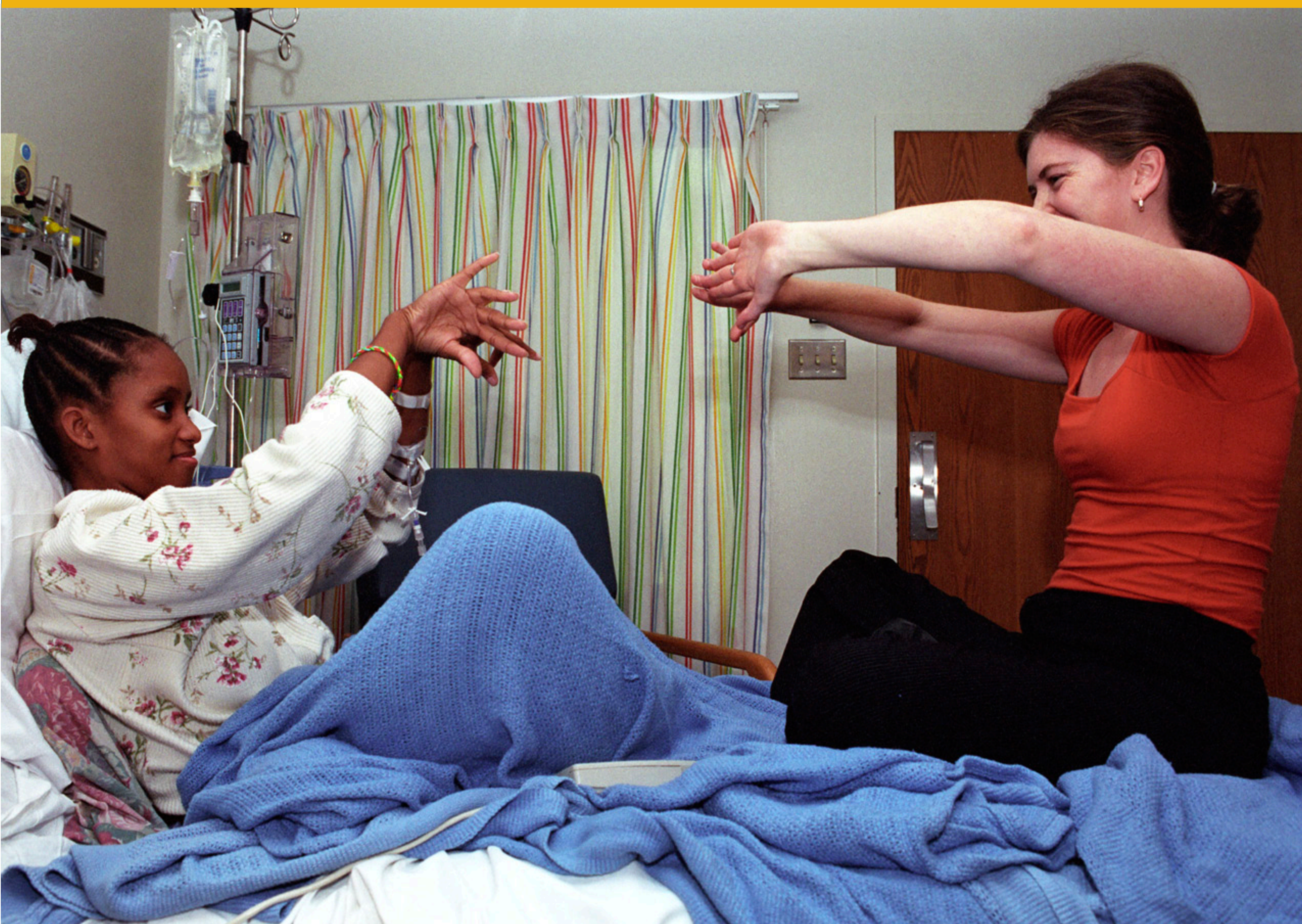
From Artist to Artist-in-Residence

Preparing Artists to Work in Pediatric Healthcare Settings

Second Edition

Rollins & Mahan



From Artist to Artist-in-Residence

Preparing Artists to Work in Pediatric Healthcare Settings

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Studio G

In 1993, a grant from the Catherine Filene Shouse Foundation launched a unique multicultural artists-in-residence program—Studio G. The program helps children and their families cope with the stresses related to illness and hospitalization by using the arts. Studio G brings a full range of professional artists—poets, dancers, musicians, visual artists, puppeteers, storytellers—to provide a full palette of expressive activities to children hospitalized at Georgetown. Children unable to join in the group activities are visited in their rooms.

Because of the program's unique training and internship components, Studio G has captured national and even international recognition as a model program. Since 1993, Studio G has received financial support from other private foundations, individuals, and the Faculty and Staff of the Department of Pediatrics at Georgetown.

Georgetown University Hospital

Georgetown University Hospital was founded in 1898 to promote health through education, research, and patient care. This mission has been shaped by and reflects Georgetown's Catholic, Jesuit identity and heritage. With a 609-licensed bed hospital and 1,100 physicians, Georgetown University Hospital's clinical services represent one of the largest healthcare delivery networks in the area.

Georgetown Pediatrics is a 'Hospital for Children' within the Hospital. Georgetown Pediatrics provides medical and surgical care to neonates, children, and adolescents up to age 20 in the Neonatal ICU, General Pediatric Unit, and the Pediatric ICU and Pediatric Transplant Units.

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Preface

Children need their creative and constructive powers for their own benefit, for developing their own capacity and strengthening their own defenses. It is very important for children to meet daily with some facet of this growing capacity.

Bjornsdottir, 1980

Increasing numbers of hospitals are opening their doors to artists. Although artists usually can be "turned loose" with minimal preparation to work with hospitalized adults, the same does not hold true for artists working with children.

As was the initial book published in 1996, this updated edition of *From Artist to Artist-in-Residence: Preparing Artists to Work in Pediatric Healthcare Settings* (2nd ed.) is designed to help arts administrators and healthcare professionals plan, implement, and evaluate an artists-in-residence training program that prepares artists to work with children who are hospitalized. It details the four step process used to prepare professional artists—musicians, dancers, poets, storytellers, and a variety of visual artists—for employment in Studio G, a pediatric artists-in-residence program launched at Georgetown University Medical Center in Washington, DC, in 1993.

From a planning process through implementation and evaluation, each component of preparation thoughtfully incorporates a family-centered care approach (see "Key Elements of Family-Centered Care," p. 42). For example:

- A multidisciplinary team of healthcare professionals, parents, and children comprise the Studio G advisory board.
- Family members are always invited to participate in Studio G activities; some use the session as an opportunity to take a break.
- Studio G staff and activities reflect the range of cultural diversity of the pediatric population at Georgetown University Medical Center.
- Artists facilitate group activities as well as individual sessions to help families get to know each other and to encourage informal family-to-family support.

We have found that this family-centered approach provides a psychosocially sound arts program that best meets the needs of children in healthcare settings, their families, and the artists who serve them.

Introduction

Children are not simply "little adults." They are growing and changing almost by the minute. How they experience hospitalization is very different from how an adult experiences hospitalization, and the same child will experience hospitalization differently from one year—or even one week—to the next.

The fact that a child is not just a smaller version of an adult is but one reason that some sort of artist preparation is needed. Other reasons may focus on the concerns of hospital staff members, parents, and the artists themselves. Uppermost in the minds of physicians, nurses, child life specialists, and other hospital staff should be to "do no harm." Lacking preparation, artists with even the very best intentions run the risk of hurting children emotionally and perhaps even physically. Parents, as advocates for their children's safety, also share this concern. Having a formal selection, training, and supervisory process in place can ease these concerns.

Preparation also can quell many concerns that artists may have. Artists may have worked in a variety of other settings. Some may have taught art or music to children, and many of these skills transfer nicely to the hospital setting. However, most artists have not worked with children who are dying or children who are very sick. They are not accustomed to working with children hooked to the beeping machinery that people in healthcare settings take for granted. Knowing how to communicate with children and their parents and how to adapt activities to meet their special needs give artists the skills they need to become valued members of the healthcare team. Preparation also brings a level of comfort to the artists, and therefore helps them to derive more satisfaction from their work.

The aim of *From Artist to Artist-in-Residence: Preparing Artists to Work in Pediatric Healthcare Settings* is to create a common ground where artists and healthcare professionals can meet, learn from each other, and use that knowledge to best meet the needs of children who are hospitalized and their families. Throughout the preparation process, everyone will be learning from each other. This is a time

- to provide the basics for artists so that the hospital staff, parents, and the artists themselves will feel comfortable when they are working with children and families in pediatric healthcare settings;
- to help artists understand much of what hospitalization and illness can mean for children and their families;

- to learn what each artist brings—their talents, skills, and knowledge; and
- to provide guidance in integrating these gifts into meaningful experiences for children, their families, and the artist.

Learning is a process that occurs over time. *From Artist to Artist-in-Residence: Preparing Artists to Work in Pediatric Healthcare Settings* covers each of the four general steps in the preparation process:

Step 1 Artist selection—The personal characteristics, talents, knowledge, and skills to look for

Step 2 Training—An intense, two-day training to provide a foundation of knowledge, skill, and trust on which to build

Step 3 Internship—A minimum of three 3-hour sessions under the supervision of the Studio G coordinator and the Child Life coordinator

Step 4 Ongoing training and support—Formal and informal mechanisms to provide opportunities for problem solving, continued learning, mutual support, and growth

Each step is important and deserves great care. Using this four-step approach, we have found that the average artist feels very confident and capable working in a pediatric setting after about six months.

