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<td></td>
<td>Protest (less aggressive than toddler)</td>
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<td></td>
<td>Despair/Detachment</td>
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<td></td>
<td>Physical/Verbal aggression</td>
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<td>Dependency</td>
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<td>Withdrawal</td>
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<tr>
<td>6y-12y</td>
<td>Industry vs. Inferiority</td>
<td>Separation</td>
<td>Fear of loss of control</td>
<td>Regression</td>
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<td></td>
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<td></td>
<td>Fear of loss of mastery</td>
<td>Inability to complete some tasks</td>
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<td></td>
<td>Fear of body mutilation</td>
<td>Uncooperativeness</td>
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<td></td>
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<td></td>
<td>Fear of bodily injury/pain, especially intrusive procedures in genital area</td>
<td>Withdrawal</td>
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<td></td>
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<td></td>
<td>Fear of illness itself, disability and death</td>
<td>Depression</td>
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<td>Displaced anger and hostility frustration</td>
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<td>13y-19y</td>
<td>Identity vs. Role Confusion</td>
<td>Dependence on adults</td>
<td>Separation from family</td>
<td>Uncooperativeness</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Fear of bodily injury and pain</td>
<td>Withdrawal</td>
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<td>Concern about peer group status after hospitalization</td>
<td>Anxiety</td>
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<td>Depression</td>
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*Adapted from* Black-Keenan L., ATR-BC, LPC, Instructor (1995). Developmental Stages of childhood Hahnemann University Graduate School, Medical Art Therapy
A child may experience the fear or threat of separation and/or physical harm. They may experience feelings of guilt associated with their illness/injury (O’Malley, McNamara, 1993). For example, a young child who was recently reprimanded by their parents for throwing a ball in the house may feel that they are being ‘punished’ when they are hospitalized the following day for an undiagnosed condition. It is important to try to understand the child’s fantasies and misconceptions regarding their hospitalization, so that efforts can be made to inform and educate them in an age appropriate manner. Medical terms and jargon are often difficult for educated adults to fully comprehend, so it is reasonable to ascertain that children have an especially difficult time processing this information. Children may need a trusted adult to interpret information presented to them by the medical staff. They may also require repetition of this information since, children often have a poorly developed inner knowledge of their bodies and how the various medical systems function.

**Age Appropriate Interventions**

Children who are unable to comprehend the reason for their hospitalization often create fantasies to explain the current situation. It is important to establish interventions that allow and encourage children to share these fantasies in a safe, non-threatening, and supportive manner. Children who do not have the ability, for whatever reason, to verbally express their feelings regarding hospitalization need additional outlets to express themselves. Johanna Russell (1999) highlights, “how important it is that the treatment team includes mental health professionals who are not directly involved in the physical care of the patient.” She points out that it may be easier for a patient to express a range of feelings to a ‘no-needle’ mental health professional.
Malchiodi (1993) indicates the importance of the expression of a range of feelings by highlighting a recent study by Dr. David Speigel from Stanford University who, “found that women who participated in support groups in which they expressed a complete range of their feelings about their disease lived, on average, twice as long as women who were assigned to a control group. Although Speigel agrees that this research needs further validation, there seems to be a strong connections between social support, opening up to others, and resistance to physical illness” (1993).

Several organizations have developed guidelines in response to research in order to address and protect the psychosocial health and wellbeing of hospitalized children, and hospital programs have been developed as a solution to these issues. “In its Handbook of Hospital Care for Children and Youth (1986), the Academy of Pediatrics recommends that all institutions with 10 or more pediatric beds create programs addressing the emotional and development needs of children” (1995). The Association for the Care of Children’s Health (ACCH), states:

Threats posed to the emotional security and development of many children and families by serious illness, disability, disfigurement, treatment, interrupted human relations, and non-supportive human environments have been clearly demonstrated by worldwide research studies. The outcomes can range from temporary but frequently overwhelming anxiety and emotional suffering to long standing or permanent developmental handicaps. Closer contact with the emotional life of children, increased parent involvement, and communication amongst professionals has contributed to greater understanding as well as to improvements of care (1988).
Art Therapy

Art therapy is a mental health profession that is founded in both visual art and psychology. To ultimately define art therapy is a difficult task, and there is often confusion about just what art therapy means. One reason that the concept is difficult to define is that art therapy is practiced with such a wide range of patients, and it is specifically tailored to each individual. A second reason is that most art therapists come up with their own definition based on their individual experiences with unique populations, and work settings. Finally, art therapy may be difficult to define because the nature of art therapy is dynamic, and one must experience and participate in their treatment to truly understand the meaning (Malchiodi, 1993).

The American Art Therapy Association defines art therapy as:

A mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight (2008).

Although many people throughout history have thought and spoken of art as being therapeutic the profession did not formally emerge until the 1940’s. An art therapist is a master’s level clinician, who has attended an approved graduate degree program and completed a core curriculum determined by the American Art Therapy Association. They
blend their knowledge of visual art, the creative process, human development, behavior, personality, and mental health into their practice. (Malchiodi, 1999).

Art therapists attempt to gain insight into their patient’s inner-worlds through the utilization of art materials, the creative process, and patient verbalizations. Through this combination the art therapist is able to assess their patient’s developmental level, cognitive abilities, personality, interests, conflicts, and experiences. They facilitate the creative process by providing a safe, supportive, and therapeutic environment. An art therapist has an in-depth knowledge of the range of art materials, their affective properties, and the responses that each may elicit. The therapist collects the artwork throughout the duration of the patient’s therapy and takes note of common themes, symbols, and other imagery. One unique aspect of art therapy, versus traditional talk therapy, is the ability of the patient to communicate with their therapist in a non-verbal manner. The images created by each patient are often used as a catalyst to elicit verbal communication. While art therapy is used with patients of all ages and abilities, the non-verbal nature can lend itself to individuals who are unable to effectively communicate their emotions verbally. (Malchiodi, 1999). This may pertain to children, who do not yet have the vocabulary to completely express themselves, or with mentally challenged individuals who do not have the capacity to verbalize, or with individuals who have a medical reason for not being able to speak. Weldt (2003) states that, “verbal therapy emphasizes interaction on a cognitive level; drawing is nonverbal and promotes communication of affect and sensation through the materials.” Art therapy is also unique in that a tangible product is created during each therapeutic session, and creates a concrete illustration of that particular point in the patient’s life/therapy. At any time the
An art therapist traditionally conducts an initial interview with their patient. They answer any questions that a patient may have regarding art therapy and attempt to dispel any myths or misconceptions. They also discuss the therapeutic contract and specific concerns or goals for that individual. The initial session typically includes completing an art therapy assessment. There are a variety of assessments that the art therapist may utilize, but the determination of which assessment to be used is based on the specific patient, and their individual circumstances. Following the initial interview and assessment, the therapist formulates a treatment plan for their patient. The treatment plan is based on the individual’s specific history, diagnosis/needs, and estimated length of therapy. The intention of the treatment plan is to establish goals that aim to restore or improve the patient’s level of emotional and psychological functioning. (1999).

Throughout treatment the patient is encouraged to express their feelings through their artwork. While observing the form, content, color, composition, and energy of a patient’s artwork, the therapist must also be attentive to their patient’s verbalizations, as well as their body language. Throughout an art therapy session, the patient is constantly communicating with their therapist on both conscious and unconscious levels. The patient consciously communicates with the therapist through the manifest content in their artwork, as well as their verbalizations. Yet, they also communicate unconsciously through the latent content in their artwork, and their body language throughout the session. Through keen observation of both the conscious and unconscious communications, the therapist is able to assist their
patient in gaining insight, coping with stress, improving cognitive abilities, building relationships, and enjoying the creative process. (Weldt, 2003).

Medical Art Therapy

Cathy Malchiodi coined the term Medical Art Therapy and provides this definition, “medical art therapy is a term which has been applied to ‘the use of art expression and imagery with individuals who are physically ill, experiencing trauma to the body, or who are undergoing aggressive medical treatment such as surgery or chemotherapy” (1993). In 1945 Adrian Hill, a British artist and hospitalized tuberculosis patient, remarked on the benefit of art making for his own recovery, as well as the recovery of other patients (1993). Upon discovering the therapeutic value of creating artwork during his hospitalization, Hill described his work as ‘art therapy,’ and claimed to have coined the term (David, and Ilusorio 1999). Hill “was intrigued as to why the act of drawing and painting seemed to help patients come to terms with their traumas and speed up the rehabilitative process” (1999). After his discharge, Hill remained an advocate for art therapy within the hospital setting, and his passion helped to lead to the formation of the British Association of Art Therapists (1999). Cristina Weldt (2003) asserts that serious illness:

Can be one of the biggest challenges in life and may force people to experience a personal transformation and growth – presenting an opportunity to go beyond who one is and discover an inner wholeness. Art may help to articulate affective experiences through sensory responses to the materials and also to discover a relationship between the inner and outer realities.
Art therapists have traditionally worked in a variety of clinical settings including schools, community mental health centers, psychiatric hospitals, and in private practice. “It seems remarkable to note that the profession apparently had significant roots in a medical setting, with the therapeutic goal of enhancing patients’ coping abilities as related to physical conditions and treatments” (David and Ilusorio, 1999). “This had been an important but rarely practiced specialized area that is only recently returning to the forefront” (Malchiodi, 1993). Though this literature is 17 years old, it still seems relevant today. One reason for the growth of medical art therapy is an increased interest in complementary and alternative medicine. It also provides the patient with an opportunity to actively participate in their medical treatment (Malchiodi 1998). Active participation may be important for many patients as, “People often bristle at the regimentation and passivity required of the patient role, or resent frequent invasions of privacy” (Thompson, 1981). Carl Jung also points out how the patient:

Begins to play an active part. To start off with, he puts on paper what he has passively seen, thereby turning it into a deliberate act. He not only talks about it, he is actually doing something about it…Moreover, the concrete shaping of an image enforces a continuous study of it in all its parts, so that it can develop its effects to the full…In this way something of inestimable importance is won – the beginning of independence, a step toward psychological maturity. (1966).

It is important to note that there are some distinct differences between art therapy practiced in the medical setting, and art therapy practiced in a psychiatric milieu (1993). Art therapy practiced within the psychiatric milieu is primarily concerned with the psychological health of the patient. While the psychological health of medical patients is also important,
the art therapist in the medical setting recognizes that their first goal “is to expediently treat
the presenting illness or physical condition,” (1993). Medical art therapists must be mindful
to design their interventions within the scope of the patient’s overall medical treatment.
Having a basic knowledge of each patient’s illness, medications, and procedures is important
in order to design appropriate therapeutic interventions. Medical art therapists must also be
mindful if their patient has a physical disability. There is a need for the art therapist to adapt
art supplies to meet the physical needs of the patient, e.g. wrapping brushes to be thicker for
better grip, taping paper to the bedside table so it won’t slip. Art therapists facilitate a sense
of control and mastery by providing some, where none seemingly exists.

Weldt presents a qualitative study, where researchers investigated, eight patients
responses to drawing experiences while in a hemodialysis unit… “The results indicate that all
patients enjoyed the experience of drawing; they became focused on doing the drawings and
the hours passed more quickly” (2003). “The outcomes of this study support the argument
that being involved in a meaningful creative activity is beneficial for patients undergoing
hemodialysis…Making art inspired positive attitudes, feelings of power, control, and
freedom, and the drawings gave them a sense of achievement” (2003).

**Pediatric Art Therapy**

As with any specialty, the art therapist in the medical setting has a responsibility to
become educated on the issues that arise within their specific population. Understanding the
psychosocial implications that a hospitalization may cause is a necessity when working
within a medical hospital. Working with children in a medical setting requires even more
knowledge about those implications, as children conceptualize their illness/injury differently depending on their age and developmental level.

Malchiodi indicates that, “three primary sources of stress have been identified in pediatric patients: (1) separation from parents or caretakers through hospitalization, (2) loss of independence and control which accompanies illness and hospitalization, and (3) fears and anxieties about medical procedures which may cause harm or pain, and worry about death” (1995). Providing art therapy to hospitalized children has the potential to alleviate feelings of helplessness and lack of control often associated with physical debilitation and hospitalization. Tracy Councill suggests several reasons that art therapy is particularly beneficial to pediatric patients, which include: rebuilding a sense of well being; engendering hope; and gaining a sense of mastery (2003). Diane Rode states that, “Art is believed to be a visual language for children and a developmentally appropriate form of communication, especially for young children who may not have the cognitive abilities to express themselves with words” (1995).

Most art therapists retain and preserve their patients’ artwork throughout treatment. However, it is common to let hospitalized children keep and display their artwork in their rooms and/or public display spaces. “Displaying children’s art in the treatment space can promote feelings of pride, acceptance, and safety, encouraging children to forge alliances with the medical team because they feel they are known and appreciated as whole human beings” (2003 Councill).

