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Expressive Arts Therapy and Oncology Care Teams

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Expressive Arts Therapy and Oncology Care Teams: A Literature Review

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Abstract

This literature review offers an overview of the mental health of oncology care team members, medical professionals as well as oncology floor hospital staff, and the therapeutic benefits of expressive therapies on that specific population. Working on an oncology floor means interacting with patients and their loved ones at a time of utmost suffering, uncertainty, and possible death. This environment presents risks of burnout, compassion fatigue, and a sense of isolation for the medical and non-medical professionals working with cancer patients. The results of qualitative, quantitative, and art-based studies conducted pre-and post-Covid-19 pandemic show multi-faceted and multi-layered positive impacts of expressive-arts-therapy interventions on the care team and staff members and on that milieu overall. Based on the conclusions of the studies selected for this review, the author presents three types of expressive arts interventions with mindful self-care, grief and loss processing, and vicarious resilience as goals. The author recorded their thesis research and writing process through mixed-media art-journaling after each work session.

Keywords: oncology care teams, mental health, burnout, compassion fatigue, grief, loss, vicarious trauma, vicarious resilience, expressive arts therapy, Covid-19, racism

Expressive Arts Therapy and Oncology Care Teams

Introduction

Between October 2019 and February 2020, just before COVID-19, I spent around forty days of hospitalization on the oncology floor of a large hospital in New England. I became familiar with the oncology care teams and their various roles and responsibilities. In May 2020, in the midst of the COVID-19 epidemic, I spent nine consecutive days on the same oncology floor. I witnessed described as "the realities of the COVID-19 cancer care resulted in multifold increase in oncologist distress because of numerous practice changes, intensified burnout, heightened moral distress, and personal challenges (e.g., family distress) produced by the pandemic" (Hlubocky et al., 2021, p.365). I could see how stressful the situation was for the personnel: oncology doctors, nurses, and hospital staff alike had to put on and take off protective clothes and gloves for each patient's visit and wear a face shield and a mask to address the patients. They feared contaminating their patients or their own families. They were not able to provide the optimal level of care because of restrictions in medical supplies and chemotherapy shortages. They also witnessed the distress of their patients because visits were not allowed, in any circumstances, even death. And I could see them do their utmost to make us, the patients, feel taken care of, safe, and protected.

To show them my gratitude, I created an Expressive Arts Studio with the art supplies I had brought for myself and whatever could be used in my room. They came individually into my room per the new COVID-19 protocol. I asked each person if they could spare a few minutes. The oncology doctors, the nurses, the janitors, and the food service staff, all replied that they did, and that they were intrigued. I invited them to

choose from the selection of art supplies available and explore their feelings at that moment. As they were leaving my room, every single person expressed gratitude for the opportunity to pause, be creative, and reconnect with themselves, even for a short time. That experience transformed my relationship with my oncology care team. It gave me joy and a sense of purpose. It is the reason for my choice of topic for my capstone.

I have found many studies expressing serious concerns for the mental health of the various professionals on oncology care teams due to the nature of that specialty and increased demands and constraints during the COVID-19 pandemic (HaGani et al., 2022; Hlubocky et al., 2021; Hayuni et al., 2019). Surveys to establish their needs (Lim et al., 2022), studies to better understand their lived experience (Hlubocky et al., 2021, McCracken, 2021) and interventions (Tjasink & Soosaipillai, 2019; Torres et al., 2023) have been conducted to address and improve their mental health needs. In order to ensure that oncology professionals provide the best patient care possible, they need to feel supported to practice self-care by their organization, have a sense of community, and receive grief and loss support (Uzar-Özçetin, 2019; Major et al., 2021). Art- and mindfulness-based interventions appear to have positive results with this population (Kaimal et al., 2019; Nissim et al., 2019). However, the need for support has grown since COVID-19, and more interventions customized for that particular population need to be created. Expressive arts therapy (Levine, 1998; Knill et al., 2005) has a lot to offer in terms of adaptability of its tools to a specific population and their unique needs (Phillips et al. 2020; Parekh, 2021).

Literature Review

My choice of a capstone option is a literature review. First, I researched oncology professionals' mental health concerns such as primary and secondary trauma, compassion fatigue, burn-out, to name a few, as well as the impact Covid-19 has had in that area. Second, I explored expressive therapies theories. Thirdly, I studied examples of interventions using expressive therapies to support that population and their effectiveness. Lastly, my goal was to present a customized expressive therapy intervention for the medical professionals and hospital staff on an oncology floor.

I have observed that the majority of articles related to oncology and mental health tend to focus on cancer patients, which makes sense considering the overall suffering a cancer diagnosis and its treatment(s) provoke. However, I was happy to discover quite a number of articles about oncology professionals, their experiences, the impact that type of work has on their mental health, and the use of expressive therapies to support them as whole individual beings and as medical, moral, and ethical care providers. However, I have been unable to find any research about the oncology custodial and food-service staff that work on oncology floors amongst oncology professionals and cancer patients. I assume their work environment impacts their mental health as well. I wish to include this category of workers in my interventions.

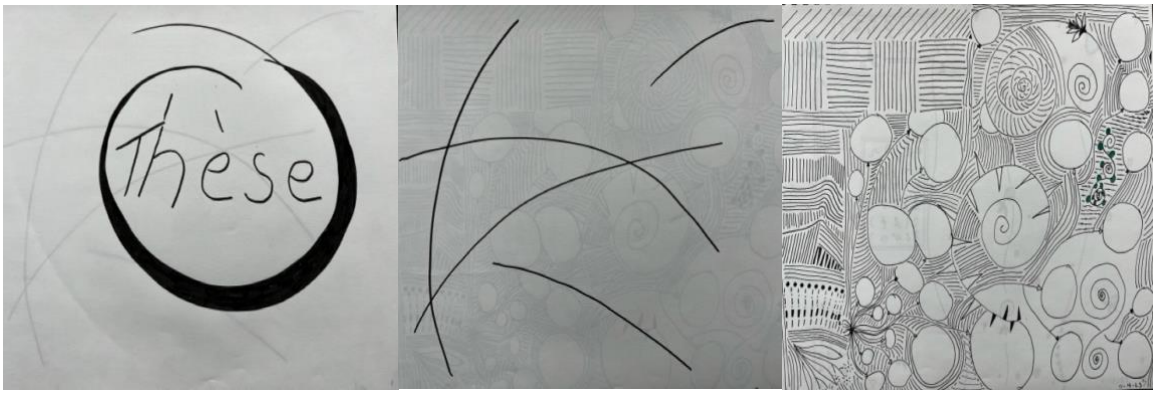
Methods

I created a broad selection of articles around my topics of interest using keywords such as burnout, resilience, and interventions to provide mental health support to oncology doctors and nurses. I searched for sources on Lesley's library website, Google Scholar, Google search, YouTube, and TEDtalks.

In parallel to the intellectual process, I practiced mixed-media art journaling after each work/study session as a form of autoethnographic exploration.

Figure 1

Autoethnographic journal, pp. 1-3.



Oncology Care Team Professionals: Roles, Mental Health, Specific Needs

Oncology Doctors and Nurses

Oncology Doctors and nurses treat patients with life-threatening diagnoses, by using taxing treatments with debilitating side effects. When a treatment is successful, the client is considered in remission. The possibility of relapse or of developing a different cancer always looms. When they must to face the patients', their families' and loved ones' reactions when delivering any form of cancer diagnosis, treatments, improvement or decline, palliative care, hospice care, imminent death, oncologists "report feeling a high level of stress" (Yi et al., 2022, p.286). Due to cancers' high mortality rates, "breaking bad news goes against their responsibility to do no harm and their professional objective to promote healing" (Yi et al., 2022, p.285). This situation may cause moral injury, i.e. "psychological distress that results from actions, or the lack thereof, that violates someone's moral or ethical code" (Litam et al., 2020, p.14) which presents as "feelings of shame, guilt, and disgust and negative thoughts about themselves, others, and

the world" (Litam et al., 2020, p.14). In 2023, Alwhaibi et al. conducted a study to measure "the emotions, perception of performance, and quality of care" amongst oncology team members delivering difficult news (pp. 2-3). The responses obtained via online questionnaires revealed that sex, age, and occupation showed no difference in the participants' emotional response. It appeared that years of experience mitigated emotional responses. However, the latter factor did not modify the levels of emotional distress sustained by oncology doctors when delivering challenging information to patients (Alwhaibi et al. 2023, p. 6). These results represent invaluable information when designing therapeutic interventions to support oncology doctors and nurses' mental health, so they are able to provide cancer patients the best care possible.

