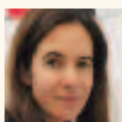
Single session art therapy for day patients receiving chemotherapy or radiotherapy — a service evaluation study



September 2019

Megan Tjasink, Art Psychotherapist, United Kingdom
David Little, Art Psychotherapist, United Kingdom

This service development initiative took place at a large London hospital which has a small yet established art therapy service serving a large population of cancer patients. Nurses on the chemotherapy day unit approached our psychological services team (made up of Art Psychotherapists and Clinical Psychologists) to ask whether there was anything we could offer on the day ward, outside of the usual process of key clinicians referring individual patients to the team.

Ward staff recognised the experience of waiting for and receiving chemotherapy on the extremely busy day unit could be stressful for patients, some of whom made their frustration known. Ward staff often felt too under-resourced to provide extra support for these patients. We decided to run an evaluation study to ascertain whether offering single session art therapy on the day unit was an effective way of supporting day patients (and our nursing colleagues on the day unit). About halfway through the evaluation it was decided to extend the study to include patients receiving radiotherapy.

Our psychological services team felt this type of supportive intervention was better suited to art therapy than clinical psychology in the first instance, as it is a model used by Art Psychotherapists within hospice and hospital settings. While art therapy at our hospital had a history of providing one-off sessions for inpatients and outpatients, this was a result of context and circumstance rather than a specific model introduced intentionally and to a specific patient group by the service. The service development initiative was therefore an opportunity to apply a single session model in a more systematic manner in order to develop our understanding of its effectiveness and efficiency with patients receiving treatment on day wards. We anticipated working with patients who were anxious and distressed but would not present with the element of "stuckness" or high levels of psychological need matching our team's usual referral criteria.

The majority of patients seen in this evaluation had no previous mental health issues and were struggling with understandable distress as a result of the life-changing impact of their cancer diagnoses and treatment. Two participants in the study who were assessed to have need beyond the single session were referred on for a block of therapy with a different Art Psychotherapist or Clinical Psychologist within the team. As well as making art therapy more accessible to day patients who would not otherwise be referred, we hoped that a more regular presence from our team would be experienced as supportive by over-burdened, stressed ward staff.

Brief Literature which informed our practice

Although previous studies have shown art therapy as helpful for day patients during their chemotherapy and radiotherapy treatment (Forzoni et al 2010, Öster et al 2014), very little has been written about single session art therapy with patients who have cancer or other life-limiting illness. Of eight papers that focus on or refer to the art therapy single session, three were quantitative studies (Nainis 2006, Rao 2009, Rhondali 2010) and five were more reflective, focussing on how the single session may be a good fit for a patient's need (Wood 1990 and 1998, Coote 1998, Tjasink, 2010) and the Art Psychotherapist's countertransference reactions (Wood 1998, Balloqui 2005).

In four of the articles (Balloqui, Coote, Tjasink 2010 and Wood 1998) the single sessions discussed were not intended as single sessions; rather, the first meeting (or assessment) turned out to be the only meeting, either due to the patient's deterioration or other circumstances, or because one session was all that was needed (Coote). All the articles point to benefits of the art therapy single session. Of the two studies that used the ESAS measure1, Nainis found reductions in eight of the nine symptoms, and Rhondali, in five of them (e.g. tiredness, anxiety); both found reductions in the ESAS Global Distress Scale. Tjasink found the patient's artwork made in a single session could act as an aid to communication with family members, allowing the patient to re-engage with his family support system. Tjasink also noted her patient showed sustained psychological wellbeing at 6 and 12-month follow-ups. Balloqui noted the single session's capacity to meet a patient's unconscious as well as conscious needs. For a dying patient, a single session was able to facilitate the transformative passage from one state of being to another (Wood 1998).

How we went about evaluating the service

The evaluation was planned and designed in consultation with the Lead Art Psychotherapist (first author) and clinical psychology colleagues within our team. Funding for an Honorary Art Psychotherapist (second author) to undertake the work was obtained from a hospital charity. The work was supervised by the Lead Art Psychotherapist and in consultation with clinical psychology colleagues. Informed consent was gained from participants.