Councill also states that:

When medical art therapy is included as part of team treatment, art expression is used by young patients to communicate perceptions, needs, and wishes to art therapist,
mental health professionals, child life specialists, and medical personnel. It is extremely useful in assessing each young patient’s strengths, coping styles and cognitive developments. Information gathered through artworks can be invaluable to the medical team as it seeks to treat the whole person, not just the disease or diagnosis (2003).

Lassetter describes Favara-Scacco, Smirne, Schiliro, & Di Catldo’s (2001) quasi-experimental study, whose purpose was to:

Examine effectiveness of art therapy in preventing anxiety and fear during painful procedures and alleviating prolonged distress in children with leukemia…In the experimental group, researchers noted decreased anxiety and negative behaviors; five of seven older children requested art therapy for subsequent painful procedures. For two- to five-year olds, parents requested art therapy for subsequent procedures, (2006).

Since children may not have the ability to verbally communicate or adequately articulate their experience with hospitalization, illness, injury, or pain, physicians, nurses, and other members of the treatment team often rely on caregiver’s reports and perceptions of their child’s experience (Barton, 1999). The specific experience of pain is subjective to each individual, so it is important for each child or caregiver to have an opportunity to describe the specific experience as accurately as possible. Lassetter reviewed 13 recent research articles regarding the effectiveness of complementary therapies on the pain experience of hospitalized children. The complementary therapies included relaxation, distraction, hypnosis, art therapies, and imagery.
Palermo, Drotar, and Lanbert (1998) found that 74% of the 42 hospitalized children in their study reported continued pain even after administration of analgesics. Such findings suggest that analgesics alone may not be sufficient, and more holistic approaches may be helpful. In fact, Polkki, Vehvilainen-Julkunen, and Pietila (2001) found that complementary therapies and non-pharmacological techniques may play an important role in pediatric pain management when used in conjunction with analgesics (2006).

Researchers have found that, “children’s drawings are proving to be a valuable source of information about pain,” (Barton, 1999). Investigations into the use of colors by children to communicate pain have also been conducted, and it has been found that, “red is reported as the color most frequently chosen by children to represent pain…with purple representing moderate pain most frequently, orange representing mild pain most often, and yellow representing no pain most frequently, (Varni, Thompson, & Hanson, 1987).

While studying the pain perceptions of juvenile rheumatoid arthritis (JRA) patients in comparison to their caregivers, Barton found that, “very young children are often able to communicate visually more effectively than verbally. It is felt that the child’s visual depictions of JRA pain is an accurate and virtually effortless mode of communication of that child’s pain experience (1999). Allowing children to play an active role in communicating their pain experience to the treatment team may provide them with the opportunity to regain a sense of power and control related to their hospitalization.

Upon the observation that many hospitalized, traumatized children exhibited behaviors that were consistent with the DSM-IV definition of PTSD, Linda Chapman created
the Chapman Art Therapy Treatment Intervention (CATTI) designed for, “incident specific, medical trauma,” in order to provide, “an opportunity for the child to sequentially relate and cognitively comprehend the traumatic event, transport to the hospital, emergency care, hospitalization and treatment regimen, and post-hospital care and adjustment,” (2001).

Valerie Appleton also affirms the use of art therapy with hospitalized children experiencing PTSD, “since trauma is stored in memory as imagery, expressive art processes provide an effective method for processing and resolving it. (2001).

Unfortunately, in the medical setting children and their families are sometimes faced with life-threatening illnesses. While many hospitalized children suffer from psychosocial stressors and upset, a terminally ill child has special emotional needs (Teufel, 1995). “Often, these needs cannot be met by people close to the child as they are dealing with personal feelings of their own” (1995). While studying the symbols found in the artwork of the dying, Tate (1989) discovered that, “accumulated data indicate that dying is made easier when individuals feel understood and can express their feelings, fears, and hopes.” Art therapy can provide support to the terminally ill child throughout the various stages of life threatening illness. The child can use art to symbolically express their emotions regarding death, and attempt to draw any unfinished family issues to a close (Teufel, 1995). The American Academy of Pediatrics (AAP) supports the inclusion of art therapy within the hospital. In 2007, the AAP stated in their Policy on Palliative Care for Children that, “Children should be encouraged to talk about feelings of anger, sadness, fear, isolation, and guilt, or to express themselves through art or music therapy.” Art Therapists work as part of a hospital’s multidisciplinary team to address the psychosocial needs of children and their families. The
following goals have been created and developed by Laura Black Keenan, ATR-BC, LPC (1997).
Table 3. The Children’s Hospital of Philadelphia. Art Therapy Goals

**Creative Art Therapy goals for hospitalized children and adolescents:**
- To promote normalization during hospitalization.
- To encourage the self-expression of thoughts and feelings related with illness/hospitalization.
- To help children process and work through traumatic experiences associated with hospitalization.
- To facilitate positive self-esteem and positive body image.
- To promote a sense of independence and feelings of control.
- To provide peer interaction and a sense of community within the hospital environment.
- To encourage the development of healthy strategies for coping with hospitalization.
- To facilitate activities which address behavioral issues i.e. impulse control

**Creative Art Therapy goals for children/adolescents living with chronic pain or chronic illness:**
- To encourage the self-expression of thoughts and feelings related with chronic pain/illness.
- To facilitate children/adolescents understanding of how chronic pain/illness affects their lives.
- To understand how situations may increase pain perception and/or stress.
- To learn effective techniques to promote self-management of chronic pain.
- To learn effective techniques to self-manage stress and anxiety related to chronic illness.
- To facilitate the process of acceptance for children struggling with a chronic condition.

**Creative Art Therapy goals for children living with newly acquired physical limitations:**
- To facilitate adaptation to physical limitations.
- To promote problem solving skills.
- To facilitate hand-eye coordination and gross motor skills.
- To encourage non-verbal communication skills.

**Creative Art Therapy goals for children recovering from brain injury:**
- To raise awareness and orientation to things such as, time, date and place.
- To facilitate activities which promote cognition i.e. organization/sequencing.
- To increase attention-span and decrease frustration level.
- To follow step-by-step directions more easily.
- To organize thoughts to make independent decisions.
- To facilitate the process of representing thoughts symbolically.
- To encourage the process of cause and effect problem-solving.
Child Life Programming

According to the Child Life Council (CLC), in 1955 Emma Plank, a pioneer in the field of child life, developed a program to address the psychosocial needs of hospitalized children in Cleveland, Ohio (2008). Today, there are nearly 500 child life programs in existence. Rode states that, “child life programs strive to promote optimum development of children, adolescents, and families, to maintain normal living patterns, and to minimize psychological trauma” (1995).

Child life specialists (CLS) are bachelors or master’s level professionals who have an educational background in human growth and development, education, psychology, or a related field of study. The child life specialist uses, “play to provide developmentally appropriate, normalizing, and educational experiences to children during hospitalization and illness,” (1995). Certified Child Life Specialists (CCLS) have participated in the rigorous process for obtaining the Certified Child Life Specialist (CCLS) credential, which is administered by CLC. All Certified Child Life Specialists must complete a supervised 480-hour clinical internship, pass a national examination, and adhere to a minimum standard for continued professional development in order to maintain their certification.

The Child Life Council (2008) indicates that child life specialists work as part of a hospital’s multidisciplinary team to address the psychosocial needs of children and their families in order to:

- Ease a child’s fear and anxiety with therapeutic and recreational play activities
- Foster an environment that incorporates emotional support
- Encourage understanding and cooperation by providing non-medical preparation and support for children undergoing tests, surgeries, and other medical procedures
• Advocate for family-centered care
• Engage and energize children and families by coordinating special events, entertainment, and activities
• Consider the needs of siblings or other children who may also be affected by a child’s illness or trauma
• Direct pre-admission hospital tours and resources, and consultations with outpatient families
• Support families confronting grief and bereavement issues
• Provide information and resources for parents and members of the interdisciplinary team

Play has long been considered the work of children, and essential to their development. When play opportunities are eliminated or disrupted, a child’s development is likely interrupted as well. In order to prevent the interruption of normal development, child life programs have designed play experiences to promote growth in physical, social, intellectual, and emotional development (Thompson and Stanford, 1981). During the stressful period of hospitalization, children use play to cope with conflict, to normalize the situation, for mastery, and self-expression (1981). Through observation of the child’s play, the child life specialist can monitor regression, understand fears and feelings, enhance communication, as well as for medical education and preparation (1981).

The Integration of Child Life and Art Therapy

You see a child play and it is so close to seeing an artist paint, for in play a child says things without uttering a word. You can see how he solves his problems. You can
also see what’s wrong. Young children, especially, have enormous creativity, and whatever’s in them rises to the surface in free play (Erik Erikson, 1994).

The integration of child life and art therapy has been researched and suggested by Diane Rode (1995), who is both an art therapist and child life specialist. She recognizes art therapy and child life as, “parallel professions” and states that, “collaboration between these two disciplines within a pediatric setting encourages optimal adjustment for patients and families based on a thorough perception of the individual child’s psychosocial reality and illness” (1995). Research has been conducted that incorporates both play therapy and art expression in hospitalized children. In 2005, Wikstrom conducted a study whose, “purpose was directed toward investigating what takes place during play therapy when children were given the opportunity to use expressive arts such as clay, paint, and/or textile, and the meaning children input into their art objects.” The researcher studied communication via the expressive arts in the context of non-directed play therapy with 22 hospitalized children, and found that the themes fear, longing, and powerlessness were expressed in the patients’ artwork. The American Academy of Pediatrics also supports collaboration between art therapy and child life and states that:

Engaging in developmentally appropriate play, creative or expressive arts (including music therapy, art therapy, drama, video work, and creative writing), and reading activities all help moderate children’s anxiety and decrease the possibility that health care encounters will disrupt their normal development. Auxiliary programs…when used in conjunction with child life services, provide additional supportive activities for all ages of pediatric patients (2006).
Art therapists and child life specialists share many goals in the pediatric setting. One shared goal is to provide patients with an opportunity for mastery and control, and both play and art making involve active engagement. They provide the child with an opportunity to abandon their passive role as a patient, to make choices, and to exert power over their situation. The facilitation of self-expression, social interaction, and normalization of the hospitalization experience are additional goals shared by both art therapy and child life. Medical art therapy and child life goals are often so similar, that the modalities often share one single department within a hospital. While it is important to note that the modalities share common goals, it is equally important to make a distinction between the two. It is both their inherent similarities and differences that allow them to work together to, “share these goals and find dynamic ways to collaborate within the pediatric setting,” (Rode, 1995).

The child life specialist is educated in the theories of play and play therapy, and they often use art activities as interventions. Play and creativity/art are considered to be intrinsically related, as play is a fundamental component of creativity, and creativity is always involved in play (Rode, 1995). Malchiodi points out the similarities between art therapy and play therapy:

In medical settings, therapeutic uses of art are very similar to three types of therapeutic play described by Gibbons and Boron. First, many children may naturally use art as a pastime, a creative activity for self-expression, personal gratification, and recreation. This spontaneous art making is similar to recreational play in that it originates from the child’s initiative and is self-directed (1995).

While there are similarities amongst therapists and child life specialists, there are also several distinctions. Judith Rubin (2005) acknowledges a close relationship between art and
play, but also recognizes and distinguishes the differences between art therapy and play therapy. While a play therapist or child life specialist may provide art materials to their patients, they are often limited in range, and are also frequently offered in addition to a wide variety of play equipment. On the other hand, an art therapist, “usually makes available a much greater range of art media and tools, and is able to teach and to facilitate the use of materials - something the average play therapist[child life specialist] is not equipped to do” (2005). An art therapist also has the ability to adapt art materials to meet the physical needs of their patient. In order to provide art therapy, one must be educated in, the media and processes of art, the creative process involving the language of art, symbolism, form and content, as well as therapy and therapeutic relationships, which includes development, psychodynamics, and interpersonal relations (Rubin, 2005).

Since the creative process itself is often central to the art therapeutic encounter, the clinician’s ability to facilitate that process is as important a component of successful art therapy as his or her equally refined understanding of the symbolic meanings of the child’s visual communications (Rubin, 2005).

The encouragement of emotional expression through artwork within the pediatric setting is common, and not just by art therapists and child life specialists, but by psychologists, social workers, and nurses (Rae 1981; 1991; O’Malley and McNamara 1993; Stein 1997; Nadler 1983; Cameron, Juszak, and Wallace 1984). There are numerous articles in nursing journals that suggest art making as a method of communicating. “Art expression may be therapeutic and often becomes so, when a helping professional or supportive individual is able to provide an art activity and to be present during the child’s art making activity,” but Malchiodi cautions that, “it is inaccurate to say that by simply introducing
hospitalized or seriously ill children to art making, emotions are communicated and safely released, while children automatically master traumatic events and feelings” (1995). She also states that, “medical art therapy does not automatically happen when physically ill children are offered the chance to express themselves through art,” (1995). It is important that a therapeutic alliance be formed between the patient and the art therapist in order to provide a safe environment for exploration of issues and opportunity for healing trauma through creativity and artwork. To specifically practice medical art therapy, one must have, “knowledge of the specific practice, theory, and methodology of medical art therapy and how play therapy complements and interfaces with art making, is necessary for successful therapeutic exchange, conflict resolution, and emotional reparation to occur” (1995).