Other Oncology Personnel

There is an invisible workforce on oncology floors who I could not find represented in the literature. Groups of individuals who work on oncology floors are left out of the existing research. During my research on oncology floor hospital staff, my findings were limited to one video interview of a janitor on an oncology floor (Ochsner Health, 2020). They are people that see the same patients as doctors and nurses. They take care of the patients' rooms, their food, their beds, their bathrooms, their sheets, and bring them warm blankets. They all interact with the patients. While I was hospitalized, most of them belong to what are considered minority groups such as African American, Caribbean, Latinx, etc. Most of them could not afford to live in the city and had long commutes, adding to their long, tiring, days, compounded by their irregular schedules. They were often victims of microaggressions: being ignored, feeling invisible, mistreated. That population matters to me tremendously, and it saddens me to observe

their absence in research as a population whose mental and physical health is worth considering.

Trauma and Secondary Trauma

Giving and receiving a cancer diagnosis engenders discomfort and fear of the unknown for all parties involved. The diagnosis and the treatment for the patient and the patient's reaction for the doctor represent possible "traumatic stressor (s)" (Gieseler et al., 2018, p.753). The DSM-V (2013) describes "traumatic stressors as "any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a friend" (APA, 2013, p.265) "Trauma itself is defined as a direct reaction to a stressor that exceeds an individual's capacity to cope (...). Secondary trauma also known as vicarious traumatization" (Gieseler et al., 2018, p.753) is defined as "indirect exposure to trauma through a firsthand account or narrative of a traumatic event. (...) this potentially includes the situations of oncologists communicating a diagnosis of a lethal disease such as cancer" (Gieseler et al., 2018, p.752). In their research, Braun et al. described how secondary trauma manifests itself in individuals: "its symptoms include intrusive thoughts, avoidant behavior, and high levels of tension (p. 1635). In 2020, secondary trauma for oncology care teams was compounded by Covid-19 as they experience trauma in their professional and personal lives due to fears of contaminating patients or family members, deaths of relatives or friends, increased stress caused by all precautionary measures and protocols in place in hospitals, among other traumatic stressors (Litam et al., 2020).

Compassion Fatigue and Burnout

In their 2022 article, Braun et al. gave definitions for burnout and compassion fatigue as they are understood in the context of working in healthcare, and more particularly, in oncology:

> Compassion fatigue is defined as a state of tension, which can cumulatively develop in the helping professions in response to witnessing others' suffering as well as the constant wish to relieve this suffering. The consequences of compassion fatigue include the caregiver's reduced capacity and interest in being empathetic towards others who are suffering, and in reduced personal and professional well-being. (...) Burnout usually develops in response to work environment characteristics (e.g., workload and non-supportive work environment) and includes feelings of exhaustion, frustration, anger, and depression. (p. 1635)

Burnout and compassion fatigue have vast consequences impacting the healthcare system as a whole, "stress and burnout are implicated in a growing list of health- and job-related consequences accounting for some 50%-60% of all lost working days" (Sallon et al., 2017, p. 47).

In a 2021 study, qualitative data were obtained over four months from semi-structured, moral-distress-theory-based interviews led by two investigators during eight focus groups of a total of thirty-two members with different roles on an oncology unit in Wisconsin. The data were analyzed and coded for audit-trail by two independent investigators and reviewed by two others to ensure triangulation. Six main oncology-specific, moral-distress related themes emerged for the study: caring for patients with a life-threatening disease, witnessing the suffering of the patients and their families, feeling

disempowered in treatment decision making, observing mis-management of palliative care, being disappointed for not providing best care possible, and aspiring to see improvements in teamwork, “goals-of-care” (p. E39), and support around “loss” (p. E41). However limited in scope, this study shed light on moral distress contributing factors, and ways to mitigate them. The number of interviewees in each specialty on an oncology-care team varied and thus put the emphasis on certain care professionals’ experiences and needs, to the detriment of others less represented. The large participation of female volunteers (27/32) and of white volunteers (27/32) adds bias to the results.

Oncology Professionals and Staff of Color Facing Racism

Systemic racism along with racist microaggressions are insufficiently addressed and concrete measures to combat them are rarely offered in hospital settings. Goldberg, in their 2020 article, described how doctors of color are victims of microaggressions. In their 2020 article, Chary et al. showed how urgent the need to address racism amongst medical personnel is. They organized a “Health Equity retreat to teach emergency medicine residents about forms of racism and skills for responding to racial inequities in clinical environments" (p.41) as such training appeared to be lacking in medical upper education. The retreat format included anonymous testimonies of personal or witnessed experiences of racism between medical personnel and patients, and observed manifestations of racism in inequity of care whether a patient is white or a person of color. Participants discussed examples of microaggressions, “brief, commonplace words or actions (intentional or nonintentional) that communicate hostility to or insult members of marginalized groups” (p. 42) in racially mixed groups. The third part of the retreat consisted of training the participants to perform “un-biased (...) strategies to facilitate

verbal de-escalation" (p. 43). In the oncology field, a more systemic and flagrant form of racism exists in the "underrepresentation of minority groups in the oncology physician workforce" (Owoyemi et al., 2021, p. 630). This underrepresentation exists at other levels such as medical school faculty and medical student body. The hindering factors of this situation are described as being "an exclusionary medical culture, bias in measures of merit, financial barriers to medical subspecialty training, under recognition of achievement, and poor representation and satisfaction among underrepresented faculty" (Owoyemi et al., 2021, p. 630). Interestingly, minority groups are overrepresented amongst custodial and food service hospital staff in general, including on oncology floors. Numbers are hard to come by, but this situation is obvious to whomever spends any time on any hospital floor. According to Goldberg's 2020 *New York Times* article, doctors of color encounter regular put-downs by patients and/or colleagues such as having their credibility undermined, being mistaken for custodial staff, being ignored if a white physician is also in the room, etc. Black female doctors experience over-familiarity with being addressed by their peers as "sweetie" or "Honey" (Goldberg, 2020). These experiences of microaggressions act as "death by a thousand papercuts" (Goldberg, 2020). Because of the lack of research in the experiences of racism by minority clinical staff, inferences based on such articles as Goldberg (2020) indicate a possible worse reality for them. Doctors of color find it so derogatory when patients "ask you if you are coming in to take the trash out" It indicates a lack of solidarity and support amongst minority groups as if the respect one receives depends on one's position on the hierarchical ladder. And as is now common knowledge "negative experiences based on social pain can activate the brain areas related to the emotional components of physical

pain" (Zhang et al., 2019, p. 269). Such working environments create certain levels of toxicity and would benefit from more inclusive interventions such as the intervention I am proposing.