Verbal feedback was collected through a short interview with a Clinical Psychologist or by completing a feedback questionnaire. Both the interview and questionnaire had the same seven questions, which were designed to investigate whether the patient: 1) Found talking with the Art Psychotherapist or the art making helpful, 2) Found that the session offered a new perspective, and 3) Would have accepted the offer of therapy without the art making, or the offer of art making without the therapy.

Our methodological approach to evaluating the data collected from the sessions was an Interpretative Phenomenological Analysis2. A primary aim was to ascertain what aspects of the intervention patients perceived as helpful. Data considered included patient artwork, feedback questionnaires, and the Art Psychotherapist's notes. We also considered quantitative data such as the number of referrals and proportion of introductory conversations that resulted in take-up.

Referral

Patients could be referred for the single session via their Clinical Nurse Specialist (CNS) or ward staff (nurse or radiographer), either via phone or email. Patients were able to self-refer after seeing a poster or leaflet publicising the evaluation. The Art Psychotherapist also introduced the opportunity to patients via a speculative conversation either on the wards or associated waiting areas.

The session

Once referred, the patient was invited to have an introductory conversation with the Art Psychotherapist followed by a single session of art therapy if both parties agreed it would be suitable. The session took place at the patient's chair side (chemotherapy day unit) or in a room off the ward (radiotherapy day unit). The Art Psychotherapist offered the same choice of three media for each patient: oil pastel, watercolour paint or iPad.

The Art Psychotherapist first reminded each patient this would be a single session and let the patient know what to expect from the session, explaining it would be divided loosely into four parts. First the patient could ask questions about the therapy and tell the Art Psychotherapist about their cancer diagnosis, treatment, and any issues these had provoked. The second section would be dedicated to art making, and as far as possible this would be without talking. The third part would include reflective discussion of the art making process and the content of the image. Finally, the Art Psychotherapist would bring the session to an end and offer the patient information about further available support, if this seemed necessary.

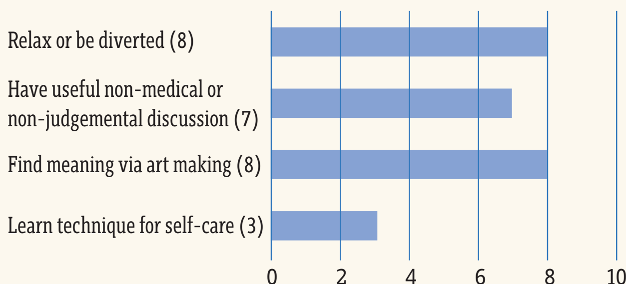
Results of the evaluation

The Art Psychotherapist had introductory conversations with 42 day patients receiving treatment. Of these 16 agreed to have the single session.

Interview/questionnaire – post-session

13 patients provided feedback (10 via questionnaire and 3 via interview). 12 patients found the session helpful, and one did not find it helpful. Analysis of the patients' comments suggests they welcomed opportunities for a) Diverting and relaxing activity, b) Non-judgmental discussion of cancer and the issues it raises, c) Making sense of conflicting feelings, often through art making, d) Learning about a therapeutic technique to aid self-care (see table below).

Feedback themes: how art therapy was helpful (total 13)



Themes

Significant themes were drawn from participants' oral and written feedback, as well as from the Art Psychotherapist's notes. A thematic analysis was also applied to patients' artwork.

Verbal content of sessions: Analysis of the Art Psychotherapist's notes suggests four areas of discussion that patients found helpful:

a) **Loss of control** Patients were uneasy about but resigned to submitting to the treatment regime. Many were anxious about the uncertainty of the future and having little control over it.

b) **Isolation and vulnerability** Patients said they had no one to speak to frankly about their emotions or other aspects of their situation. Patients felt vulnerable but were not normally able to express this.

c) **Difficulties managing relationships** Patients were anxious about increased dependence on others and loss of their normal role within the family, e.g., reduced ability to be a parent or breadwinner. Patients discussed difficulties communicating with family members, e.g., explaining the extent of their illness or fluctuating emotional needs. Some felt their artwork might be used to facilitate communication with others.

d) **Self-care** The experience of art psychotherapy prompted some patients to reflect on the value of setting aside time for themselves and engaging in activities they enjoy or find relaxing.