Diane Rode, an Art Therapist, Child Life Specialist, and nurse believes that, Creativity is the link that ties child life and art therapy together. Both play and art involve creativity, and it is in the creative act (either play or art) that a child is able to express their experience with hospitalization in a therapeutic, and non-threatening manner. Child life specialists and art therapists both have an ability to offer an integrated approach to psychosocial intervention within the pediatric setting. Art therapists typically have a higher level of education with regards to psychology coursework. Art therapists also have much more knowledge regarding the affective qualities of art materials, when it is appropriate to introduce specific materials into therapy, and how to adapt materials to meet the physical/emotional needs of their patients. While play therapists and child life specialists often offer art materials to their patients, they may not know the spectrum of structure regarding those materials, and may cause unintended frustration with their patients. There are situations when an art therapist may intentionally introduce frustration into a therapy
session, but they have the knowledge and ability to properly contain the session, and facilitate closure to ensure a positive conclusion. (Rode, 1995). In addition, Art Therapy may have an advantage over play therapy because it is indicated for patients of all ages. Play therapy may not be age appropriate for older adolescents.
CHAPTER 3: METHODOLOGY

The approach to this thesis is to write a grant proposal in order to secure funding for the development and application of a pilot pediatric art therapy program at a children’s hospital in Indianapolis, Indiana. The need addressed in this grant is the apparent paucity of psychosocial support in the treatment of hospitalized children. This chapter will describe the procedure (Figure 4) needed for grant writing, and will use examples from this researcher’s internship in a large children’s hospital in Philadelphia.

The individual/organization pursuing the grant must decide what type of grant best suits their need. There are many types of grants, but three of the most common are research, program, and special projects/demonstration grants. The grants pursued in this study are program grants. There are five regional Foundation Centers in the United States, and they are a leading authority on philanthropy. They connect nonprofits and more than 600 funding agencies by supporting them with tools that they can use, such as a comprehensive database of grant makers, public access to computer programs, and online subscriptions. This researcher used The Foundation Center’s database to search for matching grants. The terms used while searching The Foundation Center’s database were program development, pediatrics, hospitals, arts, and healthcare.

The geographic focus was Indianapolis, Indiana. The Foundation Center provides free forms online (Figure 5) to aid the grant seeker in narrowing the results of the search.
Figure 4.

The Grant Writing Process

(http://www.unc.edu/depts/wcweb/handouts/grant_proposals.html)
### Figure 5. The Foundation Center’s Prospect Worksheet – Institutional Funders

#### PROSPECT WORKSHEET

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#### Basic Information

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#### Is Funder a Good Match?

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1. Subject Focus (list in order of importance)

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<th>Type(s) of Recipients</th>
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<th>People (Officers, Donors, Trustees, Staff)</th>
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#### Application Information

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#### Sources of Above Information

- [ ] 990-PF -- Year: [ ] Requested [ ] Received
- [ ] Annual Report -- Year: [ ] Requested [ ] Received
- [ ] Directories/grant indexes
- [ ] Grantmaker Web site

#### Notes:

Follow-up:

(http://foundationcenter.org/findfunders/wrksheet/)
As the initial step, some agencies prefer a letter of inquiry as a first step in the proposal process, while others require a completed proposal. Foundations will want to know of any other sources of funding the grant seeker is pursuing. They typically want to know that they will not be the only source of funding being sought. Since most grant writers seek funding from multiple foundations or agencies, it is common to create a general grant proposal and budget. Once a general proposal has been completed, the grant seeker/researcher will tailor a specific proposal for each grant program. The general proposal will act as a framework, but every funding agency will have its own specific requirements, guidelines, and priorities.

A general proposal should include:

- Title page
- Abstract
- Introduction
- Literature Review
- Project Narrative
- Personnel
- Budget and budget justification

The title page typically consists of a brief title for the project, the names of the principal investigator, the institutional affiliation of the applicants, the name and address of the granting agency, project dates, amount of funding requested, and signatures of personnel authorizing the proposal. An abstract follows the title page and presents the reader with a brief overview of the project and usually states: the general purpose, specific goals, research design, methods, and significance. The abstract should be as concise and succinct as possible. The abstract should also show how developing a pediatric art therapy program
would support that foundation’s goals and mission. The introduction follows the abstract and provides the reader with more detailed elements of the proposal. It should include a statement of the problem to be addressed, the purpose of the research, objectives or goals, and significance of the proposed research. A literature review is included, and may also be required in the proposal.

The project narrative is the most detailed section of a grant proposal and comprises the bulk of the proposal. The narrative provides all the details of the project, including a detailed statement of problem, objectives or goals, methods, procedures, and evaluation methods of the project. Connections between the statement of problem, objectives or goals, methods, procedures, and evaluation methods should be clearly stated in this section. The project narrative should be pre-emptive in answering any questions of the reviewers. An explanation of why developing an art therapy program is suited for the specific population and the benefits that the patients will receive from art therapy should be included. A timeline is also included and presents the sequence of actions that will be taken during the project, as well as the timeframe for the project. A time line diagram may be necessary for multi-year projects.

The budget section of the grant consists of a detailed list of each cost that will be incurred to implement the program. A spreadsheet or table is typically included, and a budget narrative is also included to further explain each of the expenses. The grant writer should document the administrative fees to be reserved by the hospital to administer and handle the grant funds. Within the personnel element of the proposal, staffing requirements for the project should be detailed. The necessary skill set, educational requirements, and functions of the personnel to be recruited should be explained.
Finally, several documents will also need to be gathered and included in the grant proposal. These documents include: resumes of key staff, letter(s) of support, Internal Revenue Service (IRS) determination letter for non-profit organizations (501(c)(3)/501(a)), an audited financial statement for the fiscal year, and the organization’s yearly report.
CHAPTER 4: RESULTS

This chapter will contain The Eugene and Marilyn Glick Foundation grant proposal. This particular grant proposal is being presented in this thesis, because it is the grant proposal with the earliest deadline of the three grants currently being pursued. The material for this grant, as it appears in this thesis, is presented in complete format as requested by the foundation. Artwork illustrated in the grant proposals were obtained from the public domain, therefore do not require signed releases.

The Eugene and Marilyn Foundation Grant Proposal
July 30, 2009

Marianne Glick
Eugene and Marilyn Glick Foundation
P.O. Box 40177
Indianapolis, IN 46240-0177

Dear Marianne,

Thank you for visiting us last fall to tour Peyton Manning Children’s Hospital at St. Vincent. During your visit, we discussed the potential expansion of our art therapy services to pediatric patients, and I was so pleased to note your interest. It remains one of our greatest hopes to develop this program, so I was very thankful to receive your invitation to submit the enclosed proposal for the consideration of the Eugene and Marilyn Glick Foundation.

The mission of the Pediatric Art Therapy program is to help children, adolescents, and their family members cope with illness, injury, treatment, and the overall healthcare experience, by providing an opportunity for creative expression through art. The requested $50,000 will be used to hire a full time master’s level art therapist, and to purchase educational materials, art therapy supplies, and equipment for the program.

The St. Vincent Foundation plays an important role in bringing together the interests of donors and the needs of our pediatric patients and their families. The results are creative and life-impacting programs like the Pediatric Art Therapy Program which we know will benefit thousands of pediatric patients who are served at Peyton Manning Children’s Hospital at St. Vincent.

Thank you again for this opportunity! We look forward to notification on the grant award. Please don’t hesitate to contact me if you have any questions or need additional information.

Sincerely,

Sue Anne Gilroy
Vice President of Development and Executive Director
St. Vincent Foundation
8402 Harcourt Road, Suite 210
Indianapolis, IN 46260
(317) 338-7012 Phone, (317) 338-2171 Fax
sagilroy@stvincent.org
Peyton Manning Children’s Hospital at St. Vincent
Pediatric Art Therapy Program

A. EXECUTIVE SUMMARY

The St. Vincent Foundation is pleased to submit this proposal in the amount of $50,000 to the Eugene and Marilyn Glick Foundation in support of the Peyton Manning Children’s Hospital Pediatric Art Therapy Program. Funds to support the initiative will be used to establish the program, which will provide art therapy as a component of expressive therapy services to patients and their families, with a special focus on children with complex and/or life-limiting conditions.

The St. Vincent Foundation was established in 1968 to make a positive difference in the lives and health of individuals in the community; and to generate financial resources to benefit the mission of St. Vincent Hospital. The health services and programs supported by the Foundation are spiritually-centered, accessible, and affordable. Central to the Foundation’s mission are patient focused services and programs such as those that are provided by the Pediatric Art Therapy Program.

From its inception, St. Vincent Hospital’s mission has been to provide spiritually-centered, holistic care, which sustains and improves the health of individuals and communities, promoting and advocating for a healthier society in strong partnership with associates, physicians, patients, families, and our community. To achieve these goals, St. Vincent is focused on defining and delivering excellence through prudent management of resources, and through caring and compassionate service. St. Vincent ministers to the minds, bodies and spirits of those in need, with special attention to the poor and vulnerable.

B. NEED

The establishment of the Pediatric Art Therapy program will address the need for additional supportive services and expressive therapies for patients at Peyton Manning Children’s Hospital at St. Vincent. On an annual basis, the Hospital provides holistic and compassionate care to nearly 5,000 inpatients and 10,000 outpatients. Many of these patients suffer from life-threatening illnesses and serious injuries that result in a long-term stay, or frequent short stays in the Hospital.

With over 3 million pediatric hospitalizations occurring annually in the United States, much research has been conducted to study how those children are affected by long-term visits to the hospital and clinic. Research conducted in the 1960s indicated that a childhood hospitalization can result in significant psychological distress and depression over a period of time. These negative implications can result in ongoing mental disorders.
Dr. Cathy Malchiodi, a nationally renowned art therapy expert, indicates that, “Three primary sources of stress have been identified in pediatric patients: (1) separation from parents or caretakers through hospitalization, (2) loss of independence and control which accompanies illness and hospitalization, and (3) fears and anxieties about medical procedures which may cause harm or pain, and worry about death.”

While advances and progress in the care of these children have been made since the 1960s, current research continues to indicate that a child’s emotional well-being may be negatively impacted due to chronic complex conditions. The ongoing documentation that supports a lack of efficacy regarding the advanced care of hospitalized children recommends the need to investigate and implement additional interventions, such as art therapy.

While advances and progress in the care of these children have been made since the 1960s, current research continues to indicate that a child’s emotional well-being may be negatively impacted due to chronic complex conditions. The ongoing documentation that supports a lack of efficacy regarding the care of hospitalized children recommends the need to investigate and implement additional interventions, such as art therapy.

The American Art Therapy Association defines art therapy as, “A mental health profession that uses the creative process of art therapy to improve and enhance the physical, mental, and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight.” An art therapist is a master’s level clinician who is educated in visual art, the creative process, human development, behavior, personality, and mental health.

Providing art therapy to children chronic illnesses has the potential to alleviate feelings of helplessness and lack of control often associated with physical debilitation and hospitalization. Participation in art therapy provides patients with an opportunity to become actively engaged in their medical treatment. The therapy sessions allow children to play an integral role in communicating their experience to the treatment team, and provide them with the opportunity to regain their sense of power and control related to their hospitalization. At Peyton Manning Children’s Hospital, the Pediatric Art Therapy Program will address the three primary sources of stress as identified by Dr. Cathy Malchiodi through conducting group therapy sessions with the children to alleviate the parental separation anxiety, providing individual sessions for the children to regain their sense of control over their illness, and involving the patients healthcare team to decrease anxiety over medical procedures and treatment services.

As research continues to identify significant implications stemming from these hospitalizations, it is imperative that hospitals serving these children find and utilize new approaches to help minimize these concerns. We believe that the addition of art therapy services at Peyton Manning Children’s Hospital, will be of great benefit to the well-being of the children and families that we serve.
C. PROGRAM OVERVIEW

The mission of the Pediatric Art Therapy Program at Peyton Manning Children’s Hospital at St. Vincent is to help children, adolescents, and family members cope with illnesses and injuries and the overall healthcare experience by providing an opportunity for creative expression through art.

Art therapy will be available to all inpatients at Peyton Manning Children’s Hospital on a referral and scheduled basis. The Pediatric Art Therapy Program will hire a certified Art Therapist to be the Program Director. The Program Director will plan and facilitate all the art therapy sessions and work in conjunction with the Child Life specialists and healthcare provider teams at Peyton Manning Children’s Hospital.

Art therapy services will include individual art therapy, bedside sessions, group art therapy, and family/sibling art therapy. During an individual art therapy session the patients will be provided with the opportunity to express themselves and describe the impact art therapy has had on their well-being. The artwork will provide a non-verbal mode of communication between the patient and therapist.