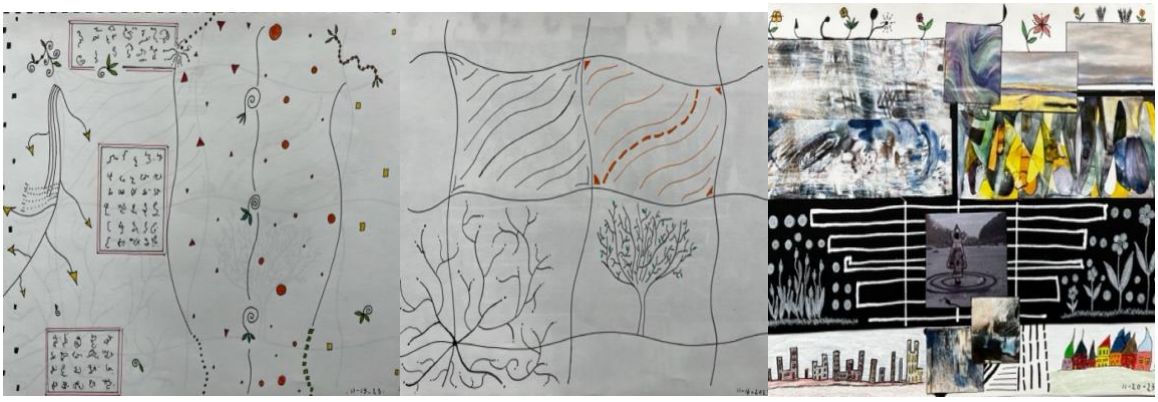
Vicarious Resilience (VR)

The definition of resilience, according to the American Psychological Association Dictionary of Psychology (2007), is "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (Vandenbros, n.d.). The term "vicarious resilience" also known as vicarious posttraumatic growth (VPTG), emerged in an article by Hernandez et al. published in 2007 (p.229). These terms, first used in the context of experiences of war survivors, have been applied more recently to oncology care team members (Tsesmelis Piccolino, 2022, p. 468). The researchers described VR as "the strength clinicians may experience through clients' resilience in facing adversity, and the meaning that practitioners can gain from supporting individuals through traumatic situations, namely life-threatening illness" (Tsesmelis Piccolino, 2022, p. 468). An important part of vicarious resilience is the capacity to make meaning of our situation. This aptitude is best embodied and conceptualized by Frankl who explained that according to him "meaning making comes from the awareness that we have the freedom to find meaning in our existence and we choose our attitude towards suffering" (as cited in Tsesmelis Piccolino, 2022, p. 471). I see a correlation between meaning-making and oncologists' locus of control, "the way individuals attribute causes to the occurrence of various events in their lives" (Braun et al, 2022, p.1635). Braun et al.'s 2022 study explored whether there were links between oncologists' locus of control

and their experiences with compassion fatigue, compassion satisfaction, and guilt. The results obtained via questionnaires showed the following results: oncologists with internal locus of control (their actions make a difference in events) experienced higher levels of compassion satisfaction, lower levels of guilt, and less prone to secondary trauma compared their counterparts whose locus of control was external (chance and other forces are at play in the events that occur, not just their actions) and who showed higher levels of compassion fatigue and higher levels of guilt, and more occurrences of vicarious trauma. Braun et al. recommend taking into account the oncology professionals' sense of locus of control when addressing compassion fatigue, secondary trauma in order to foster vicarious resilience.

Figure 2

Autoethnographic journal, pp. 4-6.



Expressive Arts Therapy (ExAT): theories, and practices

Understanding ExAT

Expressive arts therapy is one of the expressive therapies. Expressive arts therapy is the newest of expressive therapies. Its theories emerged in the 1990s on the East coast of the United States, at Lesley College, known now as Lesley University. Major early theorists are Shaun McNiff, Ellen G. Levine, Stephen K. Levine, Paolo J. Knill. Their

experiences as scholars, therapists, artists broadened their understanding of the therapeutic relationship "between art, play and imagination" (Knill, 1994, p.320). The focus of artmaking in expressive arts therapy is the process, not the product, "healing occurs through immersion in the creative process as contrasted to more analytic and verbally oriented approaches (...)" (McNiff, 2009, p. 47). At its core, expressive arts therapy is "intermodal" (Knill, 1994, p. 324) and "multimodal" (Estrella, 2005, p. 183). The therapists invite their clients to explore "with the arts in sequence, at other times using the arts simultaneously, and at still other times carefully transitioning from one art form to another within the therapeutic encounter" (Estrella, 2005, p. 183). Levine and Levine (1998) described expressive arts therapists as "specialists in intermodality; that is, (...) capable of grasping the junctures at which one mode of artistic expression needs to give way to, or be supplemented by, another" (p. 11). This therapeutic process requires the therapist to be familiar with various expressive art forms and with the properties of the materials in order to plan a therapeutic intervention that is adapted to each client's specific needs, abilities, and comfort and has a positive effect on their mental health and overall wellbeing.

Person-Centered Expressive Arts Therapy

One of the key theoretical approaches of expressive arts therapy is based on Carl Rogers' person-centered therapy. Some of its tenets are that each client "has worth, dignity, and the capacity for self-direction" (Rogers, 1993, p.3), and that the therapist must be "empathetic, open, honest, congruent, and caring" (Rogers, 1993, p.3). These conditions elicit trust between the therapist and the client, so the client feels seen and accepted for who they are. The client feels safe to explore their inner wisdom and find

ways to live a full life using their full potential. (Rogers, 1993, p.4). Rogers introduced a new non-directive therapy style. That was in complete opposition to the directive practices of his contemporaries. Rogers' reasoning behind his method was:

> This hypothesis is that the client has within himself the capacity, latent if not evident, to understand those aspects of his life and of himself which are causing him pain, and the capacity and the tendency to reorganize himself and his relationship to life in the direction of self-actualization and maturity in such a way as to bring a greater degree of internal comfort. The function of the therapist is to create such a psychological atmosphere that will permit this capacity and this strength to become effective rather than latent or potential. (Kirschenbaum, n.d., 10:35)

Carl Rogers' daughter, Natalie Rogers added the expressive arts dimension to the person-centered therapeutic practice that she called "the creative connection" (Rogers, 1993) Natalie Rogers described it as "the creative interplay among movement, art, writing, and sound" (Rogers, 1993, p.4). One main aspect of Person-Centered therapy that Natalie Rogers did not completely align with was the non-directive approach, "what I felt lacking as I worked with my father were stimulating experiences that would motivate and allow people time and space to engage in the creative process" (Rogers, 1993, p. 17). Natalie Rogers was cognizant of clients' potential fear of failure such exercises could elicit and used the phrase "There is no right or wrong to what you are doing" (Rogers, 1993, p. 24).

ExAT and the Expressive Therapies Continuum (ETC)

In 1978, Kagin and Lusebrink presented a system known as the Expressive Therapies Continuum (ETC) (Lusebrink et al, 2013, p. 75). Its aim is to provide therapists with a system to adapt the use of expressive arts modalities to the client's or group's therapeutic needs: "The client's interaction with the expressive media on different levels of expression and information processing constitutes a system" (Lusebrink, 1991, p. 397). Kagin and Lusebrink's ETC created a framework that describes and organizes the various components and healing dimensions of the expressive therapies. The ETC has another function, which is to provide a form of "common language" through which expressive therapists of various modalities can share experiences and deepen their understanding and therapeutic use of the expressive arts (Hinz, 2009, p.17). The proposed system is organized around three hierarchical levels: kinesthetic/sensory, perceptive/affective, and cognitive/symbolic. Creativity is an integral part in each one, "in creative expression several or all the levels of the ETC are present and connected" (Lusebrink, 1991, p.398). The different levels offer more or less "reflexive distance between the stimulus and the reaction to it" (Lusebrink, 1991, p397). Each level of the ETC consists of congruent activities, materials, and directions that possess "healing functions", and potential areas of growth called "emergent functions" (Hinz, 2009, p. 99).

