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Art Therapy Based Curriculums with Patients who Have or Had Cancer

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Art Therapy Based Curriculums with Patients who have or had Cancer

by

Gabriela Espinoza

A research paper presented to the

Faculty of the Department of
Marital and Family Therapy
Loyola Marymount University

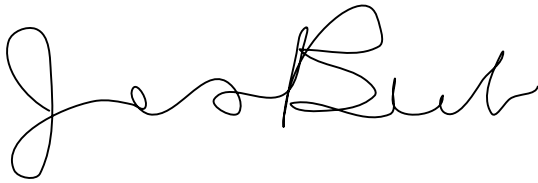
In partial fulfillment of the
Requirements for the Degree
Master of Arts

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Signature Page



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Abstract

Patients who have/had cancer are often left with emotional distress, as well as, anxiety, and depression amongst other effects. Art therapy based curriculums have been utilized with patients that have/had cancer with promising results of decreasing emotional distress and other effects.

Five different art therapy based curriculums are explored through archival research approach. Through this approach, information is collected to explore five research questions that are presented to understand how these art therapy-based curriculums can help patients who have/had cancer. These research questions explore the type of interventions being utilized in the curriculum when the curriculum is being implemented in the patient's treatment, what the demographics are for the curriculums that are being used, the structure of the workshops where these curriculums are taking place and what the impact was of the curriculums.

The significant finding was that interventions such as mindfulness, relaxation activities and reflection on self decreased emotional distress. A more extensive selection of curriculums would have been beneficial in finding more themes and provide evidence that art therapy based curriculums can help the patient that has/had cancer.

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Introduction

The Topic of Study

Art therapy can be a complementary therapy, which means it can help “control a patient’s symptoms and improve overall well-being by working in conjunction with other treatments”(Nainis, 2008, p. 115). The purpose of this study was to explore the impact and overall effectiveness of art therapy based curriculums used with patients who have/had cancer within a medical setting. For this research, an art therapy curriculum can be defined as being a protocol with fixed procedural steps that can be repeated. An archival approach was utilized in order to explore emergent themes amongst several art therapy curriculums gathered from current literature. Specifically, this research will focus on understanding how art therapy protocols were being utilized in different contexts with populations who have cancer. This study will be guided by the following questions for research:

- 1. What types of art therapy based curricular programs were being implemented with people who had or who have received cancer treatment?*
- 2. At what point were the art therapy based curriculums being utilized with people who have cancer treatment?*
- 3. What demographic patterns were there in curriculums that were utilized with patients who have/had cancer treatment.*
- 4. How were art therapy curriculums being implemented with patients who have/had cancer treatment?*
- 5. What is the impact of art therapy curriculums on the treatment of patients who have/had cancer and how is impact being measured?*

Significance of the Study

Art therapy can be based on a wide selection of creative modules that support patients with cancer in coping with their illness (Geue et al., 2010). By using the art, patients were able to express emotions that were difficult to verbalize with regular talk therapy (Nainis, 2008). Through art therapy interventions specifically designed to address the psychological symptomatology of cancer patients, patients were able to feel safe to explore their own imagery and thus their emotions (Gabriel, Bromberg, Vandenvoenkamp, Walka, Kornblith, & Luzzatto, 2001). Because having cancer can be a traumatic experience, followed by “negative feelings, such as depression, anger, and frustration, as well as a weakening of positive feelings, such as self-esteem and hope” (Gabriel et al, 2001, p. 114) utilizing art as a means for non-verbal expression “shows promise as an avenue for psychosocial support” (Collie, Bottorff, and Long, 2006, p. 762). Therefore, the significance of this study was finding a history of efficient curriculums or protocols to work with this in need population.

Background

This study discussed many aspects that go into an art therapy based curriculums specialized for patients that have/had cancer. Each curriculum had a set of clinical objectives that were determined to provide a positive effectiveness on the patients. Some clinical objectives that are mentioned are increasing the well-being of the patient, decreasing anxiety and increasing coping resources.

Content and materials were also observed because they go hand in hand with the interventions that were used for the curriculum. For instance, Monti, Peterson, Shakin Kunkel, Hauck, Pequignot, Rhodes, and Brainard (2005) set up their curriculum to have a mindfulness skills development content (body scan meditation) and to correlate with that they have a mindfulness art activity (self-portrait).

Lastly, the effectiveness of these curriculums were examined. The effectiveness of the curriculums was essential in determining which protocols would be best used for patients with cancer. All these key ideas were explored over time using archival research to find the evolution of protocols and to find the most efficient curriculums.

Literature Review

Introduction

This literature review will examine writings that explore curriculum-based art therapy programs that were being used with patients with cancer in a medical setting. The purpose of this review was to provide information that will further inquire as to the efficacy of art therapy as an effective modality with a sensitive and in need population.

The review will first begin with a brief definition/description of what an art therapy based curriculum and/or protocol might entail and then will quickly move into reviewing and describing the art therapy curriculums that were found in the literature. Following this section, I will discuss the clinical objectives of the curriculum surveyed in the literature, the interventions the curriculum utilized, and how effective the literature reports these interventions were at succeeding the clinical objectives. Within the interventions, content, materials, and time period were being informed. Finally, a summary is provided with recommendations for future research.

Descriptions of Curriculum-Based Art Therapy Protocols

Throughout this literature review, I will use the term curriculum-based art therapy protocols. According to the Merriam-Webster dictionary, curriculum can be defined as a set of courses constituting an area of specialization and protocol can be defined as a detailed plan of a scientific or medical experiment, treatment or procedure (Merriam-Webster Dictionary, n.d.).

Retrieved from <https://www.merriam-webster.com/dictionary/curriculum>

For the purposes for this review, I am defining curriculum based art therapy protocol as art therapy interventions with fixed procedural steps to help patients with cancer move in a certain direction; succeeding in their identified clinical objectives.

The protocol is a detailed plan that helps cancer patients succeed in the identified clinical objective. Within the detailed plan is an outline of each session to help patients meet the clinical objective.

Art therapy interventions follow predetermined procedural steps were repeated, and/or ritualistic. An example of this was seen in Warson's (2012) curriculum, where she worked with three different American Indian tribes. Within those tribes, she worked with cancer survivors and their families. In this study, Warson engages these three tribes in a repeated ritual that was culturally sensitive to each tribe she worked with. The protocol or ritual is described below:

...clearing the air warm-up exercise, healing circle drawing, 'response' painting and an introduction to visual journaling, and the follow-up workshop: 'clearing the air' warm-up exercise, review of a visual journal, creating a cover for the visual journal, and a 'response' clay task. (Warson, 2012, p. 50)

Clinical Objectives

The overall main clinical objective with almost all of the curriculum based art therapy protocols outlined in this literature review were aimed at positively impacting the treatment of cancer patients (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster, Svensk, Magnusson, Thyme, Sjodin, Astrom, and Lindh., 2006; Warson, 2012; Radl, Vita, Gerber, Gracely, and Bradt, 2017).

Most curriculums (Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) wanted to test the feasibility of how art therapy could be integrated with other interventions to increase the well-being of cancer patients. They tested the feasibility with questionnaires or measurements that were implemented at different times.

There was another objective for the Creative Journal that was produced by Luzzatto and Gabriel (2000), in addition to increasing the general well being of treatment with cancer patients, this curriculum focused on helping those with cancer “ re-establish their self-identity and self-confidence” (Luzzatto & Gabriel, 2000, p. 265). Through the art directives that were given.

Another curriculum, called the Mindfulness-Based Art Therapy (MBAT) was developed in 2005 by Monti et al. The clinical objective for this protocol was focused on observing the effectiveness of MBAT for the patients’ psychosocial aspect such as verbal and nonverbal expressions, giving a better sense of support and gaining different coping strategies (p. 364). This protocol will be further discussed under the “content” section of this paper.