STEP 1
Artist Selection

Each step of preparation is important, but it is critical to spend adequate time on this first one. If you have not selected appropriate artists to begin with, no amount of training or supervision can make up the difference.

Criteria

What are the personal characteristics, talents, knowledge, and skills to look for? It is unrealistic to expect your artists to have all of the knowledge and skills needed to work effectively and safely with children; training is designed to help take care of that. However, you will be wise if every artist you choose possesses certain important qualities. We believe the following qualities are essential:

1. *A genuine interest in children, a caring attitude, and sensitivity to cultural and ethnic values.* Without an appreciation for the uniqueness of each child, the trust needed to establish a helpful and enjoyable relationship with children will be absent.

2. *Knowledge and experience in a chosen art form.* If the artists are confident in their ability to do what they do best, they can communicate that to children and help them be successful in what they are trying to accomplish. Although it is desirable that the artist has knowledge and experience in more than one art form or medium, sometimes it is fun for children and the artist to explore new possibilities together.

3. *A respect for the child's creative process and products.* Respect in the uniqueness of the individual includes respect for each individual's creative process and products of that process. Artists must want to facilitate rather than interfere with that process. In the absence of this quality, disastrous consequences can result.

4. *An appreciation and respect for the power of the arts and an understanding of personal limitations.* Art is a powerful communicator, one that carries both a tremendous potential and an equally great responsibility. An artist who lacks clinical training in art therapy, dance therapy, music therapy, poetry therapy, or any of the other expressive therapies can provide children with genuinely helpful and in many ways "therapeutic" art experiences. However, Rubin (1984)

cautions those without clinical training about using such experiences to delve deeply into understanding or remediation of internal psychologic problems.

5. *Flexibility.* Artists need to be able to adapt to a variety of children and situations that may change during the course of an activity with an individual child or group of children.

6. *A sense of humor.* Artists who can laugh at themselves and humorous situations convey a sense of warmth that facilitates trusting relationships with children.

7. *The ability to collaborate with others.* Helping children through hospitalization and illness is a team effort. If artists are to be considered members of the healthcare team, they need to be able to work effectively with hospital staff, volunteers, and family members for the most successful outcome.

8. *No health condition that could result in harm to the children or to the artist.* Hospitals require persons who will have regular contact with children to undergo a limited health screening, which typically includes a PPD test for tuberculosis and proof of either having had or immunization against certain childhood diseases such as measles, mumps, rubella, and chicken pox. On the other hand, artists with certain chronic health conditions need to be aware of the possibility that their health may be compromised by exposure to children with particular diseases or conditions. So far, we have been able to make the necessary adaptations for artists on our staff with chronic or disabling conditions.

Although not a requirement, experience working with children is something we like to see in our artists, and most artists interested in our program bring such experience. We consider it a real plus if they have worked with a variety of ages of children because our pediatric population spans the entire age range.

Although we emphasize qualities needed to work with children in pediatric healthcare settings, because of the family-centered nature of our program, artists work with adults as well. And so, we seek out artists who seem to be comfortable with people of all ages.

Finding Artists

For our pilot project in 1993 we used two artists—a musician/visual artist and a storyteller/visual artist—with whom we had worked on another project. During the second year, we left application forms (see page 4) in a few of the arts agencies in the community. We also placed an ad in a free newspaper listing (see box).

Artists Sought for Pediatric Program

Studio G, the pediatric artists-in-residence program at Georgetown University Hospital, is looking for artists who enjoy working with children and would like to expand their work to children in hospitals. Artists are sought in the following disciplines: visual arts, dance/movement, music, literature, poetry, and drama. Training and support are provided. The next two-day training will be held in mid-November. For an application or more information, contact Judy Rollins, Studio G Coordinator, at jar83@georgetown.edu.

Today, artists find us though contact information on our hospital's website (http://georgetownuniversityhospital.org/body.cfm?id=555966). We also receive phone calls or emails from artists who have heard about our program—usually from one of our artists or a parent—and would like more information.

Another recruitment avenue is open to us through membership in the international organization, Society for the Arts in Healthcare (see Appendix A). A benefit of membership is the ability to post job opportunities in the Society's e-newsletter and listserv.

At times we receive calls from people who are interested in the arts and working with children in hospitals, but who are not professional artists. We explain that we employ professional artists, but use others as volunteers to work with the artists. Volunteers are encouraged to complete the Studio G training. Most of our volunteers to date have been high school seniors with interest in the arts or expressive arts therapies. They use the experience to help them decide whether or not to pursue their interest as a career goal, so, in a way, we are giving a little something back to them for their volunteer efforts.

Application

Our "Call for Artists" doubles as our application form.

Call for Artists

- ❖ Do you enjoy working with children?
- ❖ Would you like to expand your work to children in hospitals?

We are looking for artists to become part of the Studio G artists-in-residence program in pediatrics at Georgetown University Hospital.

Studio G provides training and support for professional artists wishing to work with children in a hospital setting.

- ❖ Interested?

For more information or to submit an application, please email Judy Rollins, Studio G Coordinator, at jar83@georgetown.edu.

Name ____

Address ____

____

Phone ______________________ Email ______________________

Art discipline (Please check all that apply)

- ☐ Visual arts
- ☐ Dance/Movement
- ☐ Literature
- ☐ Multidisciplinary
- ☐ Music
- ☐ Theater

Education ____

____

Please briefly describe your experience using the arts with children. ______________

____

____

____

____

____

Please list a personal reference and a professional reference.

Personal ____________________Phone __________ Email ____________

Professional _________________Phone __________Email ____________

Interview

Interviews are scheduled with potential candidates. Artists are asked to bring portfolios or any other materials to familiarize us with their work. We (the Studio G coordinator and the Child Life coordinator) interview the candidates together. Interviews generally last about 45 minutes.

A little reluctance on the part of an artist to work in a pediatric setting may be good. We have found that reluctance usually indicates that an artist recognizes that this work is important and can be difficult. The two artists in our pilot program were hesitant at first; one had limited experience working with children and the other had never been around seriously ill or dying children. We assured them that training and ongoing support would address their concerns, and that we would provide them with whatever information or support they needed to feel confident. Today, both of these very effective artists will tell you that their work with the children at the hospital is probably the most satisfying and meaningful work they do. Our experienced artists-in-residence are now able to assist us in helping our newer artists understand that these unsettling feelings are quite natural.

After each interview we rate candidates in each area on a scale of 1 (low) to 5 (high) using the "Artist Interview" form. In the "Additional comments" section we include information such as, "Maybe a little too enthusiastic. Will this artist's manner overwhelm our children?" We then compare our ratings, reach agreement on appropriate candidates, and issue invitations to training.

Artist Interview

Name ____

Interest in children	1 2 3 4 5
Experience with children	1 2 3 4 5
Caring attitude	1 2 3 4 5
Sensitivity to cultural/ethnic values	1 2 3 4 5
Knowledge/experience in the primary art form	1 2 3 4 5
Knowledge/experience in secondary art forms	1 2 3 4 5
Respect for the child's creative process/products	1 2 3 4 5
Understanding/respect for the power of the arts	1 2 3 4 5
Understanding of personal limitations	1 2 3 4 5
Flexibility	1 2 3 4 5
Sense of humor	1 2 3 4 5
Ability to collaborate	1 2 3 4 5

Additional comments ____

____

____

____

____

____

____

____

STEP 2
Training

We provide an intense, two-day training to prepare our artists to begin work with children and families. The training offers artists an opportunity to learn more about what the work involves and whether or not it is the kind of work they would really like to do. Because the main source of support for the work we do is each other, some training sessions are designed to help all of us to get to know and trust one another.

Goal and Objectives

The goal of Studio G training is to prepare artists to provide safe, psychosocially sound, meaningful expressive activities with a multicultural emphasis for children who are hospitalized and their families. In developing and updating training content, we drew heavily from the following sources:

Arts Activities for Children at Bedside, by Judy Rollins, 2004, Washington, DC: WVSA arts connection.

Caring for Children and Families: Guidelines for Hospitals, by Beverly Johnson, Elizabeth Jeppson, and Lisa Redburn, 1992, Bethesda, MD: Association for the Care of Children's Health.

Meeting Children's Psychosocial Needs Across the Health-care Continuum, by Judy Rollins, Rosemary Bolig, and Carmel Mahan (Eds.), 2005, Austin, TX: ProEd, Inc.

Psychosocial Care of Children in Hospitals: A Clinical Practice Manual From the ACCH Chld Life Research Project, by Laura Gaynard, John Wolfer, Joy Goldberger, Richard Thompson, Lisa Redburn, and Lesley Laidley, 1990, Bethesda, MD: Association for the Care of Children's Health.

If you lack knowledge in children's healthcare and/or the use of the arts in healthcare settings, you will probably want to do more reading to supplement these resources. Good places to begin are the organizations listed in Appendix A.

Our artists work directly with children in the hospital and their families; therefore, certain expectations are essential. Following training, we want our artists to be able to meet the following six objectives:

1. To demonstrate understanding of

    - the special needs of children in hospitals
    - basic child growth and development
    - the unique role of families in healthcare settings, family dynamics, and the impact of hospitalization on the child's family

2. To communicate effectively with children and adults from diverse backgrounds and disciplines

3. To interact sensitively with the diverse ethnic and cultural populations served by the hospital

4. To facilitate group or individual art sessions that

    - are safe in materials and methods
    - include necessary adaptations to allow children with special needs to participate at whatever level they are able
    - stimulate children's interest, participation, and creativity

5. To collaborate effectively in an interdisciplinary setting

6. To begin to deal with the issues of death and dying

Methods and Materials

We use a variety of methods and materials including lectures, discussions, videos/DVDs, PowerPoints, and role playing. To make the sessions more meaningful and effective, we follow certain adult learning principles:

1. We are facilitators, not teachers. Our philosophy is that everyone has something to contribute and we are there to learn from each other.