The program will also serve as a catalyst for a dialogue for the patient in expressing his/her thoughts, feelings, and experiences in the hospital environment. Children who are unable to comprehend the reason for their hospitalization frequently create fantasies to explain the current situation. The Pediatric Art Therapy program will establish interventions that encourage children to share these fantasies in a safe, non-threatening, and supportive manner.

Interventions are critical to understanding the child’s fantasies and misconceptions regarding his/her experiences, so that efforts can be made to inform and educate the child in an age appropriate manner. Children who do not have the ability, due to age, stress, or cognitive functioning, to verbally express their feelings regarding hospitalization during individual therapy will use alternative outlets, such as group art therapy.
Group art therapy sessions will be held in closed playrooms (to protect patient confidentiality), and will provide patients with the opportunity to participate in art tasks designed to improve their self-esteem, promote social interactions and provide a group outlet for emotional expression related to illness and hospitalization. At the conclusion of each session, the patient will be able to make a choice about what to do with his/her artwork.

Depending on the content of their work, many children request to display their artwork in their rooms. In 2003, Tracy Council, nationally renowned art therapist, found that, “Displaying children’s art in the treatment space can promote feelings of pride, acceptance, and safety, encouraging children to forge alliances with the medical team because they feel they are known and appreciated as whole human beings.” Peyton Manning Children’s Hospital will encourage patients to display their artwork throughout the hospital and at events, as appropriate.

D. BENEFITS AND EVALUATION

It is expected that through the development of a Pediatric Art Therapy Program at Peyton Manning Children’s Hospital at St. Vincent, patients will be provided with the opportunity for age-appropriate, self-expression through creative arts. It is anticipated that this program will also interface with the Pediatric Palliative Care Program, which serve as an additional benefit to the program. The program will evaluate its success by tracking the number of patients participating in the program, and then measuring their knowledge and attitudes through their artwork and journaling. The program will encourage positive self-esteem and promote a sense of independence and feelings of control among the participants. The program will also have group sessions to provide peer interaction and a sense of community within the hospital environment.

Program benefits will be measured through a detailed program evaluation, which will consist of a patient and/or caretaker questionnaire, healthcare provider survey, and comprehensive documentation of each child’s progress during art therapy. The patient/caretaker questionnaire will be designed to collect information related to patient satisfaction and perceived benefit(s) of art therapy during hospitalization. The surveys to be completed by the treatment team (including physicians, nurses, and child life staff) will ask them to provide information related to their perception of the art therapy program.

The evaluation records will be maintained throughout the grant award year in order to document the number of children and/or family members who receive art therapy services. These records will also track the number of sessions that each patient has received and the number of children and/or family members who attended art therapy groups. The information will be synthesized and presented to the Eugene and Marilyn Glick Foundation in a report format at the conclusion of the grant award year. With patient and/or family member consent, reproductions of artwork will also be included to illustrate specific case examples.
E. FUNDING REQUEST

Because of the Eugene and Marilyn Glick Foundation’s demonstrated interest in supporting the arts and humanities in Central Indiana, we ask that you consider this request in the amount of **$50,000** in capital funds to establish a pediatric art therapy program to improve the lives of children suffering from life-threatening conditions and diseases at Peyton Manning Children’s Hospital at St.Vincent.

The requested funds will be used to support the program operations to hire a Program Director (Art Therapist), purchase educational materials and equipment, and provide support for the Program Director who will attend an art therapy annual conference. The total cost of the program is estimated at $110,000. Of this amount, Peyton Manning Children’s Hospital at St.Vincent will be providing $35,000 (32% of the project budget) in operational support and the remainder will be raised through philanthropic support. The requested budget includes the following:

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Requested Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee compensation &amp; benefits</td>
<td>$45,000.00</td>
</tr>
<tr>
<td>Occupancy &amp; equipment (art cart/storage equip.)</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>Printing and publications</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Conferences, conventions and meetings/trainings</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>Other – Supplies/Ed. Materials</td>
<td>$1,000.00</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$50,000.00</strong></td>
</tr>
</tbody>
</table>

The St.Vincent Foundation will work to financially sustain the program by seeking additional funds from local foundations, corporations, and individuals in the community to support this vital initiative. To that end, the Foundation recently applied for a grant to the Allen Whitehill Clowes Foundation to support the initial operations of the program, which will be reviewed in October 2009.

E. CONCLUSION

As researchers continue to find significant implications stemming from childhood hospitalizations, it is imperative that hospitals find new approaches such as art therapy to improve the patient’s experience. The addition of Pediatric Art Therapy services at Peyton Manning Children’s Hospital at St.Vincent will be of great benefit to children and families served at the hospital. It is a high priority of Hospital staff to find ways to ensure that each individual child’s needs are met. We believe that the development of this program will meet those needs in a unique and highly personalized way, enabling the Hospital to help and heal these small, and particularly vulnerable patients.
ADDENDUM

• ORGANIZATIONAL INFORMATION
  o CURRENT LIST OF BOARD OF TRUSTEES, THEIR AFFILIATIONS AND BOARD SERVICE DATES.

• FINANCIAL INFORMATION
  o IRS 501(C)(3) TAX DETERMINATION LETTER
  o MOST RECENT AUDITED FINANCIAL STATEMENT
  o ORGANIZATIONAL BUDGET
  o AMOUNT OF ORGANIZATION’S OUTSTANDING DEBT AS OF APPLICATION DATE
  o NET WORTH OF ORGANIZATION’S ENDOWMENT
  o PERCENTAGE OF BOARD MEMBER FINANCIAL PARTICIPATION
  o LIST OF ORGANIZATION’S TOP THREE SALARIES, INCLUDING BENEFITS
CHAPTER 5: DISCUSSION

This discussion will concentrate on the process of the researcher’s grant writing experience, from the preliminary objective, through the development of the final grant proposals. Case vignettes from various patients at a large children’s hospital in Philadelphia will be presented, in order to demonstrate the advantages of developing an art therapy program within the context of a children’s hospital. All artwork illustrated in the case vignettes have signed consent/release forms on file. The discussion will also focus on the future implications of a pediatric art therapy program at Peyton Manning’s Children’s Hospital at St. Vincent.

Developing the Art Therapy Program

Once funds are secured, the researcher will be committed to piloting an art therapy program within the Child Life Department at a specific children’s hospital in Indianapolis, Indiana. While working at the hospital, she will aim to make art therapy a permanent service within the hospital and will attempt to secure long-term funding for the medical art therapy program. In addition, future students and professional art therapists will be able to use the grant proposal as a template for grant applications. Every awarded grant is beneficial for the future of art therapy funding, as well as legitimizing the field to non-art therapists. During the writing of this thesis, a local university, In Indianapolis developed a Master’s level art therapy program. Once the program is established, this researcher will attempt to grow the program to accept interns from that university. This researcher attended that same school for her undergraduate degree, and was consulted during the development of their art therapy program.
Throughout her internship at a large children’s hospital in Philadelphia, Pennsylvania, the researcher knew that she wanted to begin her career as a pediatric art therapist at a children’s hospital in her home city of Indianapolis. While the need for art therapy services exists, individuals within the hospital may not know the value and benefits of an art therapy program to their patients. This researcher had a dual purpose in writing the grant; to complete her thesis as partial requirement for her degree and create additional employment in the art therapy field. Thompson and Stanford (1981), present three simple steps to “creating” a job, which are:

1. Decide exactly what you want to do.
2. Decide exactly where you want to do it.
3. Thoroughly research the organization that interests you to find:
   a. Who within the organization is in a position to hire you, and
   b. What problems that person has that you can solve with the skills you possess.

The selected children’s hospital has not had any art therapy services to date, but the reception and enthusiasm for an art therapy program has been substantial. This researcher initially proposed the idea to the interim director of pediatrics who immediately welcomed the idea, as she had been previously employed at a children’s hospital with an art therapy program. She understood the basic concepts of art therapy, and the benefit that it would bring to the patients at Peyton Manning Children’s Hospital. A second meeting was arranged with the child life staff, where it was requested to have a brief presentation on art therapy, as well as a question and answer period. Throughout the meeting the child life staff appeared excited about art therapy and eager to have an art
therapist added to their team. This researcher was also given a guided tour, where she paid particularly close attention to the spaces where art therapy services would be provided. She noticed that all patient rooms are individual, so she would not have to deal with the confidentiality issues surrounding shared rooms. She also noticed playrooms on each unit that would serve as the location for future art therapy groups.

Gaining the support of influential administrators and existing staff is key to the development of a new art therapy program. Without their support, it would be difficult to get permission to write a grant on their behalf. After being granted permission to write a grant proposal on Peyton Manning Children’s Hospital’s behalf, this researcher was introduced to a couple of managers and an intern of their foundation’s grant writing team. They have been her contact throughout the entire process, and provided her with all of the necessary paperwork that is required to be included in the grant proposal, such as financial and organizational data.

Upon the inception of the art therapy program, a memorandum will be sent out to Child Life staff, doctors, nurses, and adjunctive therapists giving a brief explanation of art therapy and the services to be provided (Figure 5). Attached to the memorandum will be an art therapy referral form, which will request pertinent information regarding the referred patient as well as the reason(s) for referral (Figure 6). The art therapy referral form will also be distributed among all hospital units and regularly replenished for future use. In addition to the memorandum, an in-service explaining art therapy will be provided upon the inception of the art therapy program, and will be offered multiple times per year for newly hired staff.
PROPOSED MEMORANDUM

Date: To be determined

To: Child Life Staff, Doctors, Nurses, Therapists, and Direct Patient Care Staff

From: Lisa Rainey, Art Therapist

Subject: Art Therapy Services

The purpose of this memo is to inform you of the availability of art therapy services for your patients. Lisa Rainey, a Master’s level Art Therapist, will be available to see patients individually for art therapy throughout the children’s hospital.

Definition of Art Therapy according to the American Art Therapy Association:

“Art therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, and increase self-esteem and self-awareness, and achieve insight.”


Following is a brief description of the services offered:

Individual Art Therapy: Referred patients will receive art therapy services in their room, at bedside, or in playrooms (when empty, to protect patient confidentiality). Families/Siblings may also be included at the discretion of the patient/therapist. During an individual art therapy session the patient will have the opportunity to express themselves through an artistic medium. This artwork provides a non-verbal mode of communication between the patient and therapist, and can be a catalyst for a dialogue between the patient and therapist regarding their thoughts, feelings, and experiences regarding illness/hospitalization.

Group Art Therapy: The art therapist will work with child life and unit staff on a daily basis to determine appropriate patients for regularly scheduled group art therapy sessions. These sessions will be held in a closed playroom. Siblings may also attend at the
discretion of the patient/therapist. During group art therapy sessions patients will have the opportunity to participate in art tasks designed to improve self-esteem, promote social interactions and provide a group outlet for emotional expression related to illness and hospitalization.

**Availability of Services and Referral Process:**

Services will be available from 9 A.M. - 5 P.M Monday through Friday. In order to refer a patient for art therapy, complete an Art Therapy Referral Form (attached) and place it in Lisa Rainey’s mailbox located in the Child Life office or contact Lisa Rainey directly at ext 8723. The art therapist will make initial contact with the patient within 48 hours of receipt of referral to discuss and schedule an individual art therapy session. Patient progress will be documented and presented to the all members of the treatment team through progress notes located in the patient’s chart.

Please feel free to contact Lisa directly if you, a patient or family member should have additional questions or concerns regarding any aspect of art therapy.

- Lisa Rainey, Art Therapist
Figure 6.  ART THERAPY REFERRAL FORM

*Please fill out as complete as possible*

Date of Referral: ______/____/____  Referrer’s Name/Title/Ext: ______________________________

Patient Name: __________________________________________  Room #: __________

Age: ______  Sex (circle one):  Male    Female  Diagnosis: ________________________________

Parent’s / Caregiver’s Names: _________________________________________________________

At Bedside (circle one): Yes  / No  / Sometimes  Anticipated Length of Stay: ______

Siblings Names/Ages (If known): ______________________________________________________

Reason for Referral: Check all that apply

O Medical Stressors:
  - New / Unknown Diagnosis
  - Emergency Admission
  - Uninformed / Unprepared Prognosis
  - Poor / Questionable New / Permanent Disability
  - Multiple Symptoms

O Restrictions/Mobility:
  - Short term isolation
  - Special Diet / NPO
  - Permanent or Long Term Physical Disabilities or Changes in Body Function

O Emotional Stressors/Limited Coping Skills:
  - Poor / Limited Coping Skills
  - Depressed or Withdrawn
  - Poor Self-Esteem
  - Distortion of Medical Events / Illness

O Family/Support System:
  - Limited Family or Community Support
  - Suspected/Confirmed Child Abuse or Neglect
  - Displacement from Siblings/Family

Additional Information (continue on back if needed):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Employment as an art therapist in the medical setting can be quite different than practicing in a more traditional psychiatric setting. An art therapist in the medical setting traditionally works as part of a multidisciplinary treatment team including physicians, nurses, psychologists, social workers, child life specialists, occupational therapists, and physical therapists (Malchiodi, 1993). The art therapist may take part in medical and/or psychosocial rounds and communicate their clinical observations with the other members of the treatment team. Art therapists may have the unique opportunity to co-treat with other members of the team in the medical setting. For example, if a patient has a physical therapy treatment goal of “standing up,” the art therapist may schedule a session concurrently with the physical therapist, and request that their patient draw or paint while standing up at an easel. This may help to distract the patient from the perceived rigors of physical therapy, in addition to providing an outlet to express themselves. The addition of art therapy services to the conventional methods already in place, offer children a safe, non-threatening, creative, metaphorical, and figurative means to express their emotions.