Kinesthetic activities involve gross and fine motor-skills activities and body movements. Sensory activities revolve around activities stimulating the senses: touch, taste, sight, sounds, smells, and the inner sensations they elicit. Kinesthetic activities such as "pounding on clay" (Lusebrink, 1991, p. 398) provide immediate release of energy,

and increased self-regulation thanks to the creation of rhythm (Hinz, 2015, p. 44). In the same way, sensory activities such as “finger painting” (Lusebrink, 1991, p. 398) create instantaneous inner sensations. In both cases, the actions and the client’s experience of them occur simultaneously. As such, the Kinesthetic/Sensory level offers the least reflexive distance, and its benefits include “release of energy or tension, finding inner rhythm” (Hinz, 2009, p.57) and “increased stimulation and well-being, awareness of internal sensations” (Hinz, 2009, p.77).

Perceptual exercises focus on “line, shape, and pattern” (Hinz, 2015, p. 45), as a way to organize the world around us, such as outlining shapes on an abstract watercolor-covered page. “The perceptual component focuses on the formal or structural qualities of images such as defining boundaries, (...), and striving to achieve an appropriate representation of an internal or external experience” (Hinz, 2015, p. 45). In therapy, the structural component stimulates the client’s awareness that a whole is made or can be divided in smaller parts, that a perceived problem, feeling, situation can be approached from different perspectives. It offers the client a space for practicing discernment from a tangible level and extrapolating it to inter- and intra-personal dilemmas. Affective exercises such as music-guided drawing or abstract visual representation of emotions (Hinz, 2009, p. 121) promote the exploration of emotions, and by extension, provide skills to support clients in recognizing their emotions and finding skills “in expressing and soothing emotions appropriately through art making and other creative endeavors” (Hinz, 2015, p. 45). This level of the ETC provides a greater and more complex form of reflexive distancing. The emergent functions of activities on the perceptual level include

"increased reality testing or improved cognitive functioning,(...) increased self-understanding and self-awareness" (Hinz, 2009, p. 121).

The third and most reflexive distancing level is the Cognitive/Symbolic (C/S) level. It consists of "abstract and anticipatory operations with images, symbol formation and the corresponding verbalizations" (Hinz, 2015, p. 45). On the Cognitive level, drawing one's "lifeline or timeline" (Hinz, 2009, p. 143) for example provides a visual representation of how a client conceptualizes their understanding of their past and their present. This type of cognitive activitiy may elicit increased ownership of one's self-narrative and deeper self-understanding. It may provide the client with the tools to increase their self-agency and sense of self-determination. Self-determination is an essential factor in "intrinsic motivation" (Deci et al., 2012, p. 417). Unless a client possesses an inner desire to change to heal and increase their well-being, therapy cannot succeed, neither in the short nor in the long term. During "mask making" (Hinz, 2009, p. 167) for instance, a client creates a visual representation of what they show the world about themselves on the outside of the mask, and a visual representation of how they feel about themselves on the inside of the mask. The mask becomes the symbol of an integrated version of themselves, both on individual and universal levels, acceptance of one's complexity, and realization that this dichotomy exists in everyone. A symbolic activity may "reveal hidden parts of self" (Hinz, 2009, p. 168). The emergent functions of activities on the perceptual level include "integration of all parts of self; peace instead of conflict due to repression" (Hinz, 2009, p. 168).

The ETC provides guidelines and can be used in both bottom-up, K/S to C/Sy, and top-down, C/Sy to K/S, practices. In the intervention setup, the individuals are invited to use the form of expression they are most comfortable in and use it as their personal gateway into expressive arts therapy. The therapist may let them explore one expressive format first. When they are more familiar with the therapeutic benefits of that form of expression, the therapist may invite them to explore other components on a different level of ETC with the purpose to "emphasize and enhance the client's strengths on different levels, while at the same time addressing problems on levels which may display variation in visual expressions possibly related to the individual's difficulties in psychological functioning or his/her problems in other areas of life"(Lusebrink et al, 2013, pp. 81-82), and to increase each client's overall well-being and resilience.

Figure 3

Autoethnographic journal, pp.7-9.

ExAT for Oncology care teams: sample of interventions and studies

ExAT and Self-Care

In England, a pilot study was conducted to observe the impact of art therapy on burnout amongst doctors working in oncology and palliative care. Volunteer participants in a six-week art-based program were given the MBI-HSS (Maslach Burnout Inventory-Human Services Survey) pre- and post-program. The MBI-HSS measures emotional

exhaustion, depersonalization, and personal accomplishment (Tjasink & Soosaipillai, 2019). The results showed a significant decrease in emotional exhaustion ($p < 0.001$). Levels of depersonalization and personal accomplishment improved, but results did not reach statistical significance. A full study with more than 18 participants might establish whether art therapy significantly improves depersonalization and personal accomplishment. The authors recommended adding art therapy into medical curricula to increase self-awareness and reduce the stigma that still exists around accepting support as a health professional. The researchers also suggested following up after 6 months to evaluate the long-term effects of therapy. This pilot study was limited by the small number of participants, especially males, and by their self-selection.

In Canada, a team of researchers gathered qualitative data to evaluate the benefits of a Compassion, Presence, and Resilience Training (CPR-T) on oncology interprofessional teams (Nissim et al., 2019). It was an eight-week program the goals of which were to give healthcare workers tools to practice self-care at work and at home, to increase their sense of well-being, to decrease burnout, and to improve patients' safety. Interviews were conducted one month and five months post-training in order to evaluate the short- and long-term benefits of the training. The co-authors of the study did not take part in any stage of the study to avoid bias, and to increase trustworthiness via triangulation of data analysis. The interviews consisted of nine broad semi-structured questions to evaluate the subjective benefits and challenges of the CPR training. The data was analyzed and coded using a “utilization-focused qualitative evaluation approach” (p. 33). The results showed that the participants found useful “on-the-go mindfulness practices” (p. 33), being able to identify signs of stress, engaging in self-care, and

practicing self-compassion. Receiving support from the organization contributed to their feeling validated. However, the fact that the groups were composed of professionals from different specialties and at various levels on the institution's hierarchy made it difficult for them to show vulnerability for fear of being perceived as unprofessional or weak. The researchers concluded that such training provided early in oncology care professionals' career would be beneficial. The researchers advocated for such training to be included during work hours. They made recommendations for future studies based on their results such as focusing on specialty-specific groups, recruting large groups of participants, conducting post-training interviews on a longer-term than five months. It is noteworthy to point out that the authors self-reflexivity may be impacted by the bias created by the fact that the creators of CPR-T are part of the authors of the study itself.

Oncology care team members benefit from therapeutic tools such as mindfulness to increase their self-awareness. Being self-aware means being able to identify one's needs in one's mental, emotional, and physical health. In expressive arts therapy, the client or clients' self-awareness provides the therapist with invaluable information to establish where the clients' strengths are on the ETC, what their areas of need are, and what type of expressive activities will be most appropriate according to its healing properties and emerging components (Hinz, 2009).

ExAT and Process for Grief and Loss

Chilton and Scotti (2014) used collage to conduct their artistic inquiry and answer their research questions, "how might we use collage to broaden our understanding of arts-based research? What are the properties and implications of collage as a research practice in art therapy?" (p. 164). Chilton and Scotti each made a collage a week for four weeks.

They exchanged a photograph of their collage weekly. They conducted a thematic analysis of the content of the collages "to make meaning of their intrinsic experiences" (p. 170). One of them was "embodied discovery produced by hands-on experimentation" (p. 169). The physicality of cutting, gluing, tearing, and layering taps into and amplifies different ways of knowing. "Embodied cognition in the form of collage generates new metaphors and may be one of the particular ways that artmaking serves as a tool of discovery" (p. 169). Based on the knowledge gathered about Art-based research via collage and about the properties of collaging, the authors encourage art therapists to use collage and ABR in general to "advance clinical knowledge and practice" (p. 170).