Art making aspect of sessions:

Analysis of the Art Psychotherapist's notes and interview/questionnaire feedback suggested the art making process was helpful in four ways:

a) **Art making in the medical context** Patients responded positively to the offer of a creative outlet. In a disempowering situation art making allowed patients to have agency and make choices.

b) **Engaging with the art materials** The art materials (e.g., boxes of coloured pastel crayons and blank sheets of white paper) provoked apprehension as well as delight. Such responses enabled helpful discussion about fearful feelings in general and how these might be managed.

c) **The art making process** For most participants initial anxiety about not being 'good at art' dissolved into absorption in the creative process. Patients commented on the cathartic value of focussing on their own emotional state, trusting that this was contained and validated by the therapeutic context. For some the physical use of the materials was an opportunity to express emotions normally deemed inadmissible, e.g., anger expressed by crushing crayons into the paper.

d) **Reflective discussion with Art Psychotherapist** Patients welcomed the chance to create and share personal narratives based on their finished artwork. Patients said talking about the artwork helped them have useful perspectives on their situation. While the Therapist's suggestions were often seen as helpful, patients were empowered by correcting the Therapist's imprecise interpretations.

Thematic analysis of patient artwork

9 participants chose to work with pastel, 4 with watercolour paints, and 2 with both pastel and watercolour. Only one participant chose to work with the iPad. Three striking qualities emerged in the participants' artwork: a) **Use of colour** 15 of 16 patients used a variety of bright colours, a much higher proportion compared to artwork made by patients accessing the regular art psychotherapy service, b) **Creation of narrative** Many participants used the art making to illustrate a personal situation or series of events in the past or imagined future, c) **Capacity to symbolize** The facility with which patients could give pictorial and abstract forms and marks symbolic meaning appeared to be instinctively available even within the brief timeframe of the single session, and even to those unfamiliar with art making or art materials. Sometimes the artwork contained a mixture of these three qualities, illustrated here in the examples of participants' artwork.

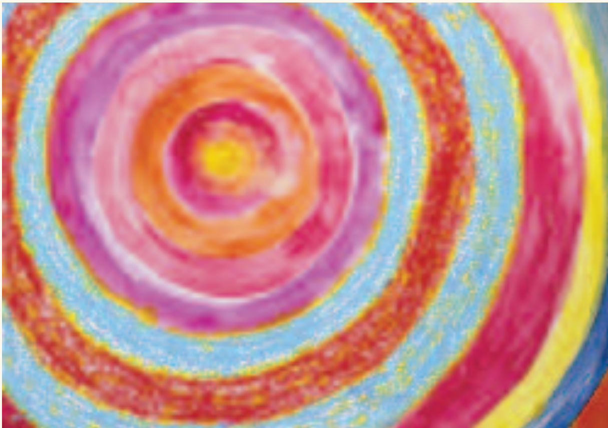


Figure 1. ***Use of colour / Capacity to symbolize***
The patient found the colouring-in of the concentric rings relaxing. She commented on the blue and red colours representing the hot and cold 'spots' on her body.

Figure 2. ***Creation of narrative / Capacity to symbolise***
The image enabled a rich conversation about the idea of a split, division or asymmetry. The patient said the two flowers might represent her difficult relationship with her sister, the contrast between her life before and after her cancer diagnosis, and the loss of her breast.

Figure 3. ***Capacity to symbolise***
What began as an apparently random collection of scribbled marks quickly acquired a symbolic dimension for this patient receiving chemotherapy treatment. She saw herself in the centre, fragmented but surrounded by the love of her family (white pastel area). She described the small blue mark on the edge of the paper as her cancer, pushed to the edge of what was important to her.

Figure 4. ***Use of colour/Creation of narrative/Capacity to symbolise***
The art making appeared to challenge the patient in terms of anxiety about the Art Psychotherapist's possible judgment and giving herself permission to do whatever she wanted to. She overcame this anxiety and reflected on the benefits of pleasing herself rather than others.