In 2006, Oster et al. observed a curriculum that had similar steps as Betensky’s phenomenological method of art therapy. Phenomenology concentrates on the process of the client’s artwork. It also focuses on “their art expressions as phenomena of consciousness” (Betensky, 1977, p. 173). Oster et al. (2006) found it was important to discuss the effects of the art therapy curriculum on coping resources for the patients (p. 57). This curriculum was also set up to help give patients time and space to reflect and express their experiences (p. 59). Oster et al. (2006) will be discussed more in detail in the “content” section of this paper.

In 2017, Radl et al. created the Self-Book to “help patients reframe their illness in a way that helps them make sense of the adversity in a safe manner” (p. 2088) in addition to evaluate the efficiency of the curriculum (p. 2087).

Throughout the investigation of this research, few were found exploring cancer patients in correlation with their culture. Warson (2012), studied American Indian cancer survivors to discover culturally appropriate art interventions on stress reduction for the survivors and their family (p. 47)

Content

Some curriculums (Monti et al., 2005; Oster et al., 2006; Warson, 2012) utilized mindfulness or relaxation as an intervention that was implemented into their curriculum. In the MBAT curriculum, they believed that MBAT would provide “a foundation for understanding reactions to perceptions of physical and emotional well-being” (Monti et al., 2005, p. 364). People cope with stress in different ways and by utilizing MBAT’s protocols, the patients were able to understand their perceptions of physical and emotional aspects and will be able to cope with utilizing the MBAT interventions (p. 364). “MBAT is designed to provide specific skills for cultivating self-regulation in a format that is not confined to verbal processing alone” (Monti et al., 2005, p. 364). The protocol for MBAT will further be discussed later in this literature review.

All of the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) mention an established protocol for certain clinical objectives; the protocol provides step by step instructions to follow. The duration that most curriculums exhibited correlated with how many sessions they had with the participants. Luzzatto and Gabriel (2000) had a total of ten weeks because they had ten workshops. Oster et al. (2006) and Monti et al. (2005) used five weeks and eight weeks to cover their sessions. Radl et al. (2017) utilized six weeks, while Warson (2012) used three hours in one day with two different American Indian settlements. In these studies, there was an average of six sessions. The remainder of this section will describe interventions or themes used in curriculums.

In the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) the first sessions began with introducing the art to the participants through free association or through a directive. The curriculums that had a directive

all related to feelings in one way or another such as Oster et al. (2006), who asked participants to create images that were similar to various feelings (p. 59).

In the second sessions, there appeared to be very few similar themes. Luzzatto and Gabriel (2000), encouraged participants to be more playful and to give “the patients an opportunity to move deeper into unconscious material,” (Luzzatto and Gabriel, 2000, p. 267). Where else other curriculums (Monti et al., 2005; Oster et al., 2006) were interested in identifying different feelings within the body. Radl et al. (2017) wanted to discover how patients can connect with others.

The three of the curriculums (Luzzatto and Gabriel, 2000; Radl et al., 2017) focused on themes of empowerment and connection with themselves during third sessions, for example, “patients are encouraged to focus on their positive attributes” (Radl et al., 2017, p. 2091). While encouraging empowerment was said and done differently in the curriculums, there appeared to be a consistent idea that “self-discovery [can] occur,” (Betensky, 1977, p.175) and this can be done by bringing the unconscious to the conscious. Monti et al. (2005) had focused on the body during the third session by utilizing yoga (p. 366). Oster et al. (2006) did not specify what the directive was. Instead, they suggested that the patients were able to have an open choice to what they wanted to do (p. 59). In some ways, this can also be seen as giving the patients a sense of empowerment to allow them to decide what they wanted to do for this session.

Moving into the fourth session, the topic of “self” surfaced for some of the curriculums (Luzzatto and Gabriel, 2000; Monti et al., 2005; Radl et al., 2017). Oster et al. (2006) again allowed the patients to decide what they wanted to do this session and gave no specific directive.

In many curriculums (Luzzatto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) there appeared to be a theme of increasing self-awareness/self-discovery.

Monti et al. (2005) and Oster et al. (2006) wanted participants to reflect on their journey through these sessions so far. Monti et al. (2005) had the patients meditate to continue to expand their awareness and attempts of stimulating, “the patients’ ability to look inside themselves”, (Luzzatto and Gabriel, 2000, p. 267). This was the final workshop for Oster et al. (2006) where they asked patients to display all the images they’ve created so far and created a piece that signifies their journey so far in these workshops.

There was no cohesive theme for the sixth session; this was the final session for Radl et al. (2017). They wanted participants to create artwork that summarized their journey throughout the workshops (p. 2089). The sixth workshop for Luzzatto and Gabriel (2000) focused on “The important experience of being accepted” (p. 267) while Monti et al. (2005) focused on the functioning of stress (p. 366).

During Luzzatto and Gabriel’s (2000) seventh workshop, they began to help patients process any feelings on confusion they may have had and reach clarity (p. 267). On the other hand, Monti et al. (2005) wanted patients to practice mindfulness with an open studio session (p. 366).

The final workshop for Monti et al. (2005) asked participants to review all the sessions and create an artwork that reflected their process (p. 267). Luzzatto and Gabriel (2000) wanted “to help patients sustain a negative thought for some time” (p. 268) and in the process of this, explore reframing those negative thoughts into positive thoughts (p. 268).

The ninth and tenth workshops for Luzzatto and Gabriel (2000), concentrated on coping with stress and review the session to make artwork based on their experience (p. 268).

The workshops for Warson (2012) were done in one day and therefore there were no multiple sessions like the other curriculums. The protocol that I will be describing was utilized

with the second and third tribes and not implemented with the first tribe. Keeping in mind cultural considerations for the American Indian tribes, Warson (2012) first cleared the air with a white feather because it was deemed appropriate from the tribe's counsel that was assisting in the interventions (p. 49). This was followed by the participants forming in a circle to paint their depiction of stress or pain (p. 49). They then identified a part of the circle they connected with a created a response piece, which was then followed by an introduction to the visual journal (p. 50).

Art Directives

Not all curriculums (Luzzatto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) described the exact directive that was utilized in each session. However, there appeared to be a cohesive theme across the curriculums for the first session. All directives that were given in the early parts of the program appeared to be intimate and personal. In one curriculum, patients were asked to give meaning to their free associated work in order to give the participants "ego-strengthening" (Luzzatto and Gabriel, 2000, p. 267). Where else in another personal directive, Monti et al. (2005) asked participants to draw a picture of themselves (p. 366) and Radl et al. (2017), allowed space for individuals to create their safe place (p. 2089). Oster et al. (2006) gave the directive for patients to visualize different feelings that were read out loud in the session (p. 59).

Oster et al. (2006) had a similar directive for the second session as Warson (2012) in the sense where patients worked with their feelings of pain or stress. Warson (2012) had the group use a mandala to visualize their pain or stress and Oster et al. (2006) had patients outline their bodies to identify their emotional and physical feelings. Luzzatto and Gabriel (2000) gave a directive of guided imagery where participants were asked to close their eyes and draw blindly

on paper (p. 267) Once they opened their eyes, they searched for an image and completed the image that appeared (p. 267). Monti et al. (2005) practiced mindful exploration (p. 366). and Radl et al. (2017) asked participants to identify their supports using collage images (p. 2089).