Practicing art therapy in a medical setting has unique aspects and challenges that other settings may not pose. Flexibility on the part of the art therapist is particularly important within the hospital. A patient may have frequent or unplanned medical treatments/procedures, and this may result in the need to reschedule the art therapy session for later in the day or week. It is not uncommon for an art therapist to arrive for a regularly scheduled art therapy session to find that their patient is absent from their room for a variety of reasons. Throughout the art therapy session there may be frequent and necessary interruptions by the medical/nursing staff. While confidentiality is always important, an art therapist working in a hospital must be especially sensitive to this,
especially if the patient is in a shared room. Another potential challenge in the medical setting can occur when a patient has a short or unknown estimated length of stay. It is not always possible or appropriate to complete a formal art therapy assessment with each patient. Art therapists in this position may create their own interventions/tasks to assess their patient’s current needs.

The following information was learned during this researcher’s training.

Infection control and prevention is extremely important to keep in mind while developing a program and practicing art therapy within the hospital. Precautions must be taken to prevent the spread of disease by having knowledge of the appropriate gowning procedures, and also knowing when one needs to gown. Precautions must also be taken with the art materials themselves because they can spread disease when shared and not properly disinfected between uses. In some instances, the art therapist may be required to provide brand new materials to a patient who is highly susceptible to infection. On the other hand, materials may have to be left with the patient permanently or even discarded if they pose a high risk of spreading infection. Selection of materials is also critical, i.e.: using pastels or other materials that can aerosolize may exacerbate asthma or other respiratory issues.

Upon receiving funding for the program initial supplies will be ordered in bulk through designated suppliers. The initial supplies will also include large storage items, such as an “art cart,” and cabinets/bins for supplies and patient artwork storage. Subsequent supplies for the program will be ordered on an ‘as needed’ basis, to be determined by the art therapist. A supply budget will be reviewed/determined at the beginning of the year and strictly followed. The use of substandard and poor quality art
supplies may cause unnecessary/unintended frustration during sessions, so every attempt will be made to supply patients with high-quality materials while keeping in mind the stated budget. Supplies procured for the art therapy program will be stored and maintained by art therapy staff and will be utilized exclusively for art therapy sessions.

The Art therapist must be aware of art materials that may not be allowed within the hospital. Certain materials may pose health risks for patients. For example, sand is generally not an accepted art media because it poses a risk of getting into and clogging IV tubing. Any material containing latex is unacceptable, due to the potential of an allergic reaction. The medical setting provides many new materials to the art therapist’s repertoire and may include, syringes, gauze, casting material, iv tubing, masks, gowns, band-aids, etc… Offering medically related materials during the art therapy session is common and provides the patient with an opportunity to engage with those materials in a safe and non-threatening manner.

Individual Art Therapy Case Vignette

The following is a case example of individual art therapy with a four/five year-old African American female, “Amaya.” She turned five during her hospitalization. She was transitioned to another art therapist at the conclusion of the internship.

History:

“Amaya,” was born to a drug-addicted mother, and was subsequently adopted by a Caucasian family, consisting of two teenage siblings, and a middle-aged mother and father. They were fully committed to providing her a home, family, and the medical treatment that she would need.
Current Medical Issue

She was admitted to the hospital for a gastrointestinal disorder, (short-gut syndrome) and remained hospitalized throughout this therapist’s internship, which concluded five months after her admission. She turned five during her hospitalization. Amaya endured multiple medical procedures and surgeries related to her diagnosis. During an early surgery, a colostomy bag was placed to help with her digestion. Due to the colostomy and other factors related to her care, she was not allowed to eat anything for a period of weeks. This meant that all of her nutrition was provided intravenously. Continued procedures were done in an attempt to allow her to eat, and were occasionally successful. She would be given permission by her doctors to eat solid foods, but this only lasted for a few days each time, as her intestinal tract could not digest it properly.

Referral to art therapy

Amaya was referred for art therapy by the child life specialist on her unit, who felt that she needed additional outlets for coping with the hospitalization experience. Upon the initial session, Amaya approached this therapist with an immediate familiarity. It appeared somewhat odd that she did not exhibit any shyness towards this therapist or hesitation for her mother to leave, because this was not typical with other children of the same age. Amaya appeared, “wise beyond her years,” in other aspects of her hospitalization. This appeared evident in her knowledge of, and participation in, her own medical care. When the medical staff would interrupt a session to draw blood, or to administer medication, she would request an accurate explanation and ask if she could take part in some way. The staff would let her “flush” her IV lines with saline after
medication was administered, and they would observe as she set her medication machines correctly. Amaya often had a “medical doll” (Figure 7) in her room that she would feed, practice placing IVs on, as well as putting on and taking off a colostomy bag.

**Art therapy themes**

Amaya had regularly scheduled art therapy sessions three times each week. Throughout Amaya’s art therapy, this therapist noticed themes related to food and medical procedures. These were two central issues in her life at the time, and she was encouraged to express her feelings related to them. When the medical doll was in the room, she often wanted to create food in order to “feed” it. She would request to have disposable plates, cups, bowls, and silverware for her artwork. Amaya would then select art materials to create “food.” She cut up yarn to symbolize spaghetti, and chose wood scraps to represent strawberries, and used glue and tissue paper to represent a milkshake (Figure 8). While she was creating the “food,” she would talk about how hungry the doll was, and how she had not eaten in months, and was not sure when the doll would be able to eat again. It appeared as though Amaya was projecting her fears, fantasies, and feelings regarding her own eating onto the doll. She did not seem comfortable answering questions about herself, so this was understood as a cue and asked questions specifically about the doll. When she finished creating the food, she would feed the doll using the utensils (Figure 6). Amaya chose this activity repeatedly throughout art therapy sessions. When she was presented with other materials, such as clay, her food themes continued, as she made a clay “pizza” for her dad (Figure 9).

At various times, during the patient’s hospitalization, a change was noticed in the theme of the artwork from food related to surgery related, based on if she was able to eat
or not. There were small fabric dolls on the art cart, and Amaya asked if she could use one during an art therapy session. This doll remained the center of art therapy sessions for many weeks. During the first session, Amaya drew a face on the doll, glued on eyes, and hair. During following sessions, she would “cut” the stomach area open, and color the filling with a red marker. She would then ask for help to “stitch” them back together. Often times, the “stitches” had been removed by our next session, and she would excitedly announce that “the doll,” needed the therapist’s help. This same scenario occurred multiple times throughout Amaya’s art therapy sessions. Through prompting, she would say that the doll did not feel well, or the doll had surgery over the weekend. It was thought that this activity was reflective of Amaya’s own hospital experience. It appeared as though she was using the doll as an opportunity for mastery and control of her current situation.

*Transference*

While Amaya’s teenage sister visited the hospital somewhat frequently, it was believed that Amaya may have been transferring feelings regarding her sister to her therapist. This may account for the immediate familiarity that Amaya exhibited with her therapist.

*Counter transference*

The therapist enjoyed her sessions with Amaya, and would become disappointed, and feel guilty if a session had to be cancelled for a surgery, or other various reasons. Despite knowledge that it was not in her control when a session was cancelled, feelings of guilt, regarding missing quality time spent with her nephew, who was approximately the same age as Amaya, emerged.
**Transition to new therapist**

Towards the end of the internship discussions were initiated about transitioning to a new art therapist. Amaya did not completely seem to understand the concept, or why the art therapist could not come to visit again, even if not for art therapy. This topic was approached for the last several weeks of the therapy. Amaya began to ask questions of her own about her new art therapist, and her competence. She wanted to make sure that the new art therapist knew what materials to bring, and how to use them correctly. She wanted to know her name, and if she had seen her before. These fears and fantasies were addressed, and the final three sessions with Amaya were utilized for the transition. The first transition session was fairly normal, led by the therapist with Amaya, and the “new art therapist” observed over to the side. The only art cart that was present during this session was the usual therapist’s. Amaya was introduced to the new art therapist, and was asked permission for her to observe, which she granted. Amaya continued to work on a fabric doll, and at certain times she would whisper into this therapist’s ear. She would suggest that the other therapist pay close attention, so that she would know how to “sew up,” the doll once the transition occurred. This therapist would then ask the other art therapist to watch closely, which seemed to please Amaya.

The second transition session was co-led by both art therapists. The new art therapist brought her art cart into the corner of the room during this session. Materials from this art therapist’s cart continued to be used, and a drawing game was played by all three people. Amaya began to direct questions to her new art therapist. She asked questions regarding when, and how often her new sessions were going to be. She appeared happy to know that the dates and times of her sessions were not going to be
affected by the transition. She also began to ask questions about the materials on the new cart. She briefly looked at the new cart, but appeared to become quite shy as she sat closely to former therapist, and began to whisper questions again.

During the final transition session, the therapist did not bring her cart into the room. Instead, the new art therapist led the session, as the former therapist observed. Amaya was given an opportunity to look through the new cart, and ask any questions about any of the materials. She appeared to enjoy this, and began making plans for future sessions. The new art therapist suggested one final art task, which was to create “hello and goodbye hands.” She talked about how ‘waving’ can either mean hello or goodbye, and suggested that we all trace our hands, decorate them, and then exchange them at the end of the session. Amaya agreed to this activity, and practiced waving hello to her new art therapist and goodbye to this art therapist throughout the session.

Amaya appeared to be able to effectively communicate her feelings and experiences regarding her hospitalization through art therapy. Amaya’s mother also stated that art therapy seemed to be a good motivator to get her out of her bed, despite the fact that she was in pain from a procedure. She used the creative process as a positive way to cope with not being able to eat, as well as to express her emotions regarding the repeated medical procedures that she endured.
Figure 1. “Amaya’s” Medical Doll
Figure 2. “Amaya’s” Food Collage
Figure 3. “Amaya’s” Pizza
Family Art Therapy Case Vignette

Family

The Hellas family consists of Mrs. Sera Hellas (40 years-old), Mr. Daud Hellas (49 years-old), and their four children (three daughters ranging in age from two to eight and a son aged 10). The couple has been married for 22 years. Mrs. Hellas is currently pregnant with a baby, due within the next two months. They are dealing with their daughter, Suri’s health, as well as a loss of income due to her medical situation. They are of Middle Eastern descent, and presently reside in Tennessee. They immigrated to the United States 10 years ago, and Mr. Hellas manages a gas station/convenience store.

Mrs. Hellas is a stay at home mother and does not fluently speak or understand English, but her husband is completely fluent. Mrs. Hellas stayed behind in Tennessee to care for their remaining children, as well as her own pregnancy. During their stay in Philadelphia, Mr. Hellas is spending the nights at the Ronald McDonald House.

Current medical issue

Mr. Hellas and his five year-old daughter, Suri, were flown to a large children’s hospital in Philadelphia, two months ago for a surgery to moderate Suri’s Hyperinsulinism disease, which means that she had an abnormally high level of insulin in her blood, and this was causing her to have hypoglycemia.

Referral to art therapy

The clinician received an Art Therapy referral for Suri shortly after her admittance to the hospital, and saw her on an individual basis until her discharge. The referral noted that Suri had “been acting out, had limited social supports, and could benefit from additional outlets of self-expression related to her hospitalization”.
Initial Art therapy session/Behavior

When the art therapist arrived to meet Suri for the first time, a nurse was chasing her down the hallway because she was riding her IV pole like a scooter. According to the unit staff, Suri had been reprimanded several times for this unsafe behavior, but refused to comply. Suri’s father was not present at the time, and the unit staff commented that even when he was there, he did not discipline his daughter or keep an eye on her. Suri had been found by staff several times, wandering the hallways and in playrooms on other units. During the first individual session, Mr. Hellas left Suri’s room to “take a break,” while the therapist was there. Shortly after the session started, the phone rang. Suri answered and after realizing who was on the other line said, “I’m going to hang-up…(pause)…I’m going to hang-up now…(pause)…OK, I’m busy, I’m hanging up”. She hung up the phone, and this was questioned who was on the other end. She said that it was her mother. When questioned further about hanging up on her mother she said, “My mom is mean. I hate her. I never want to talk to her again”. Her mother called twice more during this session, and Suri reacted in a similar way each time. During another session, Suri’s mother phoned her room, and after Suri said, “Hello…” she followed with, “Shut-Up!” and proceeded to hang up the phone. This happened once more before the phone call was intercepted, and the therapist attempted to inform Mrs. Hellas that her husband was not present, but that he would be informed of her call upon his return.