A few years later, Michel Ferro (2022), an art therapist, used digital collage to conduct research on their personal and professional experiences, as well as their clients' experiences of grief during the COVID-19 pandemic. Over a four-month period in 2020, artist and researcher Ferro created one hundred and fifty-five digital collages "using an intuitive approach" (p. 16) and "active imagination" (p. 16) as a way to process their own grief in order to provide the best therapeutic care to their clients during the Covid pandemic. The choice of digital artmaking mirrored the pandemic individual and interpersonal interactions as they took place mostly via computer or phone screens during that period. For the purpose of the study, five collages representative of Ferro's process were selected to be symbolically and metaphorically analyzed. Ferro used a thematic form of analysis and grouped recurring images under labels "such as elements, plants, animal, hero archetypes, gender, body parts, mythical, and so on" (P.16). Ferro deepened their research based on "the concept of the human figure as a figure of self-development" (p. 16) and identified which archetypes among "innocent, orphan, wanderer, warrior,

altruist and magician" (p. 16) were represented in her digital collages. Ferro's symbolic analysis revealed that they "visually shifted in the art from innocent to altruist, warrior and magician" (p. 23). The making of digital collages acted as a container, a form of expressive arts enabling Ferro to gain some distance from and make meaning of the time of crisis. It provided a safe place to take care of themselves as a therapist so they could better support their patients and their grief. Creating digital collages provided an artistic outlet and enabled Ferro to use their process and the results of their research for the benefit of other therapists facing similar challenges in that moment of "collective grieving" (p. 15). It is not clear when the symbolic analysis was conducted. It seems to have been completed post-study, in hindsight. Insightful and valuable information might be gained from conducting a symbolic analysis after each collage as well for comparison purposes.

Collages, whether analog or digital, are commonly used as a therapeutic tool in expressive arts therapy. Oncology team members, faced with suffering and death every day, may experience collaging as an adaptive expressive media to explore grief and loss (Ferro, 2022).

ExAT and Transforming Vicarious Trauma into Vicarious Resilience

Oncologists are at high risk of vicarious trauma due to "cumulative exposure to client trauma narratives" (Gieser et al., 2018, p.753). Because cancer treatments involve the use of toxic products with negative side effects, such as chemotherapy, "the doctor not only witnesses the patient's trauma, he/she is, in some sense, the cause of it" (Gieser et al., 2018, p.753). One modality used in Expressive Arts Therapy is the practice of writing. In her book *Trauma and Expressive Arts Therapy,* Cathy A. Malchiodi dedicated

chapter 8 to “Trauma Narratives" (2020, pp.243-283). Malchiodi stated that “Telling one’s story in a way that can be witnessed is requisite to reparation, restoration, and (trauma) recovery” (Malchiodi, 2020, p. 243). With some clients, the top of the ETC, the Cognitive/Symbolic level, may be their preferred form of expression. Malchiodi recommended “*timing*”, i.e., using writing several months after a traumatic event to avoid re-traumatization.; “*consistency*”, i.e., writing daily about the traumatic event(s) for one or two weeks only; and “*distancing*”, since “the overall goal in writing about traumatic events is to gain psychological distance from these experiences” (Malchiodi, 2020, p. 271). Visual art is a mode of self-expression used in trauma work. In a six-session pilot study conducted to observe the impact of art therapy on burnout amongst doctors working in oncology and palliative care, the final two sessions embraced in-depth reflection on memorable, upsetting, and meaningful patient encounters (Tjasink & Soosaipilla, 2019, p. 13). Participants were asked to create an image in response to a patient of theirs who had died. They used their images as a starting point for reflection on their memories. The art therapist supported them by giving them her full attention throughout the session, listening refectively, normalizing their feelings and making links between individual participants’ experiences and images. In the final session, they produced artwork relating to a meaningful encounter with a patient. The art therapist validated individual experiences, while encouraging linking and recognition of shared experiences in the group (Tjasink & Soosaipilla, 2019, p. 14). Participants experienced their ability to transform vicarious trauma into vicarious resilience.

Witnessing trauma and being able to transcend the distress it causes is necessary for all oncology care team members. Expressive arts therapy offers tools and skills to

avoid burn-out, compassion fatigue, and health problems that lead to a decrease in the quality of care provided by oncology care team members.

This literature review encompasses qualitative, quantitative, and art-based studies of mental health needs unique to cancer care professionals and hospital staff, expressive arts therapy genesis and practices, and results of specific expressive arts therapeutic interventions in that milieu.

Figure 4

Autoethnographic journal, pp.10-12.

Intervention

The intervention seeks to provide a "nonpathological approach" (Major et al., 2021, p.1) On oncology floors, even more so during the pandemic, the challenge is to avoid pathologizing normal stress reactions. The purpose of the intervention is to provide Health Care workers with support that is "concordant with their needs on the stress continuum without inducing traumatization" (Major et al., 2021, p.5).

On an oncology floor, time is precious, and everyone has little to take a break. The intervention is adapted to that time constraint and provides a variety of activities to give the participant a sense of agency, which is often lacking due to the hierarchical medical and institutional system in place. The intervention proposed here would be

offered to every person working on the oncology floor: oncologists, nurses, nurse assistants, maintenance, and cleaning personnel, as well as food service staff. All are faced with the same distressing factors linked to caring for patients with cancer diagnoses that require hospitalization. All take care of the patients, meet their loved ones, and are in direct contact with their suffering and their possible death. All personnel would benefit from mental health support.

The intervention will be structured/constructed to meet the three main needs identified above: practicing mindfulness for self-care, processing grief, and creating individual work-life narrative. A studio, ideally on the oncology floor, will be staffed by a therapist one day a week from 2 PM to 10 PM in order for both night and day shifts to benefit from Expressive Arts Therapy. Around the studio, there will be small stations, each offering a different activity that the individual can partake in. There will always be choices, but within certain limits to avoid overwhelming the participants, considering the short time they have. The therapist will use the Expressive Therapies Continuum (Hinz, 2019) as well as the expressive therapies continuum as a framework in the treatment of trauma by Lusebrink (2021) to design each activity.

Self-Care Through Mindfulness with Coloring and Drawing (K/S level of ETC)

Mindfulness appears to be a cornerstone skill to acquire and/or hone for self-care as illustrated by two recent research articles. A 2019 study led by Nissim et al. demonstrated that “learning to pause" (p. 33) and the benefits of micro-practices such as “the brief, on- the-go mindfulness practices (...) resonated with all participants and provided them a means to pause and reset in the midst of a busy and stressful workday” (p. 33). The results of another study led by Litam et al. during COVID in 2020 showed

that mindfulness associated with compassion has a soothing and self-regulating effect on individuals with trauma: “mindfulness-based or compassion-based interventions are effective in improving symptoms of traumatic stress” Mindfulness means being in the present moment. Jon Kabat-Zin, founder of Mindfulness-based stress reduction (MBSR), writes “mindfulness is awareness, cultivated by paying attention in a sustained and particular way: on purpose, in the present moment, and non-judgmentally” (Kabat-Zin, 2017, p. 4). Meditation as a mindfulness practice often comes to mind. In an oncology setting, care team and hospital staff members who practice meditation outside of work could benefit from short, pre-recorded , guided mindfulness meditation or short recordings of meditative music. For those new to the practice, or those who may find it difficult to stop thinking about work during sitting meditation, offering an activity on the kinesthetic/sensory (K/S) level of the ETC with including texture and movement such as coloring, or drawing with markers, soft or oil pastels as focal points may help with grounding. Some of the benefits of meditation and coloring are learning to pause, becoming fully present, and practicing self-care. Coloring paper mandalas bridges two ETC levels, as it contains elements of the first level (K/S) and incorporates healing and emergent functions of the next level of the ETC, the Perceptive/Affective level. Hinz (2015) described that phenomenon as “Form gives structure or can contain emotion as is seen when stress and anxiety are reduced by coloring mandalas” (p. 45). Carl Jung used mandalas in his practice “making the processes of getting to the source of a problem and healing a colorful activity” (Karabuga Yakar et al., 2023, p.1363). Based on the rules that accompany mandala coloring, the individual hones their distress tolerance, self-compassion, and self-acceptance. “ During mandala coloring, mistakes are not just

noticed but worked through so that they become integrated into the entire mandala (...) leading in turn to the acceptance of imperfections. In this way, mandalas seem to provide a safe space for the practice of emotion regulation strategies" (Daudén Roquet et al., 2023, p. 285).