Luzzatto and Gabriel (2000), Warson (2012), Radl et al. (2017) and Oster et al. (2006) had their participants exploring with the art media in different ways. Luzzatto and Gabriel had individuals lay down tempera paint on paper and fold it over. Once folded, they moved the paint underneath the paper around with their fingers and opened it up to see the image that was created with the purpose of giving “the patients an opportunity to move deeper into the unconscious material” (Luzzatto and Gabriel, 2000, p. 276). Warson (2012) had the tribe create response art to the mandala that was created before. Radl, Vita, Gerber, Gracely, & Bradt (2017) utilized collage to have individuals identify their strengths. While Oster et al. (2006) gave the participants an open choice to create what they wanted, yet directive was given if an individual was unsure what to make. Monti et al. (2005) utilized yoga and meditation during this portion to explore the body and mind relationship.

For the fourth portion of the workshops, three articles had a similar theme. Luzzatto and Gabriel (2000) used images to create meaning and Monti et al. (2005) utilized images to explore the patient’s self-care. Where else Radl et al. (2017) used images for patient’s to make a wish for those close to them. Warson (2012) had participants using the visual journal.

During the fifth session, there was no consistent theme across the articles. Luzzatto and Gabriel (2000) had individuals contemplate two objects and create an image that reflects their feelings about the two objects. Monti et al. (2005) wanted to help patient’s increase their mindfulness skills through collage work. Radl et al. (2017) had patients reflect on wishes for themselves and create an image with collage to express that.

Now reaching the end for some curriculums, the sixth sessions did not have a theme. Luzzatto and Gabriel (2000) had individuals create a visual poem through meaningful words. Monti et al. (2005) utilized stressful and pleasant event pictures on patients to further learn about stress. Radl et al. (2017) reached the end of the workshops and asked individuals to decorate their book.

In the seventh and eighth sessions, Luzzatto and Gabriel (2000) had patients envision chaos and create a mess with tempera and then had them find clarity within that mess. In the next session, they utilized guided imagery to help patients image a scene where there's a deserted area. In that deserted area, there was a hidden seed and the patients decided how that seed would grow. Monti et al. (2005) allowed patients to create what they wanted in an open studio and then in the last session had them draw themselves once again.

In the ninth and tenth session for Luzzatto and Gabriel (2000), they had them once again visualize the opposite of stress and finally have them create an image that best describes the journey they went on throughout the sessions.

Materials

A variety of materials were used across the curriculums reviewed. Yet, not all curriculums revealed the materials they used. Despite this, the materials that were discussed were carefully thought out to be related to mindfulness and relaxation for Monti et al. (2005), Oster et al. (2006), and Warson (2012).

“Often collage materials such as magazine pictures, decorative shapes...are perceived as non-threatening for patients who were reluctant to engage in artistic expression” (Nainis, 2011, p. 117). While many workshops implemented collage materials, Radl et al. (2017) appeared to be the only curriculums that utilized this media in all workshops. Some items that were taken

into consideration was how the art materials were going to “increase in the complexity and deepening of the process of self-discovery” (Luzzatto and Gabriel, 2000, p. 266). Warson (2012) took into the culture of the participants into consideration for art materials. This researcher had an advisory committee from the tribe to guide her in using the appropriate interventions and materials. While Oster et al. (2006) and Monti et al. (2005) both did not describe in detail the materials used, Oster et al. (2006) mentioned basic materials such as pencil and paper. Monti et al. (2005), however, utilized basic materials such as color pencils, markers, pastel, and watercolors as well as collage materials and yoga.

The materials often allow different emotional statements and underlying feelings begin to emerge for the patients; The fun that the patients endure while creating may lead to an outlet for deeper emotions to arise which then can be processed therapeutically with the patient or group members (Nainis, 2011, p. 117).

Effectiveness

The overall effectiveness of the art therapy curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) reviewed suggested that patients undergoing cancer treatment experienced an increase in well-being and decrease in stress or there was not enough evidence.

Luzzatto and Gabriel (2000) received feedback from their participants through a written questionnaire. The two questions that were on the questionnaire was what the patients found helpful and unhelpful. Through this questionnaire, they noticed that a theme of “change in moods and feelings...increase in self-awareness...[and] change in attitude towards others” (p. 268) was discovered. The findings of this article suggested that it is the “most appropriate for post-treatment cancer patients...[in integrating] their new identity” (p. 269).

Monti et al. (2005) had their patients assessed pre-intervention as well as post-intervention to yield results. They discovered that there were a “statistically significantly greater decreases in symptoms of distress” (Monti et al., 2005, p. 369). This study reported that their original clinical objective was met and can help cancer patients.

Oster et al. (2006) had participants fill out a questionnaire to determine if they met their clinical goal of increasing coping skills. “In our study, participation in individual art therapy made a difference, manifested in increased coping resources” (p. 62).

Warson (2012) conducted a pre-test and post-test. From the tests, Warson indicated that she did not meet the clinical objective that was set, statistically “based on the pretest and posttest...[because] it became apparent that the inventory was not transferable to southeastern American Indian tribes” (p. 53). Warson has gone on to say that despite this, a workshop that is relevant to this culture has been created in order to be implemented in a larger study.

Radl et al. (2017) also had their participants fill out a questionnaire. They did not find significant differences in emotional distress and well-being. Thus, this researcher’s clinical objective was not met and further study was needed.

Conclusions

There were 12 curriculums examined for this review with an outcome of five being relevant to the topic of this project: curriculum-based art therapy programs with patients undergoing cancer treatment. There appeared to be an average of six workshops for the curriculums and the duration correlating with the number of workshops each curriculum had.

The longest workshop was ten and the shortest was a three-hour workshop in one day. For each workshop, a few curriculums had similar themes. However, as the sessions progressed it was harder to find a cohesive theme.

There were a variety of materials used, however, not all curriculums were specific in what materials were utilized and overall, three out of five curriculums met their clinical objectives.

Recommendations

It would have been great to find more curriculums such as the self-book and the creative journey. I felt that these curriculums had a great overview of step by step interventions while the rest were not as specific. It was hard finding curriculums that gave many details about what was happening with the process. I felt that certain areas of this paper were vague because of some curriculums, such as, Oster et al. (2006), that briefly went over the protocol but did not specify how the patients reacted or felt, what exactly the patients created or anything in great detail pertaining to the curriculum. Once they briefly went over the curriculum they jumped into results and data analysis. In future research that utilizes a curriculum, showing or stating the process from these sessions can be helpful.

Another recommendation would be stating the materials used and why materials were considered. Utilizing more culturally relevant interventions with cancer patients would be great to see and compare with other curriculums. I enjoyed Warson's curriculum because it was based on Native American which gave diversity and took culture and traditions into consideration. It would be great to see how certain religions, spirituality, and cultures can utilize art therapy interventions with cancer patients.

Research Approach

The research approach that will guide this qualitative study is an archival research approach. “A key feature that distinguish[es] archival research from traditional research is the use of pre-existing data” (Heng, Wagner, Barnes, & Guarana, 2017, p. 16). This approach was determined because this methodology analyzes previously collected data with the intention to develop new meaning and insights (Esteban, Hernandez, & Kattan, 2008).

One of the advantages of using archival research is the ability to study data from a long period of time (Jones, 2010). By looking at peer-reviewed articles that document studies describing and/or evaluating art therapy curriculums, this inquiry will be focused on uncovering emergent themes that focus on changes over time in these curriculums, populations that were engaging with these curriculums, how these curriculums might vary based on geographic location, and overall effectiveness of these programs. The literature that I will be reviewing was over a time span of 17 years. By reviewing these curriculums over this time span and by examining them through an archival lens, I will aim to identify ways that curriculums could be expanded and further researched.

Methods

Definition of Terms

Art therapy: "Art therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" (American Art Therapy Association, 2012).