2. We make sure to tell the artists the relevance or importance of each training component or activity.

3. We elicit examples from the artists and reflect on their experiences throughout the training.

4. We give the artists choices whenever possible, such as timing of sessions and breaks.

Agenda

We try to set our agenda to reflect a logical flow of topics, and alternate activities such as role playing and discussion with lectures and videos. Sometimes, however, we have to change the agenda to take advantage of a key individual's availability. For example, once the nurse who does the segment on "Infection Control" was only available during the first few hours of training. We had two choices: we could either do that segment ourselves or begin training with "Infection Control." We decided that the participants would likely gain more from listening to a specialist in infection control than from either of us on the topic, and therefore moved the segment to the top of the agenda. At the beginning of training, we explained the situation to the participants and they seemed to understand. Artists we choose for our program tend to be pretty flexible anyway.

Odds and Ends

Training usually involves Friday afternoon and evening, followed by all day Saturday, so that participants with other employment only have to take off one-half day of work. We also have considered using an entire weekend or two Saturdays in a row, but, to date, our trainees have preferred the current schedule. Once the time and place for training are determined, we email each artist directions to the training site, parking information, the agenda, and any additional information regarding costs they may incur. We ask them to wear comfortable clothing and, if they like, to bring a portfolio or anything else they may want to share with the group. This enables everyone to learn more about each artist's work and interests.

All training sessions are held in a fairly large conference room within the hospital. Most training activities take place with participants sitting around a conference table. We limit the number of participants to 12, and do so for a couple of reasons. First, the conference room is large, but not huge, and some of the activities require a good bit of table or moving-around space. Second, a small group allows more interaction and participation among participants to facilitate getting to know and trust one another.

The Saturday morning session begins in the conference room with coffee and doughnuts or bagels. We serve other refreshments in the conference room during breaks, but move to the cafeteria for lunch. At this point, a change in space is welcomed and helps orient the artists to the hospital. Although we provide all of the food and beverages served in the conference room, artists are expected to pay for lunch.

At some point during training, we schedule a time for the new artists and Studio G veteran artists to meet. Usually this informal gathering takes place over dinner on Friday evening. We provide the main course, typically something simple like chili in the cooler months or salads during warmer months, and our veteran artists each bring a dish or two. This casual potluck approach is very welcoming, and new artists see early on the incredible spirit and commitment everyone shares.

We have a few handouts that we distribute to the artists upon arrival to give them something to review until everyone arrives. Other handouts are distributed as each training component is discussed. We use different colors of paper to make it easier for everyone to identify which handout we are discussing; by the end of the day artists have a rainbow of color spread before them.

Training Components

I. Artist Pre-training Questionnaire 12

II. Introductions 14

III. Children's Hospitalization 18

IV. Children's Perceptions of Illness and Hospitalization and Meeting Their Psychosocial/Developmental Needs 23

V. Using the Arts to Meet Psychosocial and Developmental Needs of Children in Hospitals 28

VI. Psychosocial Assessment 34

VII. Family Needs of Children Who are Hospitalized 40

VIII. Tour of Pediatric Units 44

IX. Communicating with Children in Hospitals and Their Families 45

X. Relationships with Children and Families 49

XI. The Artist's Routine 55

XII. Safety Considerations 60

XIII. Infection Control 65

XIV. Cultural Issues 68

XV. Death and Dying 77

XVI. Stimulating Creativity 81

XVII. Art Activity/Adaptations 85

XVIII. Review of Internship: The Next Step 87

XIX. Summary/Questions and Answers 88

XX. Evaluation 89

I. Artist Pre-Training Questionnaire

Objectives

- To help artists assess their strengths and needs
- To help trainers adapt training to meet artists' needs
- To provide a baseline for program evaluation

Time

10 minutes

Materials

"Artist Pre-Training Questionnaire"

Procedure

1. Greet artists as they gather at the training site.

2. Explain that you will begin by asking them to complete a questionnaire:

   - Point out that you expect them as artists to bring to the program their expertise in their field. You don't expect them to know much about children and families in hospitals and that this training is designed to provide a starting point for that learning.
   - Acknowledge that some of them may have had experiences that provided opportunities for them to acquire some knowledge about these topics.
   - Highlight that the questionnaire provides an opportunity for them to assess their needs and to help you to tailor the training to meet them.
   - Explain that they will have an opportunity to reassess their knowledge by repeating the questionnaire in about a year. Point out that data from the questionnaires are used to evaluate the effectiveness of all of the artist preparation program components—training, internship, and ongoing learning and support.

2. Distribute the "Artist Pre-Training Questionnaire."

3. Collect completed questionnaires and review.

4. Provide each artist with a training folder that includes the items listed in Appendix B. Review the contents.

Studio G
Artist Pre-Training Questionnaire

Name ____ Date ____________________________

Please rate your current knowledge about the following topics using the scale below:
1 = I know nothing about the topic.
2 = I know a little bit about the topic.
3 = I probably know as much as the average person knows about the topic.
4 = I probably know more than the average person knows about the topic.
5 = I know a great deal about the topic.

1. The special needs of children in hospitals — 1 2 3 4 5
   Comments:

2. Child growth and development — 1 2 3 4 5
   Comments:

3. Communicating with children — 1 2 3 4 5
   Comments:

4. Hospitalization's impact on a child's family — 1 2 3 4 5
   Comments:

5. The role of families in hospitals — 1 2 3 4 5
   Comments:

6. Safety considerations when using the arts with children who are ill or disabled — 1 2 3 4 5
   Comments:

7. Grief issues for children and families — 1 2 3 4 5
   Comments:

8. The ways in which the arts meet the psychosocial needs of children who are hospitalized — 1 2 3 4 5
   Comments:

II. Introductions

Objectives

- To help everyone get acquainted
- To familiarize artists with major objectives of the training program
- To provide an overview of the training agenda

Time

45–60 minutes (depending upon number of artists)

Materials

Variety of colored 8 ½" X 11" paper
Colored markers
Handout: "Training Objectives"
Portfolios or other examples of artists' work

Procedure

1. Ask artists to choose a piece of colored paper, write their name on it using the markers, fold it into thirds to create name placards, and place placards before them on the table.

2. While they are working, pass out and review the handout "Training Objectives," emphasizing the following points:

   - Training is part of the process of becoming an artist-in-residence.
   - The role of the trainer is one of facilitator; much of what is learned throughout training will be from the rich experience each artist brings.

3. Review the agenda (see sample agenda), describing briefly the topics that will be covered in the training sessions.

4. Discuss details such as location of bathrooms, coffee, etc., and elicit questions.

5. Explain the importance of taking some time up front to get to know each other:

   - As members of a team, artists will be working together and with other members of the child's healthcare team; the trust needed in such relationships comes from knowing each other well.
   - Confidentiality is an important issue in healthcare settings. To encourage openness, we ask artists to hold confidential personal information participants might disclose during training.
   - Knowledge of other artists' talents and skills is helpful when planning joint

sessions. Our artists sometimes pair up on sessions; for example, the story-teller may tell a story to set the stage for particular activity a visual artist has planned.

6. Introduce yourself, setting the model for the kind of information you hope to elicit from the artists. For instance, you could begin by telling artists why you wanted to do this kind of work, how you got started, what other things you have done, information about your family—whatever feels right to you. Trainers who are artists may also want to share portfolio items of their work.

7. Go around the table until everyone has had an opportunity to introduce themselves. We like using a talking stick to facilitate the process; when the person whose turn it is has finished speaking, he or she passes the stick on to the next person.

8. If the group is fairly large, go around the table again, asking if anyone has anything else to add. Artists usually think of something else they would like to say about themselves after listening to the others. In a small group, these items usually come out in natural conversation during introductions.

Training Objectives

Objectives are designed to help artists

1. To demonstrate understanding of

   - the special needs of children in hospitals
   - basic child growth and development
   - the unique role of families in healthcare settings, family dynamics, and the impact of hospitalization on the child's family

2. To communicate effectively with children and adults from diverse backgrounds and disciplines

3. To interact sensitively with the diverse ethnic and cultural populations served by the hospital

4. To facilitate group or individual art sessions that

   - are safe in material and methods
   - include necessary adaptations to allow children with special needs to participate at whatever level they are able
   - stimulate children's interest, participation, and creativity

5. To collaborate effectively in an interdisciplinary setting

6. To begin to deal with the issues of death and dying

Studio G
Artist Training Agenda

Friday, September 6

12 noon–2:30	Artist Pre-Training Questionnaire Introductions Children's Hospitalization
2:30–2:45	BREAK
2:45–4:45	Children's Perceptions of Illness and Hospitalization and Meeting Their Psychosocial/Developmental Needs Using the Arts to Meet Psychosocial and Developmental Needs of Children in Hospitals Psychosocial Assessment
4:45–5	BREAK
5–6	Family Needs of Children Who are Hospitalized
6–6:30	Tour of Pediatric Units
7	DINNER with Current Studio G Artists

Saturday, September 7

9–10:30	Communicating with Children in Hospitals and Their Families Relationships with Children and Families
10:30–10:45	BREAK
10:45–12 noon	The Artist's Routine Safety Precautions Infection Control
12 noon–1	LUNCH
1–2:45	Cultural Issues Death and Dying
2:45–3	BREAK
3–4	Stimulating Creativity Art Activity/Adaptations
4–4:15	BREAK
4:15–5	Review of Internship: The Next Step Summary/Questions and Answers Evaluation