It soon became apparent that Suri seemed to be struggling with feelings of abandonment regarding being separated from her mother and siblings. This became a focal point in the art therapy. After discussions with Suri, it became apparent that the
five year-old was under the false assumption, that every night when her father left for the Ronald McDonald house, she believed that he was going “home to be with her mom”. At five years-old, Suri was unable to truly understand the concept of distance, and that it would not be possible for her father to travel the distance between Philadelphia and Tennessee every night. Even after an explanation regarding her father’s sleeping situation, Suri was still not convinced that he was not going home to her family, and she also did not understand why her mother could not visit her at the hospital. The art therapist informed the child life specialist on Suri’s unit of the misconception, so that they could make an appropriate attempt to dispel these false assumptions.

Future Art Therapy Sessions

Suri would always appear happy to see the art therapist, but at the beginning of the therapeutic relationship, she would appear surprised that the therapist arrived and would say in apparent shock, “You came back! You said you were going to come back. I knew you would come.” She seemed to be constantly searching for approval. This may indicate that she was seeking a nurturing relationship from a female caretaker to substitute what she was missing from her own mother. Suri constantly told the therapist that, “You are pretty. Do you think I am pretty?” She would also ask for this therapist’s approval of her artwork, “Do you like it? Is it pretty?” She would ask for the therapist to stay with her all day, and would prolong the end of the session by saying, “Just one more sticker, one more painting, and one more of this or one more of that.”
Dynamics/Themes

Throughout this researcher’s experience at the hospital, it was noticed that many young children would resist verbalizing their feelings, and would rather spend the entire session creating artwork. But in Suri’s case, she seemed to use the artwork as a catalyst for expressing her feelings, by talking through the materials or her artwork. During art therapy sessions, Suri would appear to become bored with art making rather quickly and would begin to use the art materials as “puppets.” She would pick up the markers and pretend that they were talking to each other. She would insist that this therapist also pick up a marker, and become involved in the discussion. Suri would often reprimand the markers for “being naked,” and tell me not to look at them. The researcher began to feel uneasy regarding these verbalizations, consulting with a psychologist, who saw Suri and determined that “naked” represented her feelings related to “being out of control of the hospitalization experience, and the fact that many ‘strangers’ (doctors/nurses) were often looking at her.”

The therapist took this as a cue for further sessions. During the following two sessions, Suri was directed to create puppets, once out of face shaped paper and popsicle sticks, and then by decorating fabric dolls. She always insisted that this therapist also create a puppet. Once the puppets were created to Suri’s liking, she would begin a dialogue between them. After she was able to verbalize her feelings regarding being “naked,” the themes of her discussions changed, and returned to approval seeking and feelings of abandonment by her mother. Her father would often return to her room during the last few minutes of our session, and Suri would show her puppets to him, and suggest that they keep “talking.” He always seemed happy to oblige her and their puppet
conversations continued as I departed her room. The puppets appeared to become a way to engage an emotionally distant or stressed-out father, a “transitional object” transferred from the art therapist to the Dad. They seemed to empower Suri to get the emotional attention she needed from her primary caretaker in the hospital.

English Theorist, Donald Winnicott (1965) emphasized the “transitional object,” which is typically a favorite toy, blanket, or other object to which a child attributes characteristics of their primary caregiver. When the primary caregiver is not present, or during other anxiety producing transitions, the child may use this object to self-soothe.

Art produced during hospitalization can act in the same manner as a transitional object. The child can learn to trust the art therapist, when separated from their primary caregiver, and to form an attachment in the therapeutic relationship context. The creative process can be then used by the child as a means of self-soothing (Robins, 1987).

After many individual sessions with Suri, a decision was made to initiate family art therapy sessions with Suri and her father. Mr. Hellas was receptive to this idea and agreed to participate in future art therapy sessions with his daughter. Mr. Hellas disclosed his frustration regarding his daughter's hospital stay. He did not feel that he was being provided with adequate information regarding her illness, or the length of time that she would be hospitalized in Philadelphia. He shared that he had not worked in two months, and that he needed to return home in order to work and provide for his family. Communication (or a lack there of) between the hospital staff and Mr. Hellas seemed to be causing him much stress, and possibly preventing him from being able to provide the necessary emotional support for his daughter. The nursing staff had become increasingly agitated regarding Suri's wandering of the halls unsupervised. At some point the issue of
disciplining Suri was brought up with Mr. Hellas by a member of the multidisciplinary team. He was asked to keep a closer eye on her, and not to let her out of her room unsupervised. Soon after this, a nurse reported seeing Mr. Hellas "slapping Suri around." This may have been a cultural issue, as it is usual in middle-eastern families that the father earns a living, and the mother cares for the children/home. Suri’s father may have been inexperienced in how to cope with his daughter especially in an unfamiliar setting, so resorted to verbal and physical control. This was reported to the unit social worker, but when Mr. Hellas and Suri were questioned, they both denied that it occurred, and no further action was taken. The truth remained unclear, and there was some concern regarding the events, and whether the father had told his daughter to deny the incident; perhaps in embarrassment.

**Transference**

Suri may have been transferring feelings regarding the issue of feeling abandoned by her mother to this therapist when she would attempt to keep the therapist from ending the sessions, as well as when she would appear surprised when the therapist kept her word, and returned, as she said she would for future sessions. Her apparent desire for an adult woman’s validation and approval also indicate that she may have been seeking those because she was not getting them from her father. Perhaps her mother attended to Suri’s emotional needs when at home.

**Countertransference**

The therapist was especially vigilant to not miss a session with Suri, because she did not want to exacerbate the apparent abandonment issues that seemed to be surfacing. Giving special attention may have been elicited by feelings of abandonment when her
own mother unexpectedly died when she was a small child. Countertransference was also noted when Suri was eventually discharged. The therapist was not prepared for her sudden discharge, and was saddened that there did not seem to be a proper closing session.

**Hellas Family Art Therapy Assessment Unstructured Task (Figure 10).**

In order to assess and determine how Mr. Hellas and Suri would work together they were provided with a small (8x10) piece of paper, and instructed to create a collage together (using pompoms, glue, buttons, beads, feathers). The clinician felt that the small paper and limited instruction, may be symbolic of Suri's small hospital room, and the limited amount of information that Mr. Hellas felt was being provided to him regarding his daughter's illness and length of stay. Mr. Hellas and Suri began to work on opposite sides of the paper. Suri began to create a figure out of pompoms, and Mr. Hellas created a figure out of buttons. Throughout the task, Mr. Hellas gave Suri instructions on what to do. When she was looking for a way to create the mouth on her pompom figure, Mr. Hellas said, "here...use this piece of napkin." It appeared obvious that Suri did not like that idea and she slightly protested, but Mr. Hellas quickly ripped a piece of napkin, glued it onto her figure and said, "see...there, it has a mouth." Mr. Hellas seemed to be rushing through the task, and it was sensed that there was some tension in the room. In light of the recent event allegedly involving Mr. Hellas "slapping Suri around" and the mouth being created for her, may suggest anxiety.

**Hellas Family Art Therapy Assessment Structured Task, (Figure 11)**

A structured "animal family drawing" task was chosen to attempt to assess the current dynamics between Suri and her father. They were provided with fine tipped
markers and a large sheet of paper to complete this task. Suri and her father were asked to, “draw a family of animals doing something”. Mr. Hellas quickly suggested drawing a family of birds, to which Suri happily agreed. They both began drawing, and Suri drew the four small floating figures that she identified as birds. These four birds may represent Suri and her three siblings. Mr. Hellas drew the two larger birds that are standing on the ground in the image. He stated that the two birds were the mother and father birds. Suri seemed to enjoy watching her father draw and requested that he draw, “a big mouse,” which he did. Mr. Hellas appeared to be invested in this task, and continued to add detail to the landscape surrounding the animals. Suri seemed to become bored watching her father draw, and requested to use paint on the image. She began to paint the sky. Before she could paint the entire sky, Mr. Hellas picked up a paint brush and painted a sun on the left side of the image. When Suri was finished with the sky, she wanted to paint the "big mouse," and chose the color red. She also painted the bird that her father had referred to as the "mother bird". Mr. Hellas still seemed to be invested in the artwork, and appeared to "fix" or elaborate the sky, painting over Suri’s paint.

The "big mouse" may represent Suri's illness, and the color red may be symbolic of her anger/confusion regarding the separation from her mother and siblings. Suri’s father seemed to be so focused on his own artwork that it appeared that he was ignoring his daughter. This may be representative of his inattentiveness to her unsafe behavior and wandering within the hospital. Perhaps, Suri’s father had unaddressed anxiety, and his needs were not being met. The art may have provided the container for him to safely release his emotions. Maybe once his needs were addressed, he would then be able to address his daughter’s emotional needs.
Figure 4. Hellas Family – “Animal Family Drawing”
Figure 5. Hellas Family – “Mixed Media Collage”
Suri was transferred by plane from the hospital to one closer to home with only one hour's notice to the therapist. Her therapy concluded with an impromptu last session, where she requested to string beads to create a necklace. Suri completed three necklaces, and stated that they were gifts for her sisters, and mother. The atmosphere during the session seemed excited and chaotic. The nursing staff was busy completing the necessary paperwork to schedule the transfer, but Mr. Hellas was nowhere to be found. Several calls were made to the Ronald McDonald house, and the staff was becoming nervous that his arrival might be too late. He did eventually arrive, and hurried to sign the paperwork and to gather all of Suri’s belongings. Suri seemed eager to see her mother, and was wearing all three necklaces as they placed her on the gurney for her flight home.

Art therapy for Suri appeared to be an effective means of communicating her feelings regarding the separation from her family, as well as her hospitalization experience. She was able to communicate her misconceptions about her mother’s absence, and several attempts were made to correct these misconceptions in an age appropriate manner. The art therapist was able to advocate for Suri by communicating her feelings regarding “being naked” to the rest of the team, through direct discussion and consultation with other members, as well as written documentation in her chart.

**Pediatric Art Therapy Group Vignette**

The following image (Figure 12) was created by a group of five adolescent girls ranging in age from 10 – 16 on a hematology unit at a children’s hospital. Four of the group members were patients, and the fifth member was a visiting sibling of one of the other group members. All of the members were new to the art therapist, and stated that
they had never attended an art therapy group prior to this one. The art therapist introduced herself, and asked the girls to introduce themselves to the other members. The introductions were quiet, and all of the girls appeared to be apprehensive regarding the impending task.

**Goal**

The goal for this particular group was to promote social interactions and to provide an outlet for emotional expression related to illness and hospitalization.

**Art Therapy Directive**

The art therapist selected a “group mural” as the task, feeling that this would aid in facilitating the stated goals.

**Process**

The therapist began by asking the girls if they had ever created a mural before. They nodded their heads, some in agreement, and others seemingly unsure. A discussion was prompted by the therapist explaining group murals, as well as requesting an idea for this particular mural. The group members still appeared shy and apprehensive to speak, so the therapist gave them a few ideas to choose from, including: a fish bowl, a deserted island, a zoo, and a neighborhood. After a few moments and encouragement the members selected a deserted island.

The mural paper was laid out on the table, and the group was asked to select a medium for creating the mural. They all requested to use paints, so the paints, brushes, water bowls, and paper towels were provided. The therapist then asked them how they
would like the island to be depicted, explaining that they could paint it from a birds-eye view or horizontally. They decided that a birds-eye would be best, since they were seated at a round table. Each of the girls began to work on their “slice” of the paper, seemingly careful to not “cross” onto the other’s workspace.

The room remained relatively quiet, with the only conversation resulting from a few directed questions from the therapist. The quietness of the group was disturbed by a routine visit by a member of the nursing staff, who had come in to administer medicine to the 16 year-old group member. It quickly became apparent that she was becoming fairly sedated as a result of the medication. She had begun to fall asleep at the table, and when she was awake enough to participate, she did not appear to comprehend the direction that they other group members were intending for the painting. The remaining group members began to look uncomfortable, and confused with her choices in the painting. The therapist initially attempted to help the group member better understand the direction that the group was trying to explain to her through further clarification. The painting was started with one of the girls creating the boundary for their island. She drew an organic circular shape in the center of the paper to indicate the land versus the water. While the girls painted the water, and sand on the mural, the 16 year-old, painted a sun directly on the island. The girls tried to ask her what she was doing, and they even tried to explain that the sun would not go in the sand, but she appeared to not comprehend their statements. They looked to the therapist for some assistance and seemed to get frustrated that she was not following the chosen direction for the image.