Cancer: "a malignant tumor of potentially unlimited growth that expands locally by invasion and systemically by metastasis" (Merriam-Webster).

Curriculum: "A set of courses constituting an area of specialization" (Merriam-Webster). In this research, a curriculum is defined as being a protocol with fixed procedural steps that can be repeated.

Intervention: "The act of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)" (Merriam-Webster).

Mindfulness: "The practice of maintaining a nonjudgmental state of heightened or complete awareness of one's thoughts, emotions, or experiences on a moment-to-moment basis" (Merriam-Webster).

Design of Study

This qualitative study will utilize an archival approach to collect information to explore the questions below. In doing this, the literature that has been collected will be compared and contrast to find emerging themes. The literatures being reviewed worked with patients that were currently in treatment for cancer and worked with patients that were no longer in treatment or was not specified.

1. *What types of art therapy based curricular programs were being implemented with people who had or who have received cancer treatment?*
2. *At what point were the art therapy based curriculums being utilized with people who have cancer treatment?*
3. *What demographic patterns were there in curriculums that were utilized with patients who have/had cancer treatment.*
4. *How were art therapy curriculums being implemented with patients who have/had cancer treatment?*
5. *What is the impact of art therapy curriculums on the treatment of patients who have/had cancer and how is impact being measured?*

Sampling

My research sample composed of five articles that were over a time span of 17 years. This wide range of years will help determine how curriculums and protocols have evolved over time. It will also help in answering the research questions that were mentioned.

The articles that were selected, Luzzatto and Gabriel (2000), Monti et al. (2005), Oster et al. (2006), Warson (2012), Radl, Vita, Gerber, Gracely, & Bradt (2017), were all peer-reviewed journals.

Luzzatto and Gabriel's (2000) intended audience was for all genders in outpatient between the ages of 18 years and older. This article was found in a journal called Art Therapy, which is the journal of the American Art Therapy Association.

Monti et al.'s (2005) audience was aimed at females between the ages of 18 years and older and was found in the Psycho-Oncology journal.

Oster et al. (2006) aimed their article towards females that were 18 years older or older and came from the European Journal of Cancer Care.

Warson (2012) aimed her study at females between the ages of newborn and older. Warson's article came from the Journal of Cancer Education.

Radl et al. (2017) also came from the Psycho-Oncology journal. No specific population besides cancer patients was this article aimed at.

Gathering of Data

Utilizing PsycINFO, I collected articles through this database. I selected certain key terms to help gather articles that were art therapy based curriculums. From there I determined which articles best described their protocols in a step by step procedure.

Analysis of Data

Data will be first analyzed by reading over curriculums several times, taking notes, and coding the data using color and numbers, keeping in mind my research questions. I will look for certain keywords or phrases that relate to my research questions, such as "the purpose", culture, type of cancer, duration, measurement, effectiveness, and results. In addition to answering research questions, I will be mindful to record and analyze other emergent themes.

Results

Presentation of Data

The objective of this research project is to explore art therapy curriculums that are being used with people who have/had cancer either during or after cancer treatment. The data is comprised of five different art therapy curriculums that were discovered during the literature review. In this section I will describe each of the five art therapy curriculums in more specific detail and will focus on content that is in relation to my four questions for research:

1. *What types of art therapy based curricular programs are being implemented with people who are or who have received cancer treatment?*
2. *At what point are art therapy based curriculums being utilized with people who have cancer treatment?*
3. *What demographic patterns are there in curriculums that are utilized with patients who have/had cancer treatment.*
4. *How are art therapy curriculums being implemented with patients who have/had cancer treatment?*
5. *What is the impact of art therapy curriculums on the treatment of patients who have/had cancer and how is impact being measured?*

The Creative Journey

The Creative Journey: A Model for Short-Term Group Art Therapy with Posttreatment Cancer Patients by Luzzatto and Gabriel (2000), created this curriculum for cancer patients in hopes to help them re-establish their self-identity and self-confidence; they had increasing self-awareness and trusting the environment to help them build on their self-identity (Luzzatto and Gabriel, 2000, p. 265). This curriculum was deemed “appropriate for posttreatment cancer

patients who wish to integrate their traumatic experience into their new identity” (Luzzatto and Gabriel, 2000, p. 269).

Creating this curriculum, they kept in mind that short-term groups are more beneficial for cancer patients than long-term. Luzzatto and Gabriel (2000) utilized these art therapy curriculums with those that have cancer and are outpatients with a completed course of treatment. Patients are able to use the techniques learned at home or when readmitted to the hospital (Luzzatto and Gabriel, 2000, p. 269).

When creating this curriculum they took into consideration the demographics that this could be used with: patients that feel uncreative and patients that are any age with any type of cancer (Luzzatto and Gabriel, 2000, p. 266).

Before patients were accepted into the art therapy group, they met for a short meeting to discuss the curriculum and if it fits the needs of the patient. The Creative Journey was a 10-week workshop that holds meetings for about 1.5 hours. Because the workshop was for 10-weeks, there are 10 different curriculums that go along with it.

Each workshop has a similar structure in that an art therapist will lead a guided visualization (Luzzatto and Gabriel, 2000, p. 266). This is followed by the directive being presented and the patients work on the directive for about 30-45 minutes (Luzzatto and Gabriel, 2000, p. 266). Patients are then encouraged to place their images on the wall for everyone to see and a discussion is started; patients can receive feedback from the group (Luzzatto and Gabriel, 2000, p. 266). If a patient feels negative about an image, regardless if they created it or not, they are encouraged to contact the therapist (Luzzatto and Gabriel, 2000, p. 266). About 1-2 weeks after the workshops have finished, patients are seen for a follow-up session (Luzzatto and Gabriel, 2000, p. 266).

The first workshop focused on creating a safe environment for the patients and allow them to create without feeling threatened about being creative (Luzzatto and Gabriel, 2000, p. 267). Materials used for this session were origami paper, scissors, and glue.

The second session concentrated on moving deeper into the unconscious by relaxing and being playful with the artwork (Luzzatto and Gabriel, 2000, p. 267). Materials used were black pencils and colored markers or oil pastels.

The third session challenged and empowered the patients by allowing them to accept and reflect on their lack of control with the materials, tempera and water (Luzzatto and Gabriel, 2000, p. 267).

The fourth workshop provided opportunities to create a more cohesive group (Luzzatto and Gabriel, 2000, p. 267). The materials for this session were images from magazines.

During the fifth session, patients were encouraged to explore their inner self (Luzzatto and Gabriel, 2000, p. 267). Materials for this session were objects for a still life.

A visual poem was created for the sixth session and this helped patients experience feeling accept even if they're not understood (Luzzatto and Gabriel, 2000, p. 267).

In the seventh workshop, patients "accept and use feelings of confusion to reach inner clarity" (Luzzatto and Gabriel, 2000, p. 276). Patients were given options to use pastels or tempera.

For the eighth workshop, patients were challenged to sustain a negative thought; the purpose of this objective was for them to realize negative thoughts were apart of the process for positive thoughts (Luzzatto and Gabriel, 2000, p. 268). No materials were specified for this session, however, guided imagery was provided.

The following ninth workshop focused on coping with stress and to “reinforce in their mind the awareness that the opposite feeling does exist and that they are capable of both [stress and its opposite feeling]”, (Luzzatto and Gabriel, 2000, p. 268). All materials that patients had used throughout the previous workshops were available to them.

In the final workshop, patients reviewed their work and create an art piece based on their experience (Luzzatto and Gabriel, 2000, p. 268).