III. Children's Hospitalization

Objectives

- To present an historical perspective of children's hospitalization
- To familiarize artists with the nature of children's hospitalization today
- To provide an overview of common conditions found in the pediatric population in hospitals today

Time

35–45 minutes

Materials

Handouts: (1) Summary from "Care of Children and Adolescents in U.S. Hospitals" (Owens, Thompson, Elixhauser, & Ryan, 2003), which can be downloaded from the Agency for Healthcare Research and Quality website (http://www.ahrq.gov/data/hcup/factbk4/factbk4.htm); (2) "Common Conditions of Children Who Are Hospitalized;" (3) Your hospital's "Pediatric Bill of Rights" (If your hospital has not developed a pediatric bill of rights, the document developed by the Association of the Care of Children's Health may be downloaded from http://www.goodbeginnings-csmc.org/support/inhospital/PediatricBillRights.pdf

Procedure

1. Ask if anyone was hospitalized as a child, and if so, would they be willing to briefly discuss their hospitalization, why they were in, length, of stay, etc. Highlight the following points as they arise:

   - Unfamiliar environment
   - Separation from family and friends
   - Disruption of normal routine
   - Strangers, approximately 52 people in first 24 hours (Johnson, 1975)
   - Fears
   - Beliefs (did something wrong, being punished)
   - Misunderstandings of words, concepts, events (and perhaps afraid to ask for clarification)
   - Optional: Review Marberry's figures if included in artists' folders (see p. 104).

2. Distribute handout "Care of Children and Adolescents in U.S. Hospitals" and discuss the pediatric population in hospitals today:

   - Antibiotics and immunizations have meant fewer children hospitalized for

infectious diseases, yet the diagnosis remains in the top 10 for children of all ages who are hospitalized (Owens et al., 2003).

- Injuries, including medication poisonings, are among the top reasons for hospitalizations for 13- to 17- year olds.
- Children are sicker and have more complex medical needs than in past:
  - In 1973, only 5–10% of children in hospitals required intensive care (American Academy of Pediatrics, 1986). Today, over 25% of the 6.3 million children hospitalized in the U.S. are admitted to pediatric intensive care units (PICUs) (Board & Ryan-Wenger, 2002).
  - Many children who are hospitalized today are those saved through technology as babies.
- Children with special health care needs (CSHCN)—those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health care-related services of a type or amount beyond that required by children generally (McPherson et al, 1998)—have more than threefold excess rate of hospitalization compared to the general pediatric population (Newacheck et al., 1998).
- The average age of children hospitalized today is younger than in the past. Over half of the children in hospitals are under 5 years of age (National Association of Children's Hospitals and Related Institutions, n.d.).
- Children are hospitalized most frequently for respiratory, gastrointestinal, neonatal, neurological, or orthopedic conditions (National Association of Children's Hospitals and Related Institutions, 2007).
- Typically, children's hospital stays are 29% shorter than adult stays. The average length of stay for children is 3½ days (Elixhauser, Yu, Steiner, & Bierman, 2003; Owens et al., 2003).

3. Outline the history of humanizing hospitalization for children.

   - *Early 20th century*—Untreatable infection was the most common diagnosis for children in hospitals. Care included stringent aseptic conditions, isolation, and limited staff and parent contact.
   - *1940s*—Penicillin was developed and these practices were no longer needed except in unusual instances; however, the habits of the past continued.
   - *1950s*—Classic studies on separation anxiety by British researchers Robertson (1958) and Bowlby (1952) were the impetus for developing concern about children's emotional well-being in hospitals as a result of these practices. Other research followed that identified factors that could mediate the psychological effects of hospitalization; the three areas most frequently researched were (1) decreasing parental (maternal) separation, (2) providing preparation, and (3) the use of play and other psychotherapeutic

techniques. As many of these ideas became incorporated in some hospitals, a beneficial effect—the opportunity to use the stress inherent in healthcare as a positive, growth inducing experience—came into focus.

- *1965*—A group of concerned individuals from six hospitals organized the Association for the Care of Children in Hospitals, later called the Association for the Care of Children's Health (ACCH), to provide a forum for sharing experiences and common problems and to foster sound growth in children who must undergo hospitalization.
- *1970s*—Medical and technological advances brought about differences in children who are hospitalized. No longer was the pediatric population in hospitals only children hospitalized for treatment of acute or infectious conditions, elective surgeries, or because they were terminally ill with diseases such as cancer for which few treatments existed; these dramatic advances soon offered cure and treatment for diseases and conditions that were previously invariably fatal, but often require ongoing care and support from the healthcare system.
- *Late 70s and 80s*—Policy makers, healthcare professionals, and parents realized that a new approach was needed to provide care for these children with long term, special health needs. This new approach, called "family centered care," is now recognized in the U.S. as best practice for all children. (Explain that the concept of family centered care will be covered in detail later in training.)
- *1980s*—The Child Life movement experienced rapid growth. Supporting the philosophy of family-centered care and focusing on children's strengths, Child Life specialists promote optimum development of children and their families, strive to maintain normal living patterns, and help to minimize psychological trauma. Specifically, they (1) supervise therapeutic and diversional play; (2) prepare children for and assist children during medical tests and procedures through education, rehearsal, and coping skill development; and (3) support families during hospitalization or challenging events (Child Life Council, n.d.). For more information, see the Child Life Council contact details in Appendix A.

4. Discuss your hospital's provision for accommodations for parents to stay with their children and policies for presence during anesthesia induction, procedures, and recovery room.

6. Distribute the handouts "Common Conditions of Children Who Are Hospitalized" and "Pediatric Bill of Rights" for artists to review at their leisure.

7. Elicit and answer questions.

Common Conditions of Children Who Are Hospitalized

Acquired Immunodeficiency Syndrome (AIDS)—a collection of symptoms and infections resulting from the specific damage to the immune system caused by the human immunodeficiency virus (HIV). The late stage of the condition leaves individuals prone to opportunistic infections and tumors. Although treatments for AIDS and HIV exist to slow the virus' progression, there is no known cure. HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, preseminal fluid, and breast milk. This transmission can come in the form of anal, vaginal, or oral sex; blood transfusion; contaminated hypodermic needles; exchange between mother and baby during pregnancy, childbirth, or breastfeeding; or other exposure to one of the above bodily fluids. Early recognition and improved medical care have changed HIV disease from a rapidly fatal to a chronic, but terminal disease of childhood. The ultimate prognosis for perinatal HIV infection depends on the child's age at diagnosis and the types of secondary diseases. Children diagnosed with AIDS in early infancy are more likely to die at an earlier age.

Bronchial Asthma—a reversible obstructive process characterized by an increased responsiveness and inflammation of the airway. It is manifested by labored breathing, bilateral wheezing, prolonged expiration, and an irritative tight cough caused by a reduction in the diameter of the airway. The symptoms can vary from a mild cough to severe respiratory distress that may even be fatal. The outlook for children with asthma varies widely. Although many children lose their symptoms at puberty, research indicates that 3 in 4 children with moderate to severe asthma will still have breathing problems by the time they reach their mid-20s. Some children develop other forms of allergy in adulthood.

Cystic Fibrosis (CF)—a hereditary disease that mainly affects the lungs and digestive system, causing progressive disability and early death. Difficulty breathing and insufficient enzyme production in the pancreas are the most common symptoms. Thick mucous production as well as a less competent immune system results in frequent lung infections, which are treated, though not always cured, by oral and intravenous antibiotics and other medications. A multitude of other symptoms, including sinus infections, poor growth, diarrhea, and potential infertility (mostly in males) result from the effects of CF on other parts of the body. Often, symptoms of CF appear in infancy and childhood; these include meconium ileus, failure to thrive, and recurrent lung infections. Cystic fibrosis is one of the most common life-shortening, childhood-onset inherited diseases. In the United States, 1 in 3,900 children is born with CF. It is most common among Europeans and Ashkenazi Jews; one in 22 people of European descent carry one gene for CF, making it the most common genetic disease among such people. Individuals with cystic fibrosis can be diagnosed prior to birth by genetic testing or in early childhood by a sweat test. Newborn screening tests are increasingly common and effective. With many new treatments being introduced, the life expectancy of a person with CF is increasing; life expectancy is on average 37.5 years old. Ultimately, lung transplantation is often necessary as CF worsens.

Diabetes—a disease of metabolism characterized by a deficiency of the hormone insulin, resulting in a metabolic adjustment or physiologic change in almost all areas of the body. It is the most frequent childhood endocrine disorder, with the peak incidence reached during adolescence. The most common type in childhood is insulin-dependent (IDDM) or type I, which is treated by insulin replacement. However, insulin needs are affected by emotions, nutritional intake, activity, and other life events, such as illnesses and puberty. In recent years, due to the increase in obesity in children, diabetes type II, once almost exclusively an adult disease, is now being seen in childhood.

Hodgkin's Disease—a malignant disease that originates in the lymphoid system and primarily involves the lymph nodes. Although Hodgkin's disease is extremely rare before 5 years of age, there is a striking increase in children 15–19 years of age, when it occurs with almost the same frequency as leukemia. It predictably spreads from the lymph nodes to other sites, especially the spleen, liver, bone marrow, and lungs, although no tissue is exempt from involvement. Advances in diagnosis, staging, and treatment of Hodgkin's disease have helped to make this once uniformly fatal disease highly treatable with the potential for full recovery. The most serious consequence of curative therapy is the development of secondary cancer, especially leukemia and solid tumors.