The therapist decided that it was no longer appropriate for her to remain in the group, and asked her if she would like to be escorted back to her room, which she
accepted without hesitation, stating that she needed to take a nap. The other group members immediately seemed relieved and began to discuss the events that had led up to this point. The therapist asked the girls if they had ever been administered medicine that had made them drowsy. They all responded that they had taken medicines in the past that had made them feel drowsy. They began to relate to the missing group member, and appeared to understand why she was confused. One member suggested that they “fix” the missing member’s sun, and turn it into sand, but that never happened and they preserved her contribution to the mural throughout the session. Perhaps the remaining group members chose to preserve her contribution because they could relate to her experience, and would like to believe that their own contribution would have been preserved and honored, had they been in a similar situation.

The atmosphere in the group seemed to lighten, and the remaining group members began to stand up to reach areas of the paper that were not accessible from their seats. Through prompting from the therapist, they began to discuss their particular reasons for being hospitalized. They shared the number of times they had been hospitalized, as well as their general feelings about their experiences. They asked each other questions about their diagnoses and compared their experiences. The siblings appeared to become more comfortable with talking to the other group members. Throughout the rest of the session, the energy level in the room continued to grow. The girls were talking, laughing, and making suggestions about their mural. Some suggestions were approved, while others were peacefully challenged.

When the therapist informed the girls that the group would be concluding in fifteen minutes, one member pointed out that there was a large blank spot in the center of
the mural. They were talking about what to put in the center, when one of the girls suggested that they come up with a “symbol” for their group. They all agreed that this was a good idea and began to make recommendations for their symbol. It was finally decided that a “star” would symbolize their group and their experience. When they concluded the mural, one member asked if it could be hung up for display in the playroom. The other three group members agreed that this was a good idea and they helped to locate a good place for it to be displayed. This may have made their artwork seem permanent and acknowledged. The group helped the therapist clean up all of the paint supplies and decided to stay in the playroom together to listen to music and hang out. The playroom was loud with laughter and conversation as the therapist departed, suggesting that this had been an important experience that they didn’t want to end.
Figure 6. Pediatric Art Therapy Group Mural
Summary

The mural suggests seems to be a quality or rhythm of peace that can be felt through viewing the waves. Perhaps it’s the continuity of color and similarity of style. The girls were able to respond to each other, as if in synchrony.

Implications for Future Research

Recommendations for future research include the following:

- Art therapy with hospitalized children who have a specific disorder or need (e.g. brain injury, cystic fibrosis, cancer, palliative care)
- Grant writing for the development of new art therapy programs in other settings (e.g. education, hospice, nursing homes, homeless or women’s shelters)
- New Quantitative studies on Art Therapy in the Pediatric setting
- Grant writing for the development of medical art therapy with adults

There is a great deal of literature and research regarding the arts in healthcare, and much of that research has been conducted by professionals outside of the field of art therapy. This should be encouraging to those individuals who are attempting to develop new medical art therapy programs. Malchiodi (1995) acknowledges that art therapists, “need to find ways to develop and build professional identity within the context of the pediatric health care setting, and this development must begin by acknowledging what already exists in the literature, policies, and programming related to the psychosocial needs of children and families during illness and hospitalization”.

CHAPTER 6: CONCLUSION/SUMMARY

The research and practice of pediatric art therapy continues to gain interest and grow however there also is a paucity of literature on the subject of grant writing and art therapy. This thesis examined the current literature used in the application to regional foundations for grants to fund and develop a pediatric art therapy program at a children’s hospital in Indianapolis, Indiana.

In order to prepare for the grant proposals, a literature review was conducted on pediatric hospitalization, the psychosocial implications of childhood hospitalization, art therapy, medical art therapy, and the integration of child life and art therapy. The literature review aided in completing the grant proposals, as it prepared the researcher to address the purpose of the grant request, needs assessment, goals and objectives, methods, and evaluation.

Many foundations list their fields of interest as arts, children services, and/or healthcare, but there are very few foundations, and none in the Indianapolis, Indiana region, that list the creative arts therapies as a field of interest. Unfortunately, this may detract some grant seekers from applying for funding. It is relevant that the project narrative clearly demonstrates that donating funds to an art therapy program would continue to keep within the boundaries of their stated fields of interest. The field of art therapy itself continues to grow, but there are many people who are unaware of art therapy, or have misconceptions about its purpose or definition. Information to educate the foundation about art therapy through the grant proposal may aid the entity to make an informed decision regarding the future of their funding.
Recommendations for future research include the following: Art therapy with hospitalized children who have a specific disorder or need (e.g. brain injury, cystic fibrosis, cancer, palliative care; Grant writing for the development of new art therapy programs in other settings (e.g. education, hospice, nursing homes, homeless or women’s shelters; Grant writing for the development of medical art therapy program with adults.

Research regarding art therapy and grant writing would be of great benefit to future grant seekers, as well as to the development of new art therapy programs. Establishing working relationships with influential administrators is extremely important, as it is necessary in order to receive their approval to write a grant proposal on the establishment’s behalf.
References


Informational Handout

determining the impact of cancer on the family as perceived by the child with
cancer. *Journal of Pediatric Nursing, 5*(3), 204-213.


Effectiveness of art therapy interventions in reducing post traumatic stress
disorder symptoms in pediatric trauma patients. *Art Therapy: Journal of the
American Art Therapy Association, 18*(2) 100-104.

http://www.childlife.org/The%20Child%20Life%20Profession/

cope with abnormal circumstances. *Art Therapy: Journal of the American Art
Therapy Association, 10*(2), 78-87.


C. A. Malchiodi (Ed.), *Medical art therapy with adults* (pp. 189- 209),
Philadelphia: Jessica Kingsley.


Kingsley.


Tate, F. B., (1989) Symbols in the Graphic Art of the Dying. *AIDS Patient Care and STDs*, 16(2), 115-120.


University of North Carolina: Proposals. Retrieved May 1, 2008, from
http://www.unc.edu/depts/wcweb/handouts/grant_proposals.html


March 30, 2009

William H. Marshall, President
Allen Whitehill Clowes Memorial Foundation
320 N. Meridian Street, Suite 811
Indianapolis, IN 46204-1722

Dear Mr. Marshall,

The St.Vincent Foundation is pleased to submit a grant request in the amount of $75,000 on behalf of Peyton Manning Children’s Hospital at St.Vincent for the Pediatric Art Therapy program. Funds from your contribution to the Foundation would be used to employ one full time art therapist and to purchase the necessary art supplies. This program will provide medical art therapy to hospitalized children at Peyton Manning Children’s Hospital. The therapy provides a way for the pediatric patients to utilize their creative skills while sharing their feelings in an environment that is supportive and build self-confidence and morale while battling childhood illnesses and serious health conditions.

**Organization Description.** Peyton Manning Children’s Hospital at St.Vincent is a 72-bed acute care hospital with over 80 staff physicians and 50 sub-specialists who provide exemplary and extraordinary care to patients and their families. The Hospital also includes Indiana’s only pediatric emergency room, the Hilbert Pediatric Emergency Department, the Center for Cancer and Blood Diseases, and the Pediatric Intensive Care Unit. Nearly 5,000 patients and their families are cared for at Peyton Manning Children’s Hospital each year. The Hospital provides an extraordinary experience of holistic physical, emotional and spiritual care for children, putting the child and family as the focus of the healthcare team.

**Description of Need.** The incorporation of medical art therapy in healthcare delivery is growing as an acknowledged effective method of treatment in pediatric hospitals today. In fact, this service has made a significant impact on how child healthcare is delivered in the 21st century by 70% of the nation’s top children’s hospitals that currently offer the therapy to their patient’s and families. With your partnership, this program will also become a reality for patients and families served at Peyton Manning Children’s Hospital right here in Indiana. Once implemented, it will be the only medical art therapy program offered in the state.

Even as medical technology and treatment improve, serious illness and injury will continue to require childhood hospitalizations. With over three million pediatric hospitalizations occurring annually in the United States, much research has been conducted to study these children and the impact of hospitalization on recovery. Research conducted as early as the 1960s, indicates that childhood hospitalization can result in significant psychological distress, and these negative implications can result in ongoing psychological disorders.

Although, there have been advances in the psychosocial care of hospitalized pediatric patients, current research indicates that a child’s emotional well-being may still be negatively impacted due to a hospitalization. These statistics show a lack of efficacy regarding the psychosocial care of hospitalized children and supports the need to investigate and provide additional interventions such as art therapy. The development of a medical art therapy program will address the need for
additional psychosocial care for children hospitalized at Peyton Manning Children’s Hospital at St.Vincent.

**Program Overview.** The mission of a medical art therapy program is to help children, adolescents, and family members cope with illness, injury, treatment, and the overall healthcare experience by providing an opportunity for creative expression. Art therapy will be available to all inpatients at Peyton Manning Children’s Hospital. The program will provide individual art therapy sessions, interactive play sessions, bedside sessions, group art therapy, and family/sibling art therapy. The artwork created during art therapy provides a non-verbal mode of communication between the patient and therapist, and can be a catalyst for dialogue regarding a patient’s thoughts, feelings, and experiences during hospitalization. The information generated during these sessions can be used to aid in the establishment of treatment plans and ongoing health needs for patients. Constant communication between the art therapist and the health care team is necessary to improve the patient’s health status and clinical outcomes.

**Target Population.** The medical art therapy program will target hospitalized children and their families seen at Peyton Manning Children’s Hospital. The program will focus its efforts on children ages 5-18 to improve clinical outcomes and care during their visit at the hospital. Through the development of this program, hospitalized children will be provided with the opportunity for age-appropriate self-expression through creative arts. Participation will help these children process and work through traumatic experiences commonly associated with treatment and the hospital environment. Art therapy facilitates positive self-esteem and body image, promotes a sense of independence and feelings of control, and provides peer interaction and a sense of community within the clinical environment.

**Conclusion.** As researchers continue to find significant psychosocial implications stemming from childhood hospitalizations, it is imperative that hospitals find new approaches to minimize them. The addition of art therapy services at Peyton Manning Children’s Hospital at St.Vincent will be of great benefit to the psychosocial well-being of children and their families. The Hospital continues to be committed to providing extraordinary care through its facilities, staff, and services. It is a high priority of Hospital staff to find ways to ensure that each child’s needs are met, and that each family receives the highest-quality medical care in a comfortable and relaxing environment.

Because of the Allen Whitehill Clowes Charitable Foundation’s demonstrated interest in supporting the arts and humanities in Central Indiana, we ask that you consider this request for capital funds to establish a medical art therapy program to improve the lives of children suffering from life-threatening conditions and diseases at Peyton Manning Children’s Hospital at St.Vincent.

Thank you for your consideration. I look forward to hearing from you on the status of our request. Please feel free to contact Arvetta L. Jideonwo (Manager of Grants and Research) directly if you have any questions regarding this proposal.

Sincerely,

Sue Anne Gilroy
Vice President of Development and Executive Director St. Vincent Foundation 8402 Harcourt Road, Suite 210 Indianapolis, IN 46260 (317) 338-7012 Phone, (317) 338-2171 Fax sagilroy@stvincent.org
APPENDIX B

May 5, 2009

Ms. Arvetta L. Jideonwo
Manager of Grants and Research
St. Vincent Foundation
8402 Harcourt Road, Suite 210
Indianapolis, IN 46260

Dear Ms. Jideonwo:

We are in receipt of Sue Anne Gilroy’s preliminary proposal letter for The St. Vincent Foundation in which she has designated you as the contact person. The Allen Whitehill Clowes Charitable Foundation is interested in considering a full proposal from your organization, and an application for our next capital grants’ funding cycle is attached. Your proposal and required attachments must be received in our office by 5:00 PM, June 30, 2009.

Sincerely,

William H. Marshall
President

Attachment
APPENDIX C

ALLEN WHITEHILL CLOWES CHARITABLE FOUNDATION, INC.

October 22, 2009

Ms. Nancy Frick  
Director of Foundation Advancement  
St. Vincent Hospital Foundation, Inc.  
5402 Harcourt Road, Suite 210  
Indianapolis, IN 46260

Dear Ms. Frick:

On behalf of the Board of Directors of the Allen Whitehill Clowes Charitable Foundation, Inc., I am pleased to inform you that your organization has been awarded a grant in the amount of $75,000. These funds will be paid by December 31, 2009, and are to be used for your new Pediatric Art Therapy Program at the Peyton Manning Children’s Hospital. This grant is pending confirmation of your organization's status under IRC Section 501(a)(3).

We ask that you submit a short report by the end of this period of this grant that tells us what you have accomplished with these funds. Such a report is a prerequisite for consideration of future proposals.

Each request is considered on an individual basis, and this grant is not to be construed as establishing a precedent for further support.