The Expressive Therapies Continuum as a system takes into account the fluidity between the levels and their components as it "attempts to explain the healing dimensions of various expressive experiences and the restorative power of creativity" (Hinz, 2015, p. 44). The concept of "Continuum" is at the core of the ExAT. The ETC as a system is in no way rigid and the three ETC levels and their components are not separate from each other. Lusebrink (1991) stated "This continuum is interactive(...), whereby one level embodies aspects of the other levels" (p. 395). The choice of coloring for self-care in this intervention illustrates the continuum between Kinesthetic, aka movement, and Affect, identification of emotions. Hinz (2015) reported that " Recent neurological research has shown that motor and affective aspects accompanying the acts of drawing or sculpting can produce a state of relaxation" (p. 44).

For the intervention, the therapist will provide art materials such as mandala, coloring pages with mandalas or other patterns that can be completed in a short time; big and small white and black mixed-media paper for free drawing; crayons, and oil pastels. Headphones will be available either for sound canceling, or with recordings of short gratitude and loving-kindness meditations, nature sounds, and instrumental pieces.

Between interventions, the therapist will install a large coloring poster on the wall and provide coloring markers for any oncology care professional and staff members to color when they need a quick moment of pause, and mindfulness. Kaimal et al. (2019)

observed that coloring had positive results on the participants' mental health whether a therapist was present or not during the session (2019).

The intervention will address individual needs for self-care, and the coloring poster available between sessions will contribute to building a sense of community. Even if the individuals' roles on the oncology floor are extremely different, they will have shared an experience, and that can provide a topic of conversation, a sense of commonality between the individual, and a new way to relate to each other.

Grief and Loss Processing with Collage (P/A level of ETC)

In spite of the efforts in cancer treatment research, and of the new treatments that exist today, cancer remains deadly in too many cases, whether after years of treatment or within weeks of a diagnosis. One definition of grief given by Hayuny et al. (2019) is "grief is psychological distress associated with loss" (2019, p. 2344). In their study, they specify that oncologists "experience behavioral, cognitive, physical, and emotional grief" (2019, p. 2344). After the loss of a patient, oncologists may feel responsible for their death to an extent. Their grief has "unique features, such as feelings of self-doubt, guilt, failure and helplessness" (2019, p. 2344). Other oncology personnel and hospital staff experience loss and grief as well as they often interact the most with the patients, administering their treatments, ensuring their physical comfort, adjusting their pain medication, supporting them and their family members and non-professional caregivers during this extremely difficult time. There is little time on an oncology floor for self-awareness, for observing and processing one's emotions, and for distancing oneself from the busyness and intensity of oncology care. Offering expressive arts therapeutic exercising on the Perceptual/Affective level of the ETC may help develop self-awareness through recognizing emotions. It may also strengthen the ability to identify patterns and

structures, provide a sense of order in what may seem like chaos at times, and contribute to a sense of self-agency and self-determination for the care team members (Hinz, 2009, pp. 79-120). Collage is a common practice in expressive arts therapy. The abstract nature of this activity provides some distance from the present. It offers an opportunity to organize pictures cut out of magazines for instance, following one's intuition, without having to follow any rules. There is no wrong way of practincing collage and nothing at stake. One is free to just be engrossed in the moment. In their article on creativity and self-care for caregivers, Murrant et al. (2000) conducted workshops with different types of interventions. One of them was based on art therapy. Murrant analyzed the benefits of therapeutic art making, and and wrote that "By externalizing an experience in a concrete pictorial form, artwork can act as a vehicle for verbalizing the experience by expressing the significance of color, symbols, and recurring themes" (Murrant et al., 2000, p. 46). A collage's perceptual and affective components offer a gateway to the Cognitive/Symbolic level of the ETC as the client can freely make cognitive and/or symbolic associations based on their artwork. Hinz (2015) explained that "What can emerge from work on the Perceptual/Affective level is clarity of thought about emotions, symbol formation, greater self-awareness, and empathetic self-understanding" (p. 45).

For the intervention, the therapist will provide art materials such as images and photos cut out from a large variety of magazines; white mixed-media paper of various sizes; glue sticks, scotch tape, staplers, and scissors. Headphones will be available either for sound canceling, nature sounds, or instrumental pieces to provide a sense of being removed from the workspace. Participants will be allowed to collage freely. If some would like more guidance, they will be able to choose to represent an emotion of their choice, from a list provided, or at random from a box filled with small pieces of paper

with an emotion written on each one. Some participants may be more or less familiar with collage, or more or less comfortable with being vulnerable by deciding on an emotion themselves.

Between interventions, the therapist will install a Lego platform. Its size will depend on the space available. There will be a container of Lego pieces and people available. All care team members will be invited to add a piece anytime in between sessions. Creating a collaborative sculpture provides micro moments of pause on an individual level. It is also a visual reminder that each individual makes a difference in adding their Lego piece while contributing to the construction of something new. The sculpture may be whimsical, abstract and provide some "comic relief", and help preven members from feeling overwhelmed. Each piece added makes the invisible, visible. It becomes a symbol of the interconnectedness between all medical and non-medical personnel, of the unit they form as each individual contributes to the whole.

Vicarious Resilience with Word Play (C/Sy level of ETC)

Meaning making is a key factor in vicarious resilience. On the ETC, activities on the C/Sy level hone one's capacity to own one's narrative:

> The healing dimension of the cognitive component enhances the generalization of concepts and personal experiences and promotes insight. In addition, this dimension of the symbolic component promotes resolution of symbols through the discovery of personal meaning. (Lusebrink, 1992, pp. 401-402)

The therapeutic use of writing is at the center of a sub-type of narrative therapy that Dr Rita Charon and Dr Miriam Divinsky called narrative medicine, "We have come to realize that narrative writing in clinical settings makes audible and visible that which otherwise would pass without notice " (Charon, 2007, p. 1266). The process of writing is

transformative in itself, regardless of the end product. Saint-Louis & Bourjolly conducted a study using narrative medicine with oncology care team members "as a means of coping with combined effects of work-related stress and grief on these health care providers" (Saint-Louis & Bourjolly, 2018, p. 639). In their study, participants met weekly over a four-month period, wrote, and shared their stories. This type of specialized narrative medicine is known as narrative oncology "Saint-Louis & Bourjolly, 2018, p. 639). At the end of their study, participants described the effects of their interventions on their overall wellbeing of their interventions during post-intervention interviews. The positive impacts of narrative oncology confirm the therapeutic benefits of writing as a practice of ExAT. In their conclusion, the authors stated that the participants "may find through writing and sharing with colleagues that they not only survive the rigors of their work but also that they find hope, meaning, and healing" (Saint-Louis & Bourjolly, 2018, p. 652). However, writing may be a daunting and time-consuming task. Some alternative ways of practicing writing may seem simpler and provide activities that do not necessitate as much vulnerability. Cappacchione wrote a whole book on the therapeutic practice of writing with the non-dominant hand, stating:

> My research shows that regardless of whether you are right- or left-handed, writing done with the non-dominant hand accesses feelings more directly and channels inner wisdom with qualities which have been ascribed to the right brain: spontaneity, emotional expressiveness, and creativity" (Capacchione, 2019).

The practice of Blackout Poetry is a therapeutic practice that offers another way of making meaning. The individual creates a poem made of random words that they have circled the page of a book. They cover the rest of the text in black and read the poem they

have invented. It is a quick and easy way to access one's creativity, and to practice introspection as one finds meaning in their poem as "they embark on an intimate journey of self-discovery. They find solace and embrace the beauty of simplicity" (Goodwin, n.d.).