Leukemia—a cancer of the blood or bone marrow characterized by an abnormal proliferation (production by multiplication) of blood cells, usually white blood cells (leukocytes). There are four major types of leukemia. The most common type in childhood is acute lymphocytic leukemia (ALL) cancer of the blood-forming tissues, which is the most common form of childhood cancer. It occurs more frequently in males than in females after age 1 year, and the peak onset is between 2 and 5 years. Immediate treatment is required in acute leukemias due to the rapid progression and accumulation of the malignant cells, which then spill over into the bloodstream and spread to other organs of the body. It is one of the forms of cancer that has demonstrated dramatic improvements in survival rates, in some major research centers exceeding 90% after 5 years.

Sickle Cell Disease (SCD)—a genetic condition observed primarily in Blacks, although infrequently affecting Whites, especially those of Mediterranean descent. Rigid sickle-shaped red blood cells entangle and enmesh with one another causing growth retardation, chronic anemia, delayed sexual maturation, and marked susceptibility to infection. The most acute symptoms occur during periods of sickle cell crises, which are usually precipitated by infection but can also be triggered by cold, high altitude, or emotional stress. The most common crisis is vaso-occlusive, which causes extreme pain in involved areas. The prognosis varies; the greatest risk is usually in children under 5 years, with most deaths caused by overwhelming infection. As children grow older, the crises usually become less severe and less frequent. However, death in early adulthood is not uncommon. Bone marrow transplantation offers the hope of a cure for some children, although the mortality related to the procedure is significant.

Diagnoses requiring solid organ transplantation—organ failure. Increasing success over the past two decades has established solid organ transplantation as an effective therapy for a variety of organ failures. Five year patient survival rates are more than 90% after kidney transplantation, more than 80% after liver transplantation, and more than 70% after heart transplantation (Qvist, Jalanko, & Holmberg, 2003). With this enormous success in prolonging life expectancy of children with lethal diseases, healthcare professionals now are focusing increased attention on psychosocial adjustment of children for its own sake and as a measure of outcome after transplantation. Because of the risk of infection, children spend long periods in isolation both before and after transplantation. Children undergoing solid organ transplantation have a high prevalence of medical and physical disabilities before transplantation that continue in various forms thereafter, putting them at increased risk of prolonged psychosocial adjustment problems. In particular, affected children generally experience various forms of posttraumatic stress, depression, anxiety, behavioral problems, and learning difficulties.

IV. Children's Perceptions of Illness and Hospitalization and Meeting Their Developmental and Psychosocial Needs

Objectives

- To provide an overview of children's age-related perceptions of illness and hospitalization
- To familiarize artists with the psychosocial and developmental needs of children when hospitalized
- To explore some of the methods Child Life specialists, nurses, and other healthcare professionals use to meet the psychosocial and developmental needs of children in hospitals

Time

45–60 minutes

Materials

PowerPoint slides: Several examples of children in each major age group who are hospitalized: Infants, toddlers, preschoolers, school-agers, and adolescents

Handout: "Understanding Children Who are Hospitalized: A Developmental Perspective"

"My Little Clock" MP3 song from "In the Hospital"—download for a small fee from http://www.peteralsop.com

Laptop computer

LCD projector

Procedure

1. Encourage artists to recall anecdotes from previous discussion of hospital experiences by incorporating these examples when appropriate throughout the presentation.

2. Explain that one of the most significant factors in predicting a child's perception of illness and hospitalization is the child's age/developmental level. Stress the following points (Hockenberry & Wilson, 2007):

   - Children 2 to 7 years perceive an external, unrelated, concrete phenomenon as the cause of illness. (Example: "Being sick because you don't feel well.") They perceive cause of illness as proximity between two events that occur by "magic." (Example: "Getting a cold because you are near someone who has a cold.")
   - Children 7 to 10+ years perceive cause as a person, object, or an action

external to them that is "bad" or "harmful" to the body. (Example: "Getting a cold because you didn't wear a hat.") They perceive illness as having an external cause but as being located inside the body. (Example: "Getting a cold by breathing in air and bacteria.")

- Children 13 years and older perceive cause as a malfunctioning or nonfunctioning organ or process. They can explain illness in sequence of events and realize that psychologic actions and attitudes affect health and illness.

3. Explain that dignity can be an issue for children in the hospital. Although there is no consensus regarding the age when dignity becomes an issue, research confirms that dignity and privacy are not always respected when children are hospitalized (Rylance, 1999). Play "My Little Clock" to illustrate the point.

4. Distribute the handout "Understanding Children Who are Hospitalized: A Developmental Perspective." While referring to the handout, show PowerPoint slides to illustrate each age group. Discuss age-related perceptions, psychosocial and developmental needs, and some of the methods healthcare professionals use to address these perceptions and needs. Emphasize the following points:

   - Children frequently regress when hospitalized. (Examples: Child who was previously toilet trained may have "accidents;" older children may suck their thumbs.)
   - Children may not reach pre-hospital level of development until well after discharge.
   - Infants and toddlers are two of the age groups at highest risk for negative effects of hospitalization due to their rapid development (Pearson, 2005).
   - Remind artists that over half of children hospitalized today are under 5 years of age.

5. Summarize by reading "A Glimpse of the Child's Perspective" (Johnson et al., 1992, p. 209):

   What happened to the people who love me and take care of me? Why aren't they here? Are they gone forever? Did I do something bad that made them go away?

   Are they keeping me here because I did something wrong? Why are all these strange people making me stay in bed and doing things that hurt me?

   Who are all these strange people, anyway? Why are there so many different people coming and going all day and night?

Why are the other children crying? What is happening to them? Will it happen to me too?

What it I cry, fight, yell, or move? What if I wet my bed? What if...? Will they make fun of me? Will they stop taking care of me? Will I get in trouble? Will I be punished?

What are they going to do to my body? Will I ever look the same again?

Are they telling the truth?

Am I going to die here?

Will I ever see my family and friends again? If I do get out, will they remember me and take me back? Will I ever be able to fit in?

6. Elicit and answer questions and generate discussion to reinforce concepts. Stress the importance of these concepts as the foundation artists will build upon in planning their work with children who are hospitalized.

Understanding Children Who Are Hospitalized: A Developmental Perspective

<table>
<tr><th>Erikson</th><th>Piaget</th><th>Hospitalization Issues</th><th>Possible Troublesome Responses</th><th>Interventions</th></tr>
<tr><td colspan="5">Infant (0–1 year)</td></tr>
<tr><td>Trust vs. Mistrust
• To get
• To give in return</td><td>Sensorimotor
• Exploration of physical self and environment
• Object constancy
• Cause and effect</td><td>Separation
Lack of stimulation
Pain</td><td>Failure to bond
Distrust
Anxiety
Delayed skills development</td><td>Maximize parental involvement
Maximize parental information
Provide stimulation
• Visual
• Auditory
• Tactile
• Kinesthetic
• Vestibular</td></tr>
<tr><td colspan="5">Toddler (1–3 years)</td></tr>
<tr><td>Autonomy vs. Shame and Doubt
• To hold on
• To let go</td><td>Sensorimotor
Preoperational (preconceptual phase)
• Can hold and recall images
• Increasing use of symbolization
• Highly egocentric perception of world</td><td>Separation
Fear of bodily injury and pain
Frightening fantasies
Immobility or restriction
Forced regression
Loss of routine and rituals</td><td>Regression (including loss of newly learned skills)
Uncooperativeness
Protest (verbal and physical)
Despair
Negativism
Temper tantrums
Resistance</td><td>Maximize parental involvement
Maximize parental information
Facilitate medical play
Promote therapeutic play
• Environmental exploration
• Freedom within limits
• Routine and ritual
• Self-expression
• Movement activities
• Sensory stimulation games</td></tr>
<tr><td colspan="5">Preschooler (3–6 years)</td></tr>
<tr><td>Initiative vs. Guilt
• To make (going after)
• To “make like” (playing)</td><td>Preoperational (preconceptual phase)
Preoperational (intuitive phase)
• Transition period between depending solely on perception, and depending on truly logical thinking
• Better able to see more than one factor at a time that influences an event</td><td>Separation
Fear of loss of control, sense of own power
Fear of bodily mutilation or penetration by surgery or injections, castration</td><td>Regression
Anger toward primary caregiver
Acting out
Protest (less aggressive than toddler)
Despair and detachment
Physical and verbal aggression
Dependency
Withdrawal</td><td>Maximize parental involvement
Maximize parental information
Facilitate medical play
Promote therapeutic play
• Environmental exploration
• Freedom within limits
• Routine and ritual
• Self-expression
• Movement activities
• Sensory stimulation games</td></tr>
</table>

School-ager (6–12 years)				
Industry vs. Inferiority • To make things (completing) • To make things together	Concrete operations • Increasing ability to think logically in the physically concrete realm • Understand the meaning of series of actions, of order and sequencing	Separation Fear of loss of control Fear of loss of mastery Fear of bodily mutilation Fear of bodily injury and pain, especially intrusive procedures in genital area Fear of illness itself, disability, and death	Regression Inability to complete some tasks Uncooperativeness Withdrawal Depression Displace anger and hostility Frustration	Maximize parental involvement Maximize parental information Encourage education and teacher involvement Facilitate medical play and information Promote therapeutic play • Skill building • Meaningful projects • Group activities • Peer support • Freedom within limits • Self-expression
Adolescent (12–18 years)				
Identity and Repudiation vs. Identity Diffusion • To be oneself (or not to be) • To share being oneself	Formal operations • Deductive and abstract reasoning • Can imagine the conditions of a problem—past, present, and future—and develop hypotheses about what might logically occur under different combinations of factors	Dependence on adults Separation from family and peers Fear of bodily injury and pain Fear of loss of identity Body image and sexuality Concern about peer group status after hospitalization	Uncooperativeness Withdrawal Anxiety Depression	Encourage peer group activities Provide privacy Respect independence (choices) Encourage self-expression Address body image, sexual image, and future concerns Facilitate medical preparation Encourage education and teacher involvement Facilitate visits with peers