Sincerely,

[Signature]

William H. Marshall  
President
September 18, 2009

Marianne Glick
C/O Sharon Kibbe
The Glick Fund
P.O. Box 40177
Indianapolis, IN 46240-0177

Dear Marianne,

Thank you again for visiting us last fall and taking a tour of Peyton Manning
Children’s Hospital at St. Vincent. During your visit, we discussed the potential
expansion of our art therapy services to pediatric patients, and I was so pleased to
note your interest. It remains one of our greatest hopes to develop this program, so I
was very thankful to have received your invitation to submit the enclosed proposal
for the consideration of The Glick Fund.

The mission of the Pediatric Art Therapy program is to help children, adolescents, and
their family members cope with illness, injury, treatment, and the overall healthcare
experience, by providing an opportunity for creative expression through art. The
requested $50,000 will be used to hire a full time master’s level art therapist, and to
purchase educational materials, art therapy supplies, and equipment for the program.

The St. Vincent Foundation plays an important role in bringing together the interests of
donors and the needs of our pediatric patients and their families. The results are creative
and life-impacting programs like the Pediatric Art Therapy Program, which we know will
benefit thousands of pediatric patients who are served at Peyton Manning Children’s
Hospital at St. Vincent.

Thank you again for this opportunity! We look forward to notification on the grant
award. Please don’t hesitate to contact me if you have any questions or need additional
information.

Sincerely,

Sue Anne Gilroy
Vice President of Development and Executive Director
St. Vincent Foundation
8402 Harcourt Road, Suite 210
APPENDIX E

Peyton Manning Children’s Hospital at St.Vincent
Pediatric Art Therapy Program

A. EXECUTIVE SUMMARY

The St.Vincent Foundation is pleased to submit this proposal in the amount of $50,000 to The Glick Fund in support of the Peyton Manning Children’s Hospital Pediatric Art Therapy Program. Funds to support the initiative will be used to establish the program, which will provide art therapy as a component of expressive therapy services to patients and their families, with a special focus on children with complex and/or life-limiting conditions.

The St.Vincent Foundation was established in 1968 to make a positive difference in the lives and health of individuals in the community, as well as to generate financial resources to benefit the mission of St.Vincent Hospital. The health services and programs supported by the Foundation are spiritually-centered, accessible, and affordable. Central to the Foundation’s mission are patient-focused services and programs, such as those that are provided by the Pediatric Art Therapy Program.

From its inception, St.Vincent Hospital’s mission has been to provide spiritually-centered, holistic care, which sustains and improves the health of individuals and communities, promoting and advocating for a healthier society in strong partnership with associates, physicians, patients, families, and our community. To achieve these goals, St.Vincent is focused on defining and delivering excellence through prudent management of resources and through caring and compassionate service. St.Vincent ministers to the minds, bodies and spirits of those in need, with special attention to the poor and vulnerable.

B. NEED

The establishment of the Pediatric Art Therapy Program will address the need for additional supportive services and expressive therapies for patients at Peyton Manning Children’s Hospital at St.Vincent. On an annual basis, the Hospital provides holistic and compassionate care to nearly 5,000 inpatients and 10,000 outpatients. Many of these patients suffer from life-threatening illnesses and serious injuries that

"An Art Therapy program, with a professional therapist trained in helping children with a life-threatening condition, is crucial to a comprehensive tertiary care Children's Hospital, such as Peyton Manning Children's Hospital. Expressive therapy, with the myriad of creative outlets inherent in a variety of art media, becomes an amazing way to determine what a child's concerns are, and allows us to help a child or adolescent in new ways."

- Dr. Joanne Hilden, VP of Medical Affairs
Peyton Manning Children’s Hospital at St.Vincent
result in a long-term stay, or frequent short stays in the Hospital.

With over 3 million pediatric hospitalizations occurring annually in the United States, much research has been conducted to study how those children are affected by long-term visits to the hospital and clinic. Research conducted in the 1960s indicated that a childhood hospitalization can result in significant psychological distress and depression over a period of time. These negative implications can result in ongoing mental disorders.

Dr. Cathy Malchiodi, a nationally renowned art therapy expert, indicates that, “Three primary sources of stress have been identified in pediatric patients: (1) separation from parents or caretakers through hospitalization, (2) loss of independence and control which accompanies illness and hospitalization, and (3) fears and anxieties about medical procedures which may cause harm or pain, and worry about death.”

While advances and progress in the care of these children have been made since the 1960s, current research continues to indicate that a child’s emotional well being may be negatively impacted due to chronic complex conditions. The ongoing documentation that supports a lack of efficacy regarding the advanced care of hospitalized children recommends the need to investigate and implement additional interventions, such as art therapy.

The American Art Therapy Association defines art therapy as, “A mental health profession that uses the creative process of art therapy to improve and enhance the physical, mental, and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight.” An art therapist is a master’s level clinician who is educated in visual art, the creative process, human development, behavior, personality, and mental health.

Providing art therapy to children chronic illnesses has the potential to alleviate feelings of helplessness and lack of control often associated with physical debilitation and hospitalization. Participation in art therapy provides patients with an opportunity to become actively engaged in their medical treatment. The therapy sessions allow children to play an integral role in communicating their experience to the treatment team and provide them with the opportunity to regain their sense of power and control related to their hospitalization. At Peyton Manning Children’s Hospital, the Pediatric Art Therapy
Program will address the three primary sources of stress as identified by Dr. Cathy Malchiodi. This will be accomplished by conducting group therapy sessions with the children, which will work to alleviate parental separation anxiety; providing individual sessions for the children to regain their sense of control over their illness; and involving the patients’ healthcare team in order to decrease anxiety over medical procedures and treatment services.

As research continues to identify significant implications stemming from these hospitalizations, it is imperative that hospitals serving these children find and utilize new approaches to help minimize these concerns. We believe that the addition of art therapy services at Peyton Manning Children’s Hospital will be of great benefit to the well being of the children and families that we serve.

C. PROGRAM OVERVIEW

The mission of the Pediatric Art Therapy Program at Peyton Manning Children’s Hospital at St. Vincent is to help children, adolescents, and family members cope with illnesses and injuries and the overall healthcare experience by providing an opportunity for creative expression through art.

Art therapy will be available to all inpatients at Peyton Manning Children’s Hospital on a referral and scheduled basis. The Pediatric Art Therapy Program will hire a certified Art Therapist to be the Program Director. The Program Director will plan and facilitate all of the art therapy sessions and work in conjunction with the Child Life specialists and healthcare provider teams at Peyton Manning Children’s Hospital.

Art therapy services will include individual art therapy, bedside sessions, group art therapy, and family/sibling art therapy. During an individual art therapy session, for example, the patient will be provided with the opportunity to express herself by describing the impact that creating art has had on her well being. The artwork will provide a non-verbal mode of communication between the patient and therapist.

The program will also serve as a catalyst for a dialogue for the patient in expressing his/her thoughts, feelings, and experiences in the hospital environment. Children who are unable to comprehend the reason for their hospitalization frequently create fantasies to explain the current situation. The Pediatric Art Therapy program will establish interventions that encourage children to share these fantasies in a safe, non-threatening, and supportive manner.

Interventions are critical to understanding the child’s fantasies and misconceptions regarding his/her experiences, so that efforts can be made to inform and educate the child in an age appropriate manner. Children who do not have the ability to verbally express
their feelings regarding hospitalization due to age, health status, stress, or cognitive function may find an outlet through individual or group art therapy sessions.

Group art therapy sessions will be held in closed playrooms (to protect patient confidentiality) and will provide patients with the opportunity to participate in art tasks designed to improve their self-esteem, promote social interactions, and provide a group outlet for emotional expression. At the conclusion of each session, the patient will be able to make a choice about what to do with his/her artwork.

Depending on the content of their work, many children request to display their artwork in their rooms. In 2003, Tracy Council, nationally renowned art therapist, found that, “Displaying children’s art in the treatment space can promote feelings of pride, acceptance, and safety, encouraging children to forge alliances with the medical team because they feel they are known and appreciated as whole human beings.” Peyton Manning Children’s Hospital will encourage patients to display their artwork throughout the hospital and at events, as appropriate.

**D. BENEFITS AND EVALUATION**

It is expected that through the development of a Pediatric Art Therapy Program at Peyton Manning Children’s Hospital at St.Vincent, patients will be provided with the opportunity for age appropriate, self-expression through creative arts. It is anticipated that this program will also interface with the Pediatric Palliative Care Program, which serves as an additional benefit to the program. The program will evaluate its success by tracking the number of patients participating in the program and by measuring patients’ knowledge and attitudes about their hospitalization experiences as expressed through their artwork and journaling. The program will encourage positive self-esteem and will promote a sense of independence and feelings of control among participants. The
program will also have group sessions to provide peer interaction and a sense of community within the hospital environment.

Program benefits will be measured through a detailed program evaluation, which will consist of a patient and/or caretaker questionnaire, healthcare provider survey, and comprehensive documentation of each child’s progress during art therapy. The patient/caretaker questionnaire will be designed to collect information related to patient satisfaction and perceived benefit(s) of art therapy during hospitalization. The surveys to be completed by the treatment team (including physicians, nurses, and child life staff) will ask them to provide information related to their perception of the art therapy program.

The evaluation records will be maintained throughout the grant award year in order to document the number of children and/or family members who receive art therapy services. These records will also track the number of sessions that each patient has received and the number of children and/or family members who attended art therapy groups. The information will be synthesized and presented to the The Glick Fund in a report format at the conclusion of the grant award year. With patient and/or family member consent, reproductions of artwork will also be included to illustrate specific case examples.

E. FUNDING REQUEST

Because of the Eugene and Marilyn Glick Family Foundation’s demonstrated interest in supporting the arts and humanities in Central Indiana, we ask that the Glick Fund at the Central Indiana Community Foundation consider this request in the amount of $50,000 in capital funds to establish a pediatric art therapy program to improve the lives of children suffering from life-threatening conditions and diseases at Peyton Manning Children’s Hospital at St.Vincent.

The requested funds will be used to support the program operations to hire a Program Director (Art Therapist), purchase educational materials and equipment, and provide support for the Program Director who will attend an annual art therapy conference. The total cost of the program is estimated at $110,000. Of this amount, Peyton Manning Children’s Hospital at St.Vincent will be providing $35,000 (32% of the project budget) in operational support and the remainder will be raised through philanthropic support. The requested budget includes the following:
The St. Vincent Foundation will work to financially sustain the program by seeking additional funds from local foundations, corporations, and individuals in the community to support this vital initiative. To that end, the Foundation recently applied for a grant to the Allen Whitehill Clowes Foundation to support the initial operations of the program, which will be reviewed in October 2009.

### F. CONCLUSION

As researchers continue to find significant implications stemming from childhood hospitalizations, it is imperative that hospitals find new approaches to improve the patient’s experience. The addition of Pediatric Art Therapy services at Peyton Manning Children’s Hospital at St. Vincent will be of great benefit to children and families served at the hospital. It is a high priority of Hospital staff to find ways to ensure that each individual child’s needs are met. We believe that the development of this program will meet those needs in a unique and highly personalized way, enabling the Hospital to help and heal these small, and particularly vulnerable patients.
November 19, 2009

Ms. Arveta L. Jidevwu, Manager of Grants & Research
St. Vincent Foundation
8402 Harcourt Rd.
#210
Indianapolis, IN 46260

Grant Number: 0000003489

Dear Arvetta:

Central Indiana Community Foundation (CICF) is pleased to support the St. Vincent Foundation with a grant from The Glick Fund, a fund of Central Indiana Community Foundation in the amount of $25,000.00. This grant is a matching grant for the Children’s Art Therapy Program. Your grant begins upon receipt of this letter and expires 10/31/2010. The grant is a 1:1 matching grant for contributions made specifically for the Children’s Art Therapy Program. For a contribution to count towards the match requirement, the contribution must have been received on or after 1/1/2009 and must be a contribution that has been paid in full.

CICF will process payments for this grant on a quarterly basis with the first payment report being due 12/31/2009. Quarterly matching reports should include detail of contributions towards the Children’s Art Therapy Program received for that quarter. Detail should include the date of contribution, contributor’s name and contribution amount. Please submit all matching reports to the following individuals:

Sharon Kibbe
The Glick Fund
P.O. Box 40177
Indianapolis, IN 46240

Ryan Brady
Central Indiana Community Foundation
615 N. Alabama Street, Suite 119
Indianapolis, IN 46204

In addition to matching grant reports, semi-annual grant progress reports related to the overall status of the grant are due to CICF on 6/30/2010 and 10/31/2010. The grant progress report form will be emailed to you after you receive this letter.

The grant funds referenced are to be used solely for the purposes described above and your organization’s accounting and financial records should note this restriction. Any unused funds must be returned to the foundation immediately unless an amended purpose for the grant is authorized by the foundation in writing. To comply with regulations regarding foundations, this grant must be used only for charitable and educational activities consistent with your organization’s tax exempt status under the Internal Revenue Code and we request you notify us immediately of any changes in or IRS proposed or actual revocation of the organization’s tax exempt status. Acceptance or negotiation of the funds will constitute agreement to the conditions of the grant as outlined in this letter.