Once all the workshops are over, patients are asked to fill out a questionnaire that is asking two questions: what they found helpful and unhelpful (Luzzatto and Gabriel, 2000, p. 268). There was a theme that Luzzatto and Gabriel found when looking over the questionnaires; patients felt a change in their moods and feelings, they had an increase in self-awareness and had changed in attitude towards other people (Luzzatto and Gabriel, 2000, p. 268).

The results of this curriculum have found that it may “be most appropriate for posttreatment cancer patients who wish to integrate their traumatic experience into their identity” (Luzzatto and Gabriel, 2000, p. 269).

Mindfulness-Based Art Therapy

Monti et al. (2005) created a curriculum, A Randomized, Controlled Trial of Mindfulness-Based Art Therapy (MBAT) For Women With Cancer. Their curriculum had several objectives: evaluate the effectiveness of MBAT, allow patients to express themselves verbally or non-verbally, help with coping strategies and decrease distress (Monti et al., 2005, p. 364).

Two groups were utilized for this study: one group was the control-waitlisted group that did not receive MBAT. This literature did not specify what the interventions were for this group, however, they were offered to join a MBAT group once the study was over. The other group was

the MBAT group. The patients in this study all had a cancer diagnosis and they were between 4 months to 2 years of being diagnosed (Monti et al., 2005, p. 365). However, any patients that were terminal or had a psychiatric disorder were excluded (Monti et al., 2005, p. 365).

About more than half of the patients were receiving the following treatments: chemotherapy, radiation, treatment for side effects or other outpatients procedures (Monti et al., 2005, p. 368). This curriculum worked with females only and in the Philadelphia region (Monti et al., 2005, p. 365). The types of cancers the patients' had varied between breast, gynecologic, rectal, hematologic, neurologic and other cancers (Monti et al., 2005, p. 368). Although the curriculum did not specify which gender this would best work with, women made up both MBAT group and the controlled group (Monti et al., 2005, p. 368). The average age of the patients was 53 years old (Monti et al., 2005, p. 368). A majority of the patients were Caucasian, the next being African-American and the lowest being Hispanic and other (Monti et al., 2005, p. 368).

This curriculum consisted of 8 workshops that were 2.5 hours with a general format for each session (Monti et al., 2005, p. 367). Patients received mindfulness meditation, home assignments which asked patients to practice mindfulness meditation for 30 minutes, 6 days out of the week, and nonverbal activities that allowed opportunities to verbalize their work with the group (Monti et al., 2005, p. 367).

The first workshop focused on becoming mindful with one's body when reacting to stressors (Monti et al., 2005, p. 366). Materials used for this session were not specified.

In the second session, the patients worked on their breathing and practicing sensory awareness (Monti et al., 2005, p. 366). Markers, color pencils, pastels, paint, and watercolor crayons were utilized.

During the third session, the patients discovered and explored the mind and body relationship through yoga (Monti et al., 2005, p. 366).

Receptive attention and transforming mental, emotional and physical pain was the focus for the fourth session (Monti et al., 2005, p. 366). Images were provided for this session, however, no further materials were mentioned.

In the fifth workshop, the patients are further expanding their awareness and mindfulness of feelings and thoughts (Monti et al., 2005, p. 366). Collage materials were available to patients for this workshop.

For the sixth session, the topic of the physiology of stress, as well as stressful communication and nonreactive communication, was brought up (Monti et al., 2005, p. 366). Again, images were provided as material.

During the seventh workshop, patients practiced meditating and an open studio was available to them (Monti et al., 2005, p. 366).

In the final workshop, patients were allowed discussion of the workshops (Monti et al., 2005, p. 366). The material was not specified for the final workshop.

Measurements used were Symptom Checklist -90-Revised (SCL-90-R) and Medical Outcomes Study Short-Form Health Survey (SF-36) (Monti et al., 2005, p. 365). SCL-90-R measured psychological distress such as anxiety, depression, etc. (Monti et al., 2005, p. 369). SF-36 measured health-related quality of life factors such as physical functioning, bodily pain and general health (Monti et al., 2005, p. 370). These measurements were implemented pre-intervention (0 week), 8th week and 16th week (post-intervention, follow up) (Monti et al., 2005, p. 365). For both SCL-90-R and SF-36, results for the MBAT group showed that between 0 week and 8th week “higher levels of reported distress and reduced health-related quality of life

for persons with cancer” compared to the controlled wait-list group (Monti et al., 2005, p. 368). For the MBAT group, there was little change between 8th week to 16th week for both measurements (Monti et al., 2005, p. 369). Because there was little change between 8th week to 16th week, it is suggested that “maintenance of improvements in general health, mental health, vitality and social functioning” are needed (Monti et al., 2005, p. 369).

Overall for SCL-90-R, “subjects who received the eighth-week MBAT intervention demonstrated statistically significantly greater decreases in symptoms of distress as compared to subjects in the wait-listed control [group]” (Monti et al., 2005, p. 369) and for the SF-36, MBAT group “demonstrated statistically significant improvement on some, but not all, of the SF-36 scores and subscales” (Monti et al., 2005, p. 370).

The final conclusions of this curriculum were that it provides “preliminary support for the hypotheses that the MBAT intervention can help cancer patients decrease distress levels and improve quality of life” (Monti et al., 2005, p. 370).

Art Therapy With Women With Breast Cancer

In 2006, Oster et al. created a study: Art Therapy Improves Coping Resources: A Randomized, Controlled Study Among Women With Breast Cancer. The purpose of this curriculum “was to describe the effects of a clinically applicable art therapy intervention program in coping resources in women undergoing radiotherapy for breast cancer,” (Oster et al., 2006, p. 58). In addition to that purpose, they wanted to be able to utilize the art therapy process to give the patients the time and the space to reflect, express their experiences, thoughts, and feelings via verbally or nonverbally (Oster et al., 2006, p. 59).

There were two groups that the patients were randomized in, a control group or the art therapy group (Oster et al., 2006, p. 59).

This curriculum was utilized with patients that were currently undergoing radiotherapy and had nonmetastatic breast cancer (Oster et al., 2006, p. 58). The radiotherapy would be in correlation with the curriculum. This curriculum was aimed towards Swedish women without dementia or severe psychiatric illness and with breast cancer (Oster et al., 2006, p. 59). The age of participants ranged from 37 years old to 69 years old (Oster et al., 2006, p. 58). The idea of “breasts symbolize cultural values such as sexuality, motherhood, and caring, that were closely connected to femininity,” (Oster et al., 2006, p. 58) was brought to the attention of the researchers. They concluded that this cultural value could possibly affect women’s identities (Oster et al., 2006, p. 58).

Throughout the workshops, patients completed questionnaires, three interviews and they also kept a weekly diary about their experience (Oster et al., 2006, p. 59).

In all workshops, the same materials were offered: paper, a roll of paper, oil pastels, watercolor, pencils, charcoal, tape, scissors and paint brushes (Oster et al., 2006, p. 59). The first workshop focused on making connections to words, the therapist provided, in relation to the patients' feelings. The second workshop focused on the different feelings in the patients' bodies (Oster et al., 2006, p. 59). Third and fourth sessions had the patients choose which interventions she learned and apply where necessary (Oster et al., 2006, p. 59). The fifth and sixth workshops involved a summary of the patients' experience in the workshops.

Measurements used were the Coping Resources Inventory (CRI) that were administered before and two times after radiotherapy was completed (Oster et al., 2006, p. 59). CRI consists of five areas: cognitive, social, emotional, physical and spiritual (Oster et al., 2006, p. 59).

The results indicate that women who participated in art therapy had significantly improved their coping resources in the social domain by the second and third occasions;

also, they had improved their total scores on the second occasion (Oster et al., 2006, p. 60).

The art therapy group had higher scores in all 5 areas and coping resources compared to the controlled group (Oster et al., 2006, p. 60).