V. Using the Arts to Meet Psychosocial and Developmental Needs of Children in Hospitals

Objectives

- To introduce artists to the therapeutic use of the arts in healthcare settings as distinguished from expressive therapy
- To provide an overview of current research on the physiologic response to the arts
- To familiarize artists with ways in which hospital art and design can be used to meet the psychosocial and developmental needs of children in hospitals

Time

45–60 minutes

Materials

PowerPoint slides: (a) illustrating the seven key concepts regarding the use of expressive art activities in pediatric settings, and (b) healing symbols (see Holistic Healing at http://healing.about.com/od/symbols/Symbols_Symbology.htm

Handouts: (1) "Key Concepts;" (2)"Frequencies of Stimuli That Cause Thrills"

DVD: "Charting the Course" from the Society for the Arts in Healthcare http://www.thesah.org

Laptop computer

LCD Projector

Optional Trainer Resources: (1) *Evidence of Innovation: Transforming Children's Health Through the Physical Environment*" by National Association of Children's Hospitals and Related Institutions, 2008. Alexandria, VA: NACHRI; (2) *2009 State of the Field Report: Arts in Healthcare,* download at http://www.thesah.org/doc/reports/ArtsInHealthcare.pdf

Procedure

1. Describe the critical role creative expression plays in growth and development for all children (Schirrmacher, 1988):

   - It helps the child develop large and small muscle skills.
   - The creative process itself promotes mental or cognitive development, for creating is a series of decision-making.
   - It fosters emotional and social development. Art is a universal language; children express themselves more naturally and spontaneously through art than through words.
     - We think first in images; as we grow older, we learn to translate these images into words.

   - Then we learn to play it safe with words, guarding what we reveal about our thoughts, ideas, or feelings.
- The nature of creative activities—there is no one right way to express something—promotes success and all of the good feelings that go along with it.

2. Explain the distinctions between expressive (art, music, dance, poetry) therapy and the therapeutic use of the arts. (You may want to ask an expressive therapist to guest lecture). Emphasize the following points:

   - Expressive therapists receive special training to interpret and prescribe specific expressive activities.
   - Engaging in expressive activities can be therapeutic.
   - Children may communicate thoughts, feelings, and concerns through their expressive activities.
   - The role of artist-in-residence is that of facilitator.
   - If the artist encounters a situation where a child communicates either verbally or nonverbally (for instance, in a painting, drawing, or behavior), something troubling or something that causes the artist to pause and question, the artist should communicate this information to the Studio G coordinator, the Child Life coordinator, or the child's nurse for appropriate referral.

3. Distribute handout "Key Concepts." Using PowerPoint slides of children engaged in expressive activities, discuss each of the seven concepts emphasizing the following points (Rollins, 2005a):

   - *Pain and discomfort*—Most children in hospitals experience some pain or discomfort. We know that some children engage in play and other expressive activities in an effort to distract themselves from pain or discomfort. Reports indicate that efforts have been effective to some degree even for severe pain (Rollins, 1995).
   - *Reduced opportunities to make decisions*—Children rarely are permitted to refuse treatments, medications, and procedures. Although an adult may request rescheduling for an event and perhaps have that request honored, a child's hospital schedule is most likely based on the hospital staff's timetable, not necessarily the child's. Adults can even choose to leave the hospital against medical advice; children, under most circumstances, legally cannot. The ability to make choices gives children a much-needed sense of control over something in their lives and therefore helps relieve stress. Engaging in the arts, children have endless opportunities to make choices. They can

choose colors, what to paint, what musical instrument to play, the ending to a story, poem, or song, and so on. They can even choose not to participate in an activity. This decision, too, has great value; it may be the only real choice the child has had honored that day.

- *Passive role*—Many of the things children have done to them when hospitalized—being poked, prodded, led, doctored, nursed, dressed—are unpleasant or even painful. Again, they usually have no choice. When children are creating, they are the ones in charge. They can squish lumps of clay and form animals, pound nails into wood and build airplanes, sing as loud or softly as they like. For that moment, the child is the doer, the captain of the ship, the master of the universe.
- *Emotions*—Children can experience unpleasant emotions when hospitalized. It isn't pleasant to have to "hold still" for a painful procedure, to be nauseated all the time, to get "shots" four times each day, or to miss school graduation. Hospitalization is especially confusing for young children. They may wonder why their parents are letting these terrible things happen to them and be bewildered at their feelings of anger at people as well as at events. This anger may be expressed in misbehavior or refusal to cooperate. It is often easier for children, particularly young ones, to express these feelings and concerns by participating in the arts; remember, we think first in images and then in words. Not all emotions children experience while hospitalized are unpleasant. Children can use the arts to express these good feelings, too.
- *Physical limitations*—Limitations may be permanent or temporary, such as bedrest after surgery or immobilization of an arm for an intravenous (IV) line. Methods can often be adapted, and, when this is not possible, children can still decide the important factors, such as choice of colors, where a line goes, what song to sing, and so on.
- *Unfamiliar environment*—The hospital means a strange bed; different food or not being able to eat at all; confusing sights, sounds, and smells; and strangers often replacing the familiar faces of family and friends. Creating art or engaging in other expressive activities is normal, the essential "work" of childhood. The creative process allows children to escape from their hospital beds and return to the world they know (Greaves, 1996). Children often can share these expressive hospital experiences alongside family members and friends. Parents frequently report that watching their children engaged in normal childhood activities gives them real hope that things will get better.
- *Learning and growing*—Children have the opportunity to learn about physical concerns and about themselves. They can communicate their

understanding of their condition and treatment in expressive activities, which gives parents and healthcare professionals opportunities to discuss children's understanding and concerns and correct misconceptions. The arts have a unique role for children with chronic conditions. For these children, discharge from the hospital does not mark the end of their healthcare experience. Having the opportunity to complete an art activity with a final product allows such children to experience a much-needed sense of closure, plus the personal satisfaction that comes from a job well done. A lifelong interest in the arts may begin in the hospital. For children with chronic or disabling conditions whose occupational choices may be limited, this may be the most important benefit of all.

4. Show PowerPoint slides of healing images/symbols. Discuss some ways children use these images to help cope with the stresses of illness and treatment.

5. Describe a "thrill"—a subtle nervous tremor caused by intense emotion or excitement (as pleasure, fear, etc.) producing a slight shudder or tingling through the body (Goldstein, 1980). Ask artists to describe times when they have experienced thrills. Distribute the handout "Frequencies of Stimuli That Cause Thrills." Explain that research indicates a physiologic process takes place when individuals are exposed to certain stimuli, such as an increase in endorphins, IgA levels, or oxygen saturation rates.

6. Ask artists to describe their experiences with humor, healing symbols, or other stimuli that they believe have caused physiologic responses.

7. Show the DVD "Charting the Course." Generate discussion by asking artists to cite examples from the DVD to illustrate the seven key concepts from the handout.

8. Summarize by explaining that Western medicine is just beginning to explore the healing properties of the arts and other complementary and integrative practices. For more details, see the National Center for Complementary and Alternative Medicine at http://nccam.nih.gov/.

9. Optional: Discuss the impact of hospital design on children, their families, and staff. (See *Evidence for Innovation: Transforming Children's Health Through the Physical Environment*.)

10. Optional: Review the *2009 State of the Field Report*.

11. Elicit and answer questions.

Meeting Psychosocial/Developmental Needs of Children in Hospitals Through the Arts

In the hospital, children	*The arts provide opportunities for children to*
1. May experience pain and discomfort	Develop new coping strategies Distance and distract themselves
2. Have limited opportunities to make decisions	Make choices Be independent
3. Are in passive roles, where they are led, dressed, doctored, and the constant recipients of things being done to them	Be the active ones Be the ones in charge
4. Experience many emotions, such as fear, confusion, anger, guilt, happiness, joy, and pride	Communicate feelings, both the pleasant and the unpleasant ones Safely let go Relive and master traumatic experiences
5. May be physically limited	Draw on their remaining abilities Imagine what they may be unable to do physically
6. Are in an unfamiliar place where things are strange and different	Do something "normal" and familiar Share experiences with others Experience the pleasure and joy of childhood
7. Are in a place that provides opportunities for learning and growth	Demonstrate understanding of their condition and treatment Experience closure Develop potential for a lifelong interest in the arts and creative expression

NOTE. Adapted from "Art: Helping Children Meet the Challenges of Hospitalisation," by J. Rollins, 1995, *Interacta, 15*(3), 36–41.

Frequencies of Stimuli That Cause Thrills

Item ranking	%*
1. Musical passages	96%
2. Scene in a movie, play, ballet, or book	92%
3. Great beauty in nature or art	87%
4. Physical contact with another person	78%
5. Climactic moments in opera	72%
6. Nostalgic moments	70%
6. Sexual activity	70%
7. Watching emotional interactions between other people	67%
7. Viewing a beautiful painting, photograph, or sculpture	67%
8. Something momentous and unexpected happening	63%
9. Moments of inspiration	65%
10. Seeing or reading about something heroic	59%
11. Sudden insight, understanding, solution of a problem	57%
12. Particular moments at a sports event	52%
13. Success in a competitive endeavor	49%
14. Particular fragrances	39%
15. Physical exercise	36%
16. Parades	26%

* Percent of respondents who ever experience thrills in response to each stimulus.