Discussion

Previous studies describe the single session's capacity to a) reduce and cope with symptoms associated with cancer and its treatment (Nainis 2016); b) meet a patient's needs at a particular time (Wood 1998); c) facilitate communication (Tjasink 2010); d) promote art making as an independent self-care technique (Rhondali 2010).

These findings are broadly consistent with our own. While we set out to assess the helpfulness of a single session rather than specifically measure symptom control, some patients in our study reported that art psychotherapy acted as a diversion from the anxiety provoked by long waits for treatment, and as a distraction from pain. Over a period of 7 months the Art Psychotherapist had introductory conversations with 42 day patients receiving treatment; the take-up rate was 38%. Reasons given for not taking up the session suggested some patients were apprehensive about the idea of therapy and were reluctant to enter an introspective state. The Art Psychotherapist wondered whether patients might have feared the single session would be exposing without the possibility of resolution in subsequent sessions. He also extrapolated from patients' responses that some may have felt the intervention did not correspond with their habitual means of coping with the experience of the day ward (such as talking to a friend, reading, doing crosswords etc.). It may be, as Balloqui, Coote and Wood suggest, that unconscious processes drive the patient's choice to decline or take up the offer of therapy and to use it in a specific way (Wood 1998).

Participants in our study were generally grateful for the offer of support, and for the chance to offload and share troubling thoughts. Some patients said the single session allowed them to make sense, often via the non-verbal medium, of confusing or conflicting thoughts and feelings. It seemed important that patients had in mind the brevity of the therapy, although rather than resulting in a tentative approach, this tended to stimulate an intense therapeutic encounter in which people unburdened themselves and engaged fully in the limited time they had. Our evaluation highlights participants' capacity to make therapeutic use of colour, symbolism and narrative in the art making even within this very short timeframe.

Institutional challenges and co-learning

The Art Psychotherapist, who was on a fractional, one-day-a-week contract, found the low rate of suitable referrals frustrating given that the request for support originally came from ward staff and given his sustained attempts to encourage referrals. As referrals were not forthcoming he resorted to speculatively approaching ward staff and patients. However, with the high turnover of ward staff and lack of dedicated contact staff members on the chemotherapy ward, the lack of uptake left him feeling despondent and isolated. While these feelings were useful to reflect on in supervision, and in relation to countertransference, it became clear this type of speculative approach was not an efficient use of resources. The Lead Art Psychotherapist therefore suggested broadening the evaluation to include an additional department – Radiotherapy Outpatients. The Art Psychotherapist's experience of this department was very different, with a significantly higher level of suitable referrals and two dedicated liaison staff members. Discussions with radiotherapy colleagues suggested the single session initiative could be developed through lunchtime training sessions and by identifying and supporting particular radiotherapy staff members who would become 'champions' of the art psychotherapy service.

Whilst this evaluation revealed some intrinsic difficulties in the establishment of psychological therapy in a busy, medically-orientated environment such as a chemotherapy day unit, it also highlighted the pivotal importance of establishing strategic relationships to allow effective co-working.

Staff feedback

With this in mind, it was important to gather feedback from participating clinicians. Their feedback identified a number of operational hurdles:

a) Time constraints at pre-treatment meetings only allow for the most urgent diagnosis and treatment issues to be addressed. CNSs in some specialities are under-resourced and describe their role as 'fire-fighting'.
b) Chemotherapy ward nurses have little time to get to know their patients or to make referrals. It was suggested some might struggle to confidently make referrals due to a lack of relevant training and knowledge.
c) The lack of an existing protocol for this type of intervention on the day ward meant that it became an "extra thing" to hold in mind within an existing and very full routine. This felt an additional burden to staff even though they had requested the resource. The lack of an existing mandate and the lack of resources had significant operational impact.

Some would argue that working to support staff is as important as directly supporting the patients (Tjasink and Soosaipillai 2018). It is recognised within our team that staff tend to feel supported when they know someone is looking after their patients' psychological needs. This evaluation is part of an on-going responsive and adaptive approach to the shifting needs of both patients and staff, being as effective as we can with limited resources.

In conclusion

Our evaluation suggests a single art therapy session on two busy cancer day units provided patients with an opportunity to address their concerns both through talking with the Art Psychotherapist and via the experience of art making.