Art Therapy For American Indian Cancer Survivors

The article, *Healing Pathways: Art Therapy For American Indian Cancer Survivors* (2012) talks about a curriculum created by Warson. The purpose of this curriculum “was to explore the effects of culturally relevant art interventions on stress reduction for American Indian cancer survivors and their family members” (Warson, 2012, p. 47). This curriculum is to be implemented with survivors and their family members; it did not specify if it could be implemented with patients currently undergoing treatment. This literature has a large number of cultural considerations that has affected the way the curriculum was finalized. According to Warson (2012), this native community believed the following:

a person is understood in relation to his or her family, tribal community, history, culture, environment, work, and so on... quality of life factors by achieving balance and harmony through the reciprocal relationship between mind, body, spirit, and context (Warson, 2012, p. 47).

Because of the cultural beliefs and ideas must be taken into consideration, Warson collaborated with the tribes to make sure the curriculum was culturally appropriate. In addition to being culturally sensitive, this curriculum did not have specific criteria to gender, current medical treatment, duration of time as a survivor, or who was allowed to join the workshops; family members of cancer survivors were encouraged to join (Warson, 2012, p. 48).

Since Warson (2012) was working with 3 different tribes in different locations, the workshops were only a one time workshop for each tribe that was 3 hours long. In order to implement this curriculum, Warson turned to the advisory committee that consisted of members of the different tribes who were also cancer survivors or family members of survivors (Warson, 2012, p. 48-49). The committee would help determine if an activity or art material was culturally appropriate for their tribe (Warson, 2012, p.49). Materials that were deemed appropriate watercolor and drawing materials (Warson, 2012, p. 49). Collage was considered appropriate for the participants to use for their journals (Warson, 2012, p. 50).

Before the workshop began, an altar was created and a candle was lit to honor those that have passed away from cancer, followed by a prayer (Warson, 2012, p. 49). The first workshop consisted of “28 elder women who had overlapping health conditions (diabetes or stress-related problems due to stress)” (Warson, 2012, p. 49).

The group first took turns clearing the air with a feather; this was deemed appropriate for the tribes as a white feather “signifies ‘purity’ and was an acceptable choice for this purpose” (Warson, 2012, p. 54). Clearing the air was how participants were centered in body, mind, spirit, and context before the workshops began (Warson, 2012, p. 54).

This was followed by creating a gestural drawing on 18x24 grey paper. They then visualized stress or pain and created a response piece (Warson, 2012, p. 49). By visualizing pain or stress they focused “on the relationship between psychological processes and the immune system” (Warson, 2012, p. 54).

After this, the women were guided through breathing exercises to reflect on their pain or stress (Warson, 2012, p. 49).

The women were then given model magic to experiment on their own and were then given a visual journal as a means to reduce stress (Warson, 2012, p. 49-50).

The advisory committee gave modifications for the next workshop such as fewer art media choices and no gestural drawing “because it was not perceived as being purposeful enough” (Warson, 2012, p. 50).

The second workshop included ten women and men and the third workshop included eight women cancer survivors and family members (Warson, 2012, p. 50).

The format for the second and third workshop went as followed: clearing the air, response piece, introduction to visual journaling and a follow-up workshop (Warson, 2012, p. 50). A follow-up workshop was not included for the first workshop, this was implemented for the second and third workshops. Follow up workshop included clearing the air, review of visual journals to identify themes or patterns (Warson, 2012, p. 55), creating a cover for journals, and a response clay task (Warson, 2012, p. 50).

The State-Trait Personality Inventory (STAI) measures stress reduction and was administered to the patients before and after the workshops were over (Warson, 2012, p. 49). The STAI was reviewed and re-formatted due to it not being culturally appropriate to the tribes (Warson, 2012, p. 50).

There was no significance in the measurement due to it not being “transferable to southeastern American Indian tribes (Warson, 2012, p. 53).

Self-Book

In 2017, Radl et al. created a curriculum that is “an art therapy process that integrates the concept of strengths and virtues from positive psychology in a 10-page visual book, created over 6 individual sessions” (p. 2088). Radl et al. recognized that the mind experiences invasive stress

when negative situations arise (Radl et al., 2017, p. 2088). The Self-Book “can help patients reframe their illness in a way that helps them make sense of the adversity in a safe manner” (Radl et al., 2017, p. 2088). This curriculum involves the process of creating a self-reflective journal to document the sessions (Radl et al., 2017, p. 2089).

There were two types of participants: Some patients would see an art therapist during their treatment, usually the same day as treatment; the other was a group of patients that were considered the standard care control group (Radl et al., 2017, p. 2089). The Standard care control group did not participate in the Self-Book intervention and therefore will not be mentioned further.

While the curriculum is being implemented, questionnaires and assessments are being administered before and after the sessions (Radl et al., 2017, p. 2089). For the patients “each of these measurements occurred during their oncology treatment session and before the start of the art therapy session on a given measurement week” (Radl et al., 2017, p. 2090).

These sessions were open to patients diagnosed with any type of cancer (Radl et al., 2017, p. 2088). However, female patients were wanted only and “receiving active oncology treatment at a major urban hospital” (Radl et al., 2017, p. 2089). Patients also needed a specific score on the Karnofsky Performance Status as well as a specific emotional distress score and proficient in English (Radl et al., 2017, p. 2089). Patients that had visual or cognitive impairment or a major mental health disorder were excluded (Radl et al., 2017, p. 2089).

According to Radl et al. (2017), there appeared to be an enhancement of spiritual well-being because the patients saw it “as God’s will and trusting that cancer will be okay” (p. 2093). Because a majority of the patients were African-American, the coping skill of God’s will was frequently observed (Radl et al., 2017, p. 2093).

During the first workshop, patients focused on feelings of safeness due to this being a basic need for well-being (Radl et al., 2017, p. 2091). In the second session, feeling connected to others was a focus for them to create a stronger support system (Radl et al., 2017, p. 2091). Becoming aware of inner coping skills was the topic for the third session (Radl et al., 2017, p. 2091-2092). For the fourth workshop, patients were “reminded of gratitude and the need for attachment” (Radl et al., 2017, p. 2092). The fifth workshop was centered around communicating non-verbally their feelings through the artwork (Radl et al., 2017, p. 2092). In the final workshop, patients finished their self-book and utilized it as a transitional object for psychological comfort (Radl et al., 2017, p. 2092). Materials used for all workshops were magazine images, however, the last workshop included anything items that could be attached and decorate their journals.

Measurements used was Distress Thermometer (DT), Perceived Emotional Distress Inventory (PEDI), Patient Reported Outcomes Measurement Information System Brief Psychological Well-Being test, and the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-sp) (Radl et al., 2017, p. 2087). Patients took these assessments before the workshops, at week 3, week 6, and 1-2 months post-intervention (Radl et al., 2017, p. 2087). DT “screened all participants and to measure ongoing emotional distress before and after Self-Book art therapy sessions” (Radl et al., 2017, p. 2089). PEDI “measured the perceived and present state of emotional distress in cancer patients” (Radl et al., 2017, p. 2089). The Patient-Reported Outcomes Measurement Information System Brief Psychological Well-Being test measured psychological well-being and FACIT-sp measured psychological well-being as well, however, focused on spiritual well-being (Radl et al., 2017, p. 2090).

There were more improvement art therapy patients spiritual well-being compared with the standard care control participants (Radl et al., 2017, p. 2090); this is “suggesting that Self-Book art therapy may offer some emotional benefit” (Radl et al., 2017, p. 2090). The FACIT-sp assessment showed that the art therapy group became accepting of their cancer compared to the control group (Radl et al., 2017, p. 2093).