NOTE. Adapted from "Thrills in Response to Music and Other Stimuli," by A. Goldstein, 1980, *Physiological Psychology, 8*(1), 126–129.

VI. Psychosocial Assessment

Objectives

- To introduce artists to the key components of psychosocial assessment
- To help sharpen and guide artists observation skills to gather meaningful information
- To familiarize artists with some of the ways psychosocial assessment is used in pediatric settings

Time

15–20 minutes

Materials

Handouts: (1)"Basics of Psychosocial Assessment;" (2) "Common Facial Expressions, Body Movements/Appearance, and Verbal Expressions That May Reflect Affective States of Children Who Are Hospitalized"

Cards: "Hospital Scenarios" (Photocopy and cut)

Procedure

1. Explain the purpose of reviewing psychosocial assessment. Although artists will be in the role of facilitators, not "therapists," knowledge of various elements of psychosocial assessment can help them plan activities for individual children, monitor the children's responses and progress, and make adaptations and recommendations. Emphasize the following points:

   - Artists will be given pertinent psychosocial information about individual children during "report"—the pre-session meeting when they are given census sheets listing the children's names and room numbers.
   - Report is covered in detail in training session XI, "The Artist's Routine."

2. Distribute and review the handout "Common Facial Expressions, Body Movements/Appearance, and Verbal Expressions That May Reflect Affective States of Children Who Are Hospitalized." Highlight the following points:

   - Children who are hospitalized usually have lower energy levels and may not appear very enthusiastic about participating in an art session.
   - Children's responses when hospitalized may be swift, subtle, and, therefore, difficult to see.

3. Pair artists and divide "Hospital Scenarios" cards among them. Ask the pairs to discuss the scenarios, the issues involved, and the facial expressions, body

movements/appearance, and verbal expressions that might reflect the child's affective state when faced with the given scenario.

4. After artists have discussed their scenarios in pairs, have them present their conclusions to the entire group.

5. Elicit and answer questions. Reinforce the following facts:

   - Children who are hospitalized bring with them stressors from the world outside the hospital as well as those generated by illness and hospitalization.
   - Although some responses are predictable, individual factors, such as a child's typical coping style or temperament, make each child's response unique.

Basics of Psychosocial Assessment

1. *Affect.* Nonverbally expresses the child's inner state.
   - happy (smiling)
   - flat (little expression on face, "blank look")
   - sad (looking downward, mouth downturned)
   - depressed (quiet, withdrawn, possibly tearful)
   - lability or pervasiveness of affect (if affect changes rapidly or remains constant)

2. *Temperament.* The basic mood or behavioral style of the child.
   - activity level
   - rhythmicity
   - approach
   - adaptability
   - threshold
   - intensity
   - mood
   - distractibility
   - persistence

3. *Ability to communicate and interact with peers, adults, and family.* Younger children primarily communicate psychosocial needs nonverbally, through actions and interactions. Older children and adolescents generally have verbal skills needed to discuss psychosocial needs.

4. *Personal or family stressors.* Children who are hospitalized may have multiple stressors that can affect their ability to cope.

5. *Coping style.* When under stress, children typically use coping methods consistent with their coping style and may regress to an earlier developmental level.
   - cries
   - approaches with caution
   - approaches with fearlessness
   - clings to parent
   - requests help from adults
   - becomes sullen
   - whines
   - becomes aggressive
   - uses breathing or relaxation techniques
   - screams
   - reads

- listens to music
- counts to ten

6. *Amount and type of defense mechanisms used, e.g., denial, repression, projection.*

7. *Self-concept and level of self-esteem.*
   - statements the child makes about self
   - ability to be goal oriented
   - readiness to take risks
   - need for approval from adults
   - ability to delineate strengths and weaknesses
   - ability to make independent choices based on personal likes and dislikes
   - bonding behaviors

NOTE. Adapted from "Psychosocial Assessment of the Child," by D. Brantly, 1991, In D. Smith (Ed.), *Comprehensive Child and Family Nursing Skills: Assessment and Intervention*, St Louis: C.V. Mosby.

Common Facial Expressions, Body Movements/Appearance, and Verbal Expressions That May Reflect Affective States of Children Who Are Hospitalized

Affective state	*Facial expressions*	*Body movements/ appearance*	*Verbal expressions*
Fear	Eyes: wide; clenched; shut; eyebrows raised Mouth: open or tightly shut Grimaces Has blank look	Avoids eye contact Clings Stiffens Hands are clenched Curls into fetal position Makes self small Pushes away Runs or turns away Hides under covers Holds head down Jerks	Cries Screams Whines Moans Voice: tremulous; stutters; low
Surprise	Eyes: wide; eyebrows raised Mouth: round; smiling	Jerks Jumps Raises hands Draws hand to mouth, eyes, or face Shakes head	Voice: loud Gasps Laughs Screams Uses exclamations such as "Oh!" or "Wow"
Happiness	Eyes: wrinkled; "twinkling" Mouth: smiling; grinning	Flushed with warmth Fidgets Relaxed; release of muscle tension from head to toe Reaches out Hugs	Voice: high pitched, full of excitement Giggles Uses statements such as "I'm happy!" or "This is fun!"
Anger	Eyes: squints; eyebrows furrowed Mouth: square; clenched teeth; grinds teeth Grimaces	Hits Kicks Bites Shakes fist Lashes out Stiffens Tenses Handles materials aggressively	Voice: loud or low Cries Screams Yells Swears Is silent
Sadness	Eyes: downcast; may avoid eye contact Mouth: frowns; straight	Limp, like a rag doll Moves slowly Reaches out Clings	Voice: wispy, low, quiet Is silent Ignores questions Uses self-critical statements such as "I'm so dumb, ugly, etc."
Disgust	Eyes: Avoids or makes direct eye contact Mouth: downturned Wrinkled nose May stick out tongue	Turns away Draws away Uses dismissive gestures such as sweeping away with arm	Voice: forceful tone; may be loud or soft
Interest	Eyes: wide; maintains eye contact with person or materials; eyebrows raised Mouth: smiles Licks or chews lips	Sits up straight Engages with materials Leans forward or toward activity Nods Draws finger or hand to mouth	Voice: may be loud or soft May be quiet so can hear what is being said Laughs Is talkative Asks questions

NOTE. From "Children's Affective Responses to Three Creative Offerings of a Hospital Pediatric Artists-in Residence Program," by J. Rollins, 1996, unpublished manuscript.

Hospital Scenarios

You are 9 years old. Your doctor just told you and your family that you will be going to surgery in the morning. Your mother and father just left for the cafeteria to eat lunch. *What are some of the issues?* *How might this child respond?*	**You are 16 years old have been in the hospital for 5 days for tests, and still no one knows what's wrong. Your best friend just phoned and told you that your (boy/girl) friend has asked someone else to the prom.** *What are some of the issues?* *How might this child respond?*
You are 2 years old and just had your blood drawn. It wasn't easy. They had to stick you three times. *What are some of the issues?* *How might this child respond?*	**You are 4 years old, cannot speak English, and really need to pee.** *What are some of the issues?* *How might this child respond?*
You are 12 years old and found out yesterday that you have diabetes. The shots have already begun. Now they are telling you that later this week they will teach you how to give yourself the shots. *What are some of the issues?* *How might this child respond?*	**You are 13 years old and are getting poor grades in school. You are hospitalized with your leg in traction. You have missed two weeks of school so far, and don't know when you will be able to return.** *What are some of the issues?* *How might this child respond?*
You are 9 months old and just woke up from a nap. You are in this strange hospital room, all alone, and a stranger walks in. *What are some of the issues?* *How might this child respond?*	**You are 10 years old and have been in the hospital for a couple of days. Before coming to the hospital, a bully at your school teased you and threatened to beat you up. You doctor says that you should be able to return to school next week.** *What are some of the issues?* *How might this child respond?*

VII. Family Needs of Children Who are Hospitalized

Objectives

- To introduce artists to the key components of family-centered care
- To familiarize artists with the unique role of families when a child is hospitalized
- To increase artists' understanding of the needs of family members when a child is hospitalized

Time

20–25 minutes

Materials

Handouts: (1) "Key Elements of Family-Centered Care;" (2) "A Pediatric Bill of Rights" (Previously distributed)

Optional: Video/DVD: Choose from a selection that best meets your needs from your hospital, the Institute for Family-Centered Care (http://www.familycenteredcare.org/), or other sources

Optional: VCR and monitor or DVD player

Trainer Resource: Download "Welcome to Holland" by Emily Perl Kingsley from http://www.our-kids.org/Archives/Holland.html

Procedure

1. Discuss the meaning of the saying: "When a child is a patient, the patient is the family." Ask artists to help define who they believe "the family" is.

2. If necessary, clarify that "the family" is whomever the family considers the family. Ask artists to give examples of people who are considered family in various cultures.

3. Discuss some of the issues parents may face, such as feeling:

   - overwhelmed
   - tired
   - helpless
   - loss

4. Describe some of the ways artists may see parents respond, such as:

   - protective
   - depressed
   - angry
   - sleepy

- frustrated
- regressed

5. Explain that most parents of children with chronic illness or disability tend to experience "chronic sorrow" or "living loss," a natural grief reaction to a loss that is not final, but continues to be present in the life of the griever (Roos, 2002). Periods of acceptance are interspersed with periods of intensified sorrow for the loss (Clubb, 1991). Grieving is most likely seen at each period of the child's development when the parent is again reminded of what could have been, or when the child experiences a situational or developmental crisis. Hospitalization may qualify as such a crisis.