For the intervention, the therapist wil provide art materials such as paper of various sizes; colored and black pens; prompts; pages from discarded novels, and thick black markers. Headphones will be available either for sound canceling, nature sounds, or instrumental pieces to provide a sense of being removed from the workspace. Participants can write or create blackout poetry freely. Participants will be able to opt for including their creative pieces in a portfolio available for consultation between sessions.

Between interventions, the therapist will place a magnetic board with magnetic tiles with words in the room. All care team members will be invited to create short phrases anytime in between sessions creating a composite, whimsical poem. Its purpose is to keep connectedness and a sense of community between the sessions.

Figure 5

Autoethnographic journal, pp.13-15.

Discussion

"We are not broken. We are human" (Nissim et al., 2019, pp. 33-36)

Adding expressive arts therapy to explore moral distress and ways to prevent it could expand research, broaden self-care practices, and consequently improve patient care in professional oncology care teams. Burnout is increasingly recognized as a serious problem among oncology medical personnel. The various studies and interventions indicate that expressive arts therapy can help to alleviate negative effects on the care team members' health and on the quality of the patient care they provide. However, it remains to be established how best to use art therapy and what aspects of mental health it most affects.

During my research for this capstone, I have compiled specific information about and expended my knowledge of oncology professions, and their work environment. Based on my findings, I have developed customized expressive arts therapy interventions.

Expressive arts therapy and its intermodality offer a very malleable and adaptable therapeutic approach. I believe in and have witnessed the power of expressive arts in that milieu. I have obtained evidence-based data through my research in order to promote and advocate for more expressive arts therapy interventions for oncology care professionals as well as staff members, and to convince hospital systems to make that not only a priority, but an integral part of their organizations.

Figure 5

Autoethnographic journal, pp.16-18.

Directions for Future Research

More research in areas such as the use of ExAT with oncology care teams to increase DEI; whether and if so, how gender, age, years of practice impact the benefits of ExAT in that population; and what ExAT session format(s) are more adapted, accessible, and beneficial on hospital oncology floors.

Final Reflection

I believe further research and endeavors to study and improve the mental health and well-being of hospital medical professionals and staff in general, and on oncology floors in particular would benefit the healthcare system at large, reducing absenteeism due to burnout, improving care, and strengthening interpersonal and hierarchical relations.

Figure 6

Autoethnographic journal, p. 16.

References

Alwhaibi, A., Alenazi, M., Almadi, B., Aljabali, N., Alkhalifah, S., Syed, W., & Al-Arifi, M. N. (2023). The impact of cancer relapse and poor patient outcomes on health care providers practicing in the oncology field. *Cancer Control*, *30*, 10732748231170930. https://journals.sagepub.com/doi/pdf/10.1177/10732748231170930

Braun, M., Naor, L., Hasson-Ohayon, I., & Goldzweig, G. (2022). Oncologists' locus of control, compassion fatigue, compassion satisfaction, and the mediating role of helplessness. *Current Oncology*, *29*(3), 1634-1644. doi: 10.3390/curroncol29030137

Capacchione, L. (1988). *The Power of the Other Hand*. North Hollywood, CA: Newcastle.

Capacchione, L. (2019). *Jounaling for inner guidance: The wisdom of the other hand* [Speech audio recording]. Medium.com https://medium.com/@luciaccapa/journaling-for-inner-guidance-the-wisdom-of-your-other-hand-c18e8394ea16

Charon, R. (2007). What to do with stories: the sciences of narrative medicine. *Canadian Family Physician*, 53(8), 1265-1267.

Chilton, G., & Scotti, V. (2014). Snipping, gluing, writing: The properties of collage as an arts-based research practice in art therapy. *Art Therapy*, 31(4), 163-171.

Chary, A. N., Molina, M. F., Dadabhoy, F. Z., & Manchanda, E. C. (2021). Addressing racism in medicine through a resident-led health equity retreat. *Western Journal of Emergency Medicine*, 22(1), 41. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7806337/

Daudén Roquet, C., Sas, C., & Potts, D. (2023). Exploring anima: A brain–computer interface for peripheral materialization of mindfulness states during mandala coloring. *Human–Computer Interaction*, 38(5-6), 259-299. https://www.tandfonline.com/doi/full/10.1080/07370024.2021.1968864

Deci, E. L., & Ryan, R. M. (2012). Self-determination theory. *Handbook of theories of social psychology*, 1(20), 416-436.

Estrella, K. (2019). Expressive arts therapy: An integrated arts approach. *Handbook of expressive arts therapy. Guilford Press. Manuscript in preparation.*

Ferro, M. J. (2022). Connecting within: Digital collage as art-based research to process a pandemic. *Journal of Applied Arts & Health*, 13(1), 11-26.

Frankl, V. E. (1985). *Man's search for meaning*. Simon and Schuster.

Gieseler, F., Gaertner, L., Thaden, E., & Theobald, W. (2018). Cancer diagnosis: A trauma for patients and doctors alike. *The oncologist*, 23(7), 752-754. https://www.sciencedirect.com/science/article/abs/pii/S2468749920300181

Goldberg, E. (2020). For doctors of color, microaggressions are all too familiar. *The New York Times.* https://www.nytimes.com/2020/08/11/health/microaggression-medicine-doctors.html

Goodwin A. (n.d.). *UnveilingcCreativity: The Art of Blackout Poetry*. Wondershare. https://pdf.wondershare.com/protect-pdf/black-out-poetry.html,

HaGani, N., Yagil, D., & Cohen, M. (2022). Burnout among oncologists and oncology nurses: A systematic review and meta-analysis. *Health Psychology*, 41(1), 53. https://web.p.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=0&sid=57fc448a-c4f4-4b43-b5b9-a7f6991e1a79%40redis

Hayuni, G., Hasson-Ohayon, I., Goldzweig, G., Bar Sela, G., & Braun, M. (2019). Between empathy and grief: The mediating effect of compassion fatigue among oncologists. *Psycho-oncology*, 28(12), 2344-2350.

Hernández, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family process*, 46(2), 229-241. https://web-p-ebscohost-com.ezproxyles.flo.org/ehost/pdfviewer/pdfviewer?vid=3&sid=5ce48ea1-cb2d-4e1f-b611-5c7f59f6ae18%40redis

Hinz, L. D. (2009). Order out of chaos: The expressive therapies continuum as a framework for art therapy interventions in substance abuse treatment. *The use of creative therapies with chemical dependency issues, 51-68*.

Hinz, L. D. (2015). Expressive therapies continuum: Use and value demonstrated with case study (Le continuum des thérapies par l'expression: étude de cas démontrant leur utilité et valeur). *Canadian Art Therapy Association Journal*, 28(1-2), 43-50. https://www-tandfonline-com.ezproxyles.flo.org/doi/full/10.1080/08322473.2015.1100581

Hinz, L. D. (2019). *Expressive therapies continuum: A framework for using art in therapy*. Routledge.

Hlubocky, F. J., Back, A. L., Shanafelt, T. D., Gallagher, C. M., Burke, J. M., Kamal, A. H., ... & Srivastava, P. (2021). Occupational and personal consequences of the COVID-19 pandemic on US oncologist burnout and well-being: a study from the ASCO clinician well-being Task force. *JCO Oncology Practice*, 17(7), e427-e438. https://ascopubs.org/doi/pdfdirect/10.1200/OP.21.00147

Kaimal, G., Carroll-Haskins, K., Mensinger, J. L., Dieterich-Hartwell, R. M., Manders, E., & Levin, W. P. (2019). Outcomes of art therapy and coloring for professional and informal caregivers of patients in a radiation oncology unit: A mixed methods pilot study. *European Journal of Oncology Nursing*, 42, 153-161.https://www.ejoncologynursing.com/article/S1462-3889(19)30115-2/fulltext

Karabuga Yakar, H., Yılmaz, B., Çelik, E., Özkol, O., Gevher, F., Oruc, Ö., & Şen, H. (2023). The effect of the meditation based mandala programme on distress, anxiety and depression in the caregivers of cancer patients in palliative care unit. *OMEGA-Journal of Death and Dying*, 00302228231181936.