No statistically significant differences were present between the groups for the primary outcomes, several positive trends were noted including greater improvements in Self-Book art therapy participants spiritual well-being compared with standard care control participants (Radl et al., 2017, p. 2093).

Radl et al (2017) note that emotional distress and overall psychological well-being between both groups were not significantly different. However, they recommend that further studies be implemented.

Analysis of Data

Data analysis consisted of first engaging in a close read of the articles that described the five curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) explored in this study. I then took notes as I read and began to code the curriculums a few times using different colors and numbers that correlated with my research questions. I looked for certain keywords or phrases that I felt related to my research questions including, “the purpose”, culture, religion, body, mind, type of cancer, duration, measurement, pre and post interventions, effectiveness, and results. I then utilized post-it notes to create a chart-like structure to compare and contrast the curriculums. On these post-it notes, I summarized the color-coded items to better compare and contrast.

The following data is organized in order by the research questions in order to explore the patterns and establish the possible evolution of the curriculums.

Question #1: *What types of art therapy based curricular programs were being implemented with people who had or who have received cancer treatment?*

After analyzing, the data illuminated that all five of the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) in this study focused on decreasing any emotional distress into their curriculums, for example, stress and negative mood. By focusing on emotional distress, the curriculums are allowing the patients to “reflect over, and express, [their] experiences, thoughts, and feelings about [their] situation” (Oster et al., 2006, p. 59).

The most common directives that were used in relation to emotional distress for all five curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) were guided imagery, identify virtues and strengths.

In addition, three of the curriculums (Monti et al., 2005; Oster et al., 2006; Warson, 2012) implemented aimed to focus on the body alone (or in addition to emotional distress). Some interventions that were used in the curriculums were deep breathing exercises, meditation or yoga. Monti et al. (2005) explains that “mindfulness practices may foster self-regulation through cultivation of focused attention and acceptance of self in the present moment” (p. 364) which is why focusing on the body is important as well for patients who have/had cancer due to the cancer possibly changing their body in some way. Some common examples of the directives that were used were body mapping and guided imagery.

Question #2: *At what point are art therapy based curriculums being utilized with people who have cancer treatment?*

In the analysis of the five curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017), I discovered that all of the curriculums touched on the time in treatment when implemented, however, they did not specify *why* they were implementing the curriculums before, during or after treatment.

There were three out of five of curriculums (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) that were implemented during the patients' treatment and measurements were usually administered pre-intervention and post-intervention.

All five of the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) had some follow up sessions and three of them (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) utilized measurements as the follow up.

Warson (2012) was the only curriculum where families were involved in the process and the participants were cancer survivors. Warson (2012) also did not specify if the survivors were in current treatment or not.

Question #3: *What demographic patterns are there in curriculums that are utilized with patients who have/had cancer treatment?*

There was a majority of female participants for three of the curriculums (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017). Oster et al. (2006) had a focus on breast cancer which is why they only had female participants, Monti et al. (2005) had specified females only, but no reason why. Radl et al. (2017) specified that they wanted to “achieve a homogenous population” (p. 2093). Because these three curriculums had women-only patients, the culture of these

interventions that were utilized had different meanings for the patients compared to other curriculums that may have had a mixture of women and men. Oster et al. (2006) described that women who have cancer (specifically for this curriculum breast cancer) still take on the responsibility of domestic work and have a stronger burden than men possibly could have (p. 63). Therefore, the patients need to be encouraged to have their own space to reflect (Oster et al., 2006, p 63).

The median age for the female patients for Oster et al. (2006) and Monti et al. (2005) was between 53-59 years old. Oster et al. (2006) was based in Sweden and Monti et al. (2005) was based in the United States, Monti et al. (2005) had a wider demographic when it came to ethnicity; a majority of the women were Caucasian and next was African Americans (p. 368). While Radl et al. (2017) were also based in the U.S a majority of the women were African-American (p. 2093). In addition to Monti et al. (2005) and Radl et al. (2017) being based in the U.S., two more curriculums were also based in the U.S (Luzztto and Gabriel, 2000; Warson, 2012).

Three of the curriculums (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) specified that certain patients were excluded from participating if they had certain criteria; the most common criteria that a patient could not have was serve mental health disorder.

When it came to age, all five curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) did not specify a particular age group to use the curriculums with, however, they did all appear to be adults.

Four of the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) did not specify which ethnicity or cultural group to implement the curriculums with. Warson was different as she worked with Native Americans only.

It seemed as four out five of the curriculums did not specify what type of cancer the patients had to have in order to participate (Luzztto and Gabriel, 2000; Monti et al., 2005; Warson, 2012; Radl et al., 2017). Oster et al. (2006) were the only one to specify the curriculum was for women with breast cancer.

Question #4: *How are art therapy curriculums being implemented with patients who have/had cancer treatment?*

All curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) had their own structure to the workshops as well as the frequency and duration of them. The average duration of the workshops was about two hours long according to three of the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Warson, 2012).

The structure for three of the curriculums (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) first had their patients split into a controlled group or the art therapy group to help identify the effectiveness.

When it came to homework/assignments and materials, two of the curriculums (Luzztto and Gabriel, 2000; Radl et al., 2017) did not implement homework/assignments and three (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) did not have a variety of materials. The most common materials utilized for all five (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) of the curriculums were oil pastels, collage, and paint.

The last session for all five curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) were about reflecting on the patient's progress and all five had a follow-up intervention or workshop.

Question #5: *What is the impact of art therapy curriculums on the treatment of patients who have/had cancer and how is impact being measured?*

The outcome in two of the curriculums (Warson, 2012; Radl et al., 2017) did not have significant evidence that showed they improved the patients' well-being as indicated by the measurements that were utilized and it was concluded that further research was needed. For the other three curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006;) there was significant evidence that concluded their curriculums improved patients well-being such as, lowering anxiety and depression.

All curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) used different methods of measuring the effects on the patients. Four of the curriculums (Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) worked with the central idea of measuring stress or emotional distress using measurements such as SCL-90-R, SF-36, CRI, STAI, DT, PEDI, and FACIT-sp. With three curriculums (Monti et al., 2005; Oster et al., 2006; Radl et al., 2017), general health was a concern and two (Oster et al., 2006; Radl et al., 2017) of those three also focused on spiritual and psychological well-being.

The measurements of two curriculums (Oster et al., 2006; Warson, 2012) were being implemented either before or after the workshops. However, two other curriculums (Monti et al., 2005; Radl et al., 2017) utilized their measurements pre and post-intervention, as well as during one of the sessions. There was only one curriculum (Luzztto and Gabriel, 2000) that used their measurement at the end of the workshops. For this particular curriculum (Luzztto and Gabriel, 2000) they used a questionnaire instead of an instrument. One other curriculum (Oster et al., 2006) utilized questionnaires as well as measurements. They also interviewed the patients three times and had them use their diary weekly.

Meaning and Findings

The purpose of this qualitative archival study is to explore art therapy curriculums that already exist for patients that have/had cancer. In my analysis I discovered two main findings which I will outline in this section. The first is decreasing emotional distress, and the second is directives. This is then followed by some final thoughts. I also noticed that many of the programs are focused on women and breast cancer.

Decreasing emotional distress.

There was evidence gained from the analysis that determined some art therapy based curriculums could be on the right path to benefiting cancer patients who have/had cancer. For example, three of the curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006) decreased emotional distress by using interventions and directives such as, mindfulness, relaxation activities, developing empowerment, reflecting on the self and the patients progress. These interventions and directives helped the patients decrease their emotional distress.