The written and verbal feedback from the art therapy single session suggest patients welcomed an opportunity to be distracted from physical discomfort and diverted from the anxiety provoked by long waits for treatment. They valued being able to discuss aspects of their illness in a non-medical framework and to make sense, often via the non-verbal medium, of confusing or conflicting thoughts and feelings. They also appreciated discovering the therapeutic benefit of art making, which they felt was a new resource they could use at home.

Our evaluation was limited due to context and resource, and further research into the benefits of the art psychotherapy single session is indicated. The success of future research in this area requires co-operation with clinicians and managers who may not yet be familiar with art psychotherapy in particular and psychological need and support in general.

Understaffing, high turnover, and increased busyness on day units impacts on nurses' capacity to embrace new projects and invest in aspects of patient care seen as non-essential. This can also lead to ambivalence that needs to be negotiated sensitively by the Art Psychotherapist. There may be mixed feelings about treatments seen as "nice" or "non-essential". There may be envy – towards patients receiving something nice and / or to the therapist whose role might be seen as more attractive. An Art Psychotherapist may be seen as offering something inappropriate, e.g., 'art' may seem irrelevant to some in this context. Alternatively a psychological therapist may be seen as raising issues – such as dying and death – that some patients and staff would understandably wish to avoid.

Notes

1. The Edmonton Symptom Assessment System. This tool is designed to assist in the assessment of nine symptoms common in cancer patients: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing and shortness of breath. See http://www.npcrc.org/files/news/edmonton_symptom_assessment_scale.pdf

2. See https://en.wikipedia.org/wiki/Interpretative_phenomenological_analysis

References

Balloqui, J., 2005. The Efficacy of a Single Session. In Waller, D. and Sibbett, C. (eds.) *Art Therapy and Cancer Care*. Maidenhead: Open University Press

Coote, J., 1998. Getting started: Introducing the art therapy service and the individual's first experiences. In Pratt, M. and Wood, M. (eds.) *Art Therapy in Palliative Care: The Creative Response*, London: Routledge, pp.53-63.

Hardy, D.C., 2013. Working with loss: An examination of how language can be used to address the issue of loss in art therapy. *International Journal of Art Therapy*, 18(1), pp.29-37

Forzoni, S., Perez, M., Martignetti, A. and Crispino, S., 2010. Art therapy with cancer patients during chemotherapy sessions: An analysis of the patients' perception of helpfulness. *Palliative & Supportive Care*, 8(1), pp.41-48

Nainis, N., Paice, J.A., Ratner, J., Wirth, J.H., Lai, J. and Shott, S., 2006. Relieving symptoms in cancer: innovative use of art therapy. *Journal of pain and symptom management*, 31(2), pp.162-169

Öster, I., Tavelin, B., Thyme, K.E., Magnusson, E., Isaksson, U., Lindh, J. and Åström, S., 2014. Art therapy during radiotherapy – A five-year follow-up study with women diagnosed with breast cancer. *The Arts in Psychotherapy*, 41(1), pp.36-40

Rao, D., Nainis, N., Williams, L., Langner, D., Eisin, A. and Paice, J., 2009. Art therapy for relief of symptoms associated with HIV/AIDS. *AIDS Care*, 21(1), pp.64-69

Rhondali, W. and Filbet, M., 2010. Art therapy effectiveness on pain and other symptoms for palliative care inpatients: A Pilot Qualitative Study. *Psycho-Oncology*, 19, p.s52, pp1–29

Tjasink, M., 2010. Art psychotherapy in medical oncology: A search for meaning. *International Journal of Art Therapy*. 15(2), pp. 75-83

Tjasink, M. and Soosaipillai, G., 2018. Art therapy to reduce burnout in oncology and palliative care doctors: a pilot study. *International Journal of Art Therapy*, DOI: 10.1080/17454832.2018.1490327

Wood, M.J.M., 1990. Art therapy in one session: Working with people with AIDS. *Inscape: the Journal of the British Association of Art Therapists*, pp.27-33

Wood, M.J.M., 1998. The body as art: Individual session with a man with AIDS. In Pratt, M. and Wood, M. (eds.) *Art Therapy in Palliative Care: The Creative Response*, London: Routledge pp.140-152