Kirschenbaum H. (n.d.). *Carl Rogers and the person-centered approach*. Psychotherapy. https://www-psychotherapy-net.ezproxyles.flo.org/stream/lesley/video?vid=274

Knill, P. J. (1978). *Intermodal learning in education and therapy*. Cambridge, Mass.

Knill, P. J. (1994). Multiplicity as a tradition: Theories for interdisciplinary arts therapies: An overview. *The Arts in Psychotherapy.*

.Knill, P. J., Levine, E. G., & Levine, S. K. (2005). *Principles and practice of expressive arts therapy: Toward a therapeutic aesthetics*. Jessica Kingsley Publishers.

Kirschenbaum H. (n.d.). *Carl Rogers and the person-centered approach.* Psychotherapy.net https://www-psychotherapy-net.ezproxyles.flo.org/stream/lesley/video?vid=274

Levine, E. G., & Levine, S. K. (Eds.). (1998). *Foundations of expressive arts therapy: Theoretical and clinical perspectives*. Jessica Kingsley Publishers.

Lim, K. H. J., Murali, K., Thorne, E., Punie, K., Kamposioras, K., Oing, C., ... & Banerjee, S. (2022). The impact of COVID-19 on oncology professionals—one year on: lessons learned from the ESMO Resilience Task Force survey series. *ESMO open*, 7(1), 100374. https://www.sciencedirect.com/science/article/pii/S2059702921003367

Litam, S. D. A., & Balkin, R. S. (2021). Moral injury in health-care workers during COVID-19 pandemic. *Traumatology*, 27(1), 14. https://psycnet.apa.org/record/2020-91612-001

Lusebrink, V. B. (1991). A systems oriented approach to the expressive therapies: The Expressive Therapies Continuum. *The Arts in Psychotherapy*. https://psycnet.apa.org/record/1992-24593-001

Lusebrink, V. B., Mārtinsone, K., & Dzilna-Šilova, I. (2013). The expressive therapies continuum (ETC): Interdisciplinary bases of the ETC. *International Journal of Art Therapy*, 18(2), 75-85.

Lusebrink, V. B., & Hinz, L. D. (2021). The expressive therapies continuum as a framework in the treatment of trauma. *Art therapy, trauma, and neuroscience* (pp. 42-66). Routledge.

Major, A., Recklitis, C. J., & Bober, S. (2021). Providing effective mental health support for oncology health-care workers in the COVID-19 era: Responding quickly but carefully. *JNCI cancer spectrum*, 5(3), pkab031. https://academic.oup.com/jncics/article/5/3/pkab031/6209079

Malchiodi, C. A. (2020). *Trauma and expressive arts therapy: Brain, body, and imagination in the healing process*. Guilford Publications.

McCracken, C. (2021). Moral distress: A qualitative study of experiences among oncology team members. *Number 4/August 2021*, 25(4), E35-E43 https://eds-s-ebscohost-com.ezproxyles.flo.org/eds/pdfviewer/pdfviewer?vid=1&sid=0fdb908a-2d2b-4ec0-b1ab-638ac3bf9f80%40redis

McNiff, S. (2009). *Integrating the arts in therapy: History, theory, and practice*. Charles C Thomas Publisher.

Murrant, G. M., Rykov, M., Amonite, D., & Loynd, M. (2000). Creativity and self-care for caregivers. *Journal of Palliative Care*, 16(2), 44-49. https://journals-sagepub-com.ezproxyles.flo.org/doi/pdf/10.1177/082585970001600208

Nissim, R., Malfitano, C., Coleman, M., Rodin, G., & Elliott, M. (2019). A qualitative study of a compassion, presence, and resilience training for oncology interprofessional teams. *Journal of Holistic Nursing*, 37(1), 30-44. https://journals.sagepub.com/doi/pdf/10.1177/0898010118765016

Ochsner Health (2020, October 9). *Day in the life with Terrence Murrill, floor technician* [Video]. YouTube. https://www.youtube.com/watch?v=WhtZL8-Cb9E

Owoyemi, O., & Aakhus, E. (2021). Underrepresentation in oncology: identifying and addressing structural barriers. *The Oncologist*, 26(8), 630-634.

Parekh, A. (2021). Exploring the therapeutic relationship as a central focus through expressive arts therapy in oncology. https://digitalcommons.lesley.edu/expressive_theses/396/

Phillips, C. S., Volker, D. L., Davidson, K. L., & Becker, H. (2020). Storytelling through music: A multidimensional expressive arts intervention to improve emotional well-being of oncology nurses. *JCO Oncology Practice*, 16(4), e405-e414. https://ascopubs.org/doi/full/10.1200/JOP.19.00748

Rogers, N. (1993). *The creative connection: Expressive arts as healing*. Science and Behavior Books.

Rogers, N. (1998). *The Creative Connection. Foundations of Expressive Arts Therapy: Theoretical and Clinical Perspectives*, 113-131.

Saint-Louis, N. M., & Bourjolly, J. N. (2018). Narrative intervention: Stories from the front lines of oncology health care. *Social Work in Health Care*, 57(8), 637-655.

Sallon, S., Katz-Eisner, D., Yaffe, H., & Bdolah-Abram, T. (2017). Caring for the caregivers: results of an extended, five-component stress-reduction intervention for hospital staff. *Behavioral Medicine*, 43(1), 47-60. https://www.tandfonline.com/doi/abs/10.1080/08964289.2015.1053426

Tjasink, M., & Soosaipillai, G. (2019). Art therapy to reduce burnout in oncology and palliative care doctors: a pilot study. *International Journal of Art Therapy*, 24(1), 12-20. https://www.tandfonline.com/doi/full/10.1080/17454832.2018.1490327?scroll=top&nAccess=true

Torres, K. A., Glaros, C., Henry, M., Reed, K., Moss, M., & Tietbohl, C. (2023). Creative arts intervention to reduce burnout and decrease psychological distress in healthcare professionals: A qualitative analysis. *The Arts in Psychotherapy*, 83, 102021.

Tsesmelis Piccolino, S. (2022). Vicarious resilience: traversing the path from client to clinician through a search for meaning. *Social Work in Health Care*, 61(6-8), 468-482. https://www.tandfonline.com/doi/epdf/10.1080/00981389.2022.2134274?needAccess=true

Uzar-Özçetin, Y. S., Sarıoğlu, G., & Dursun, S. I. (2019). Resilience, burnout, and psychological well-being levels of oncology nurses. *Psikiyatride Guncel Yaklasimlar,* 11, 147-164. https://www.proquest.com/docview/2347790476?pq-origsite=gscholar&fromopenview=true

Yi, J., Kim, M. A., Choi, K. H., & Bradbury, L. (2022). Oncologists' experience of delivering bad news in Korea. *OMEGA-Journal of Death and Dying*, 85(2), 285-302. https://journals.sagepub.com/doi/10.1177/0030222820944087

VandenBos, G. R. (2007). *APA dictionary of psychology*. American Psychological Association. https://dictionary.apa.org/resilience?_gl=1*1j333lg*_ga*MjA1NjQ5MTQ5LjE3

Zhang, M., Zhang, Y., & Kong, Y. (2019). Interaction between social pain and physical pain. *Brain Science Advances*, 5(4), 265-273. https://journals.sagepub.com/doi/epdf/10.26599/BSA.2019.9050023

Zinn, J. K. (2017). *Mindfulness for beginners*. Jaico Publishing House.

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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