Despite Warson (2012) and Radl et al. (2017) needing more research because there was no significant evidence, the outcome of all five curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Warson, 2012; Radl et al., 2017) showed that “art therapy can be a valuable complementary therapy in routine oncology practice” (Oster et al., 2006, p. 63).

I find it interesting that Luzztto and Gabriel (2000), Monti et al., (2005) and Oster et al. (2006) were all successful in decreasing emotional distress and they were all within the time span of six years of each other; where else the curriculums of Warson (2012) and Radl et al. (2017) were six years or older. This prompts the question of what was done differently between

the time span of three successful curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006) and the two not as successful curriculums (Warson, 2012; Radl et al., 2017).

As I further examined the question of why Luzztto and Gabriel (2000), Monti et al. (2005), and Oster et al. (2006) were successful and Warson (2012), Radl et al. (2017) were not; I found that instruments of measuring stress or emotional distress were used pre and post-intervention for Monti et al. (2005), Oster et al. (2006), and Radl et al. (2017). A follow-up session was held and a measurement was incorporated. Monti et al. (2005) and Oster et al. (2006) were both successful in decreasing emotional distress and increasing overall well-being. Warson (2012) was not successful because the measurement that was utilized was determined not appropriate for the American Indian tribes.

Directives.

Luzztto and Gabriel (2000), Monti et al. (2005), Oster et al. (2006) and Radl et al. (2017) had some similarities when it came to directives and homework. However, Monti et al. (2005), Oster et al. (2006), and Radl et al. (2017) were extremely similar. All four curriculums (Luzztto and Gabriel, 2000; Monti et al., 2005; Oster et al., 2006; Radl et al., 2017) incorporated guided imagery in their curriculums, had follow-up sessions and their final workshops had patients reflect on their journey. Monti et al. (2005) and Oster et al. (2006) had very different directives for their curriculum, however, there were other similarities. While they had different directives, they both incorporated guided imagery in their directives and they also both had patients explore their bodies to identify pain and to become more mindful of it. Monti et al. (2005) reported that mindfulness can promote self-regulation through the cultivation of acceptance of oneself at the moment and Luzzatto (2003) describes that exploring the body can give patients a sense of relief if they're exploring with positive and negative emotions.

Both curriculums gave their patients homework and the materials used the most for both was collage, paint and oil pastels. For Radl et al. (2017) collage was the only material used.

Need for more details.

It is unclear why Radl et al. (2017) did not have enough significant evidence when it was very similar to Monti et al. (2005) and Oster et al.(2006). It is also unclear why Luzztto and Gabriel (2000) were successful when they were not very similar to Monti et al. (2005) and Oster et al. (2006). Monti et al. (2005) and Oster et al. (2006) created directives in their curriculum that were extremely helpful in decreasing emotional distress; perhaps there is a connection between the materials used and how they are paired up with the directives that create a great impact on the patient's well being.

The findings of these curriculums concluded for me that more research was needed despite there being successful curriculums. My question about why Luzztto and Gabriel (2000), Monti et al. (2005), and Oster et al. (2006) were successful and Radl et al. (2017) goes unanswered. It would be beneficial to have more details about the curriculums in order to more accurately compare and contrast. There appears to be a lack of consistent details to draw conclusions from. For example, all curriculums did not specify why they were implementing the curriculums during, before or after the patient's routine treatment. If the curriculums specified this detail, I feel that it would have given more information for other researchers to tweak these curriculums to gain similar or better results.

The same goes for other details such as, the demographics, what materials were being used and why, and how the structure of these workshops came about. Warson (2012) utilized the tribal committee to help define what the structure of the workshop would look like and why it should be structured that way due to cultural factors.

I found that the way some curriculums utilized a controlled group and the art therapy group provided further evidence in regards to how effective the curriculums were. This proved useful as it allowed the researchers to compare and contrast the two groups and further determine how to improve the curriculums. I think it would have been helpful for all curriculums to have used two groups because it could have allowed for better insight into how effective they were in this research.

Another important key factor was the follow-up sessions or follow up measurements. I found it essential that the curriculums provided some sort of follow up session, regardless if it was a measurement being implement or another workshop, to help further the evidence of how effective the curriculums were. In fact, providing a pre-intervention, post-intervention and an intervention administered in the middle of the workshops appeared to be useful. By having all three, researchers are able to compare and contrast the progress of patients and the effectiveness of the curriculums. The only curriculums that did something similar to this was Monti et al. (2005), Oster et al. (2006), and Radl et al. (2017); the rest did not show the progress of the patients that reflect the effectiveness of the curriculums.

Monti et al. (2005) showed that their measurements were implemented pre-intervention (0 week), 8th week and 16th week (post-intervention, follow up) (p. 365). For both SCL-90-R and SF-36 which measured anxiety, depression, etc. and physical functioning, bodily pain and general health. Results for the MBAT group showed that between 0 week and 8th week they had higher levels of anxiety, depression, etc. and bodily pain, physical functioning and general health compared to the controlled waitlist group (p. 368). For the MBAT group, there was little change between 8th week to 16th week for both measurements (p. 369). Because there was little change between 8th week to 16th week, it is suggested that “maintenance of improvements in general

health, mental health, vitality and social functioning” are needed (p. 369). The final results concluded that MBAT can be utilized with patients that have/had cancer (p.370).

Oster et al. (2006) administered their measurement to the controlled and art therapy group before and two times after radiotherapy was completed (p. 59). They utilized CRI which measured cognitive, social, emotional, physical and spiritual domains (p. 59). The patients from the art therapy group increased their social domain in the 2nd and 3rd occasion of being administered the measurement (p. 61). They also increased their cognitive, emotional, spiritual and physical between the 1st occasion and 2nd occasion, however it was slightly lowered during the 3rd occasion of being administered the measurement (p. 61). Despite it being slightly lowered, they succeed in increasing all five domains compared to the controlled group (p. 60).

Radl et al. (2017) utilized DT, PEDI, and FACIT-sp and they were administered before the workshops, at week three, six and 1-2 months post-intervention (p.2087). For the DT measurement, it increased from the pre-intervention to the week three then decreased in week six and decreased again 1-2 months post-intervention (p.2092). For PEDI, it decreased from the pre-intervention all the way to 1-2 months post-intervention (p.2092). FACIT-sp overall decreased from pre-intervention to week three and increased from week six and increased again 1-2 months post-intervention (p.2092). There were no significant differences between the controlled group and the art therapy group and therefore felt that further study was needed (p.2093).

Lastly, having the patients reflect on their progress during the last session seemed to be another key factor. This would allow the researchers to determine how effective the curriculums were and to visibly see the progress of the patients.

Conclusions

The beginning of this research was difficult, however, as I started to analyze and present data it became clearer where I was headed. I had several different ways of processing this information. I was constantly writing on scratch paper and rereading the curriculums and this paper as well to help further define where I was going.

This research was found to be difficult in the sense that there did not initially appear to be many themes found. This complicated this research because I feel that a wider selection of curriculums could have helped find more themes and further provide evidence that art therapy based curriculum can help patients that have/had cancer. Despite this, the curriculums that were used did provide enough evidence that art based curriculums can help patients that have/had cancer in either decrease symptoms such as, decreasing emotional distress or at least help maintain their quality of life.

For further research on art therapy based curriculums, I would suggest the curriculums be more detailed as I discussed in the findings and meanings section. Determining why certain materials, interventions, and activities are preferred and how that conclusion came about can help branch out into different possible curriculums as well as determining how effective these curriculums were. Providing more insight into demographics and culture will be great in determining how to be culturally considerate such as how Warson (2012) was.

Overall, I believe this research was successful in finding some curriculums that were effective with patients with cancer. I found that it can also be helpful in branching out and further researching art therapy based curriculums.

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