6. Have an artist read aloud the essay, "Welcome to Holland." Highlight the fact that parents experience an ongoing loss—the death of a dream.

7. Point out that with many families relying on two incomes, more and more grandparents are involved in their grandchild's hospitalization. Grandparents face a "double grief"—sorrow for their own child's situation as well as that of their grandchild's.

8. Explain that siblings often visit and they also have special issues. Highlight the following points:

   - Siblings of children who are hospitalized often experience more stress than the child in the hospital or the parents.
   - Siblings' routines are disrupted, and they often are shuttled among relatives, neighbors, and friends.
   - Older siblings are frequently expected to assume greater responsibility with younger brothers and sisters and household chores.
   - It is not unusual for a sibling to feel responsible for and perhaps guilty about their brother or sister's illness/hospitalization.
   - Siblings are sometimes jealous of the attention/gifts their brother or sister receives.
   - Preschoolers tend to withdraw or become irritable; older siblings tend to act out.
   - Siblings also can feel anxious, resentful, rejected, and have a negative self-image, severe separation anxiety, poor peer relationships, or poor school performance. They may stammer, have nightmares, wet the bed, complain of headaches and stomachaches, and be preoccupied with their own health.
   - At times parents may neglect addressing their other children's legitimate health needs because of the overwhelming demands of caring for the hospitalized child.

9. Optional: Show video/DVD about family-centered care.

10. Distribute and review the handout "Key Elements of Family-Centered Care." Refer to section on parents' rights and responsibilities in the previously distributed handout "A Pediatric Bill of Rights."

11. Explain that parents, grandparents, siblings, and other visiting family members or friends can be invited to participate in the art sessions. Some will choose to participate and others will want to use the time to take a break.

Key Elements of Family-Centered Care

- Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service systems and support personnel within those systems fluctuate.
- Facilitating family/professional collaboration at all levels of hospital, home, and community care.
- Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.
- Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational, and geographic diversity.
- Recognizing and respecting different methods of coping and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports to meet the diverse needs of families.
- Encouraging and facilitating family-to-family support and networking.
- Ensuring that hospital, home, and community service and support systems for children needing specialized health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs.
- Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

NOTE. From *Family-Centered Care for Children Needing Specialized Health and Developmental Services* by T. Shelton and J. Stepanek, 1994, Bethesda, MD: Association for the Care of Children's Health.

VIII. Tour of Pediatric Units

Objectives

- To familiarize artists with the pediatric inpatient units
- To introduce artists to staff members who work on these units
- To monitor and evaluate artists' reactions to children, equipment, and other aspects of the pediatric setting

Time

15–30 minutes

Materials

Handout: Map of the pediatric units

Procedure

1. Distribute a map of the pediatric units to each artist.

2. Walk artists through the pediatric areas and answer questions as they arise.

3. Point out where artists will store their belongings, supplies, communications book, and so on.

4. Carefully observe artists for signs of distress, discomfort, or other strong reactions to the pediatric setting.

5. Reconvene for group discussion of reactions to the children and the setting. If needed, provide follow-up support to individual artists.

IX. Communicating with Children in Hospitals and Their Families

Objectives

- To offer artists an overview of techniques used to communicate with children who are hospitalized and their families
- To introduce artists to special considerations regarding words or phrases to use with children who are hospitalized
- To provide an opportunity for artists to practice communication techniques

Time

20–30 minutes

Materials

Handout: "Strategies for Communicating Effectively With Children"

Optional: "Psychosocial Care of Children in Hospitals: A Clinical Practice Manual for the ACCH Child Life Research Project" by L. Gaynard et al., 1990, Washington, DC: Association for the Care of Children's Health, which is available from the Child Life Council (http://www.childlife.org/)

Procedure

1. Remind artists that in their role they are not to ask children about their conditions; children may want to use the session to forget about hospitalization, illness, or injury for a time. However, it is okay to talk about the topic with the child if the child initiates the issue.

2. Distribute the handout "Strategies For Communicating Effectively With Children" and review. Ask artists to think of ways the strategies suggested for the medical scenarios can translate to their work with children.

3. Point out that expressions children hear in medical settings often have dual meanings and may confuse and therefore upset them. For example, children hearing the term "stretcher" may think, "Stretch her? Stretch who? Why?" A clearer phrase would be "bed on wheels." Optional: Additional examples are discussed in Chapter 6: Talking with Children and Families, in Gaynard et al. (1990).

4. Explain the importance of the artist's first contact with a child:

   - Many strangers enter the child's hospital room each day.
   - Some who enter are there to do something unpleasant or perhaps painful to the child.

- The room is the child's "sanctuary" and his or her privacy should be respected.
- The child's first thought upon seeing a stranger is likely, "What are you going to do to me?"

5. Discuss the procedure for first contacts with children:

- Knock on the door (or say, "Knock, knock" if a curtain is used).
- Wait for the child or family member to respond.
- In a sentence or two, call the child by name, introduce yourself, and explain why you are there: "Hi Juan, my name is Bill. I've stopped by to see if you'd like to print a T-shirt with me today. Would you like me to tell you more about it and then you can decide?"
- Provide the child with the information he or she needs to make the decision, such as showing the child a completed project, explaining the process and the time involved, and so on.
- If the activity is in the playroom and the child does not want to participate, briefly try to ascertain the reason. Often children are reluctant to leave their rooms out of fear of missing an expected visitor or a pending test or procedure. Explain: "We can leave a note or let the nurse know where to find you (when your Mom arrives; when it's time for your test)."
- Note: The serious nature of the conditions of many children hospitalized today calls for more activities taking place at bedside.

6. Ask each artist to role-play a first contact. Have artists offer each other suggestions on ways to introduce their particular art modality that will generate interest among children.

7. Explain to artists that, for a variety of reasons, children may say "no" to participating in even the most exciting arts experiences. Remind them about the importance of choices. Whether or not the child participates, they have brought that child a true gift: they have given the child the opportunity to say "no" to something and to have that "no" honored. This does not happen often for the hospitalized child; it may be the only real choice the child has had all day.

Strategies For Communicating Effectively With Children

General Strategies

1. Use a calm, unhurried, and confident voice.
2. Speak clearly, be specific, and use as few words as possible. As a general guide, use sentences whose sum of words is equal to the child's age in years plus one.
3. Use play as a strategy for getting to know the child. For example, if the child has a doll or stuffed animal, you can begin by speaking to the toy, then initiate conversation with the child by asking simple questions about the toy.
4. Listen and observe the child at play. Often children will express important information such as complicated and/or difficult feelings through this familiar medium.
5. Look for opportunities to offer the child choices, but offer them only when they exist. For example, when a child must change into a gown, a statement such as, "I need your dress off so I can listen to your chest. Shall I help you take it off?" gives the child an explanation, a choice, and some measure of control.
6. Be honest. It is best to describe how something might feel than to simply say, "It will hurt."
7. Avoid phrases that might be misinterpreted. For example, the statement, "Let's see how warm your body is," is preferred to, "Let's take your temperature." The child may wonder what you are going to do with his or her temperature and if you are planning to give it back. Words such as "shot" can be frightening if a child envisions a shot from a gun. Instead substitute with the phrase, "Putting some medicine under the skin."
8. Avoid expressions with dual meanings, such as "put to sleep."
9. Substitute words that may be interpreted as threatening with words that are less emotionally charged, such as replacing "stick" with "gently slide."
10. State directions and suggestions in a positive way. For example, say, "You need to stay very still" rather than, "Don't move."
11. Avoid prying, asking embarrassing questions, and lecturing when giving advice.

Communication Techniques

Give children an opportunity to express their thoughts, concerns, and feelings. Listen and respond to underlying messages rather than just verbal content. Be attentive, try not to interrupt, and avoid comments that convey disapproval or surprise.

Acknowledge and validate the child's feelings. Instead of denying them with a statement such as, "Don't be angry," say, "You sound really mad." This permits the child to accept the emotion and to begin to deal with it.

Avoid negative "you-messages," that often start with "you" followed by something that tends to blame, accuse, or attack the person to whom the message is directed. Use alternatives such as:

1. *Describe the child's situation or problem without mentioning the child.* For example, instead of saying, "You took off your bandage," say, "The bandage is off; it needs to be on."
2. *Send "I-messages" to communicate thoughts, feelings, expectations, or beliefs without imposing blame or criticism.* For example, say, "I feel frustrated when I cannot hear what Johnny is trying to tell me because of all the noise in here."
3. *Provide descriptive praise to point out the child's attributes or to identify your feelings about the child.* For example, after obtaining a blood sample, saying, "You sat very still and told me it hurt instead of moving your arm," is more helpful than making an evaluative statement such as, "You're a great patient," which may cause the child to feel doubt, denial, or fear of not measuring up at a later time. In summary, comment on the behavior, not the person.
4. *Use the third-person technique by expressing a feeling in terms of "he," "she," or "they." This gives the child an opportunity to agree or disagree without being defensive.* For example, say, "Sometimes children who are sick tell me they feel angry or sad because they cannot do what others can do." Then wait silently for a response or encourage one by saying, "I wonder if you have ever felt that way."

Age-Specific Considerations

Infants

1. Consider body language, such as gestures and posture, as well as pitch, intonation, and intensity of voice.
2. Nonverbal behaviors work especially well for infants, with cuddling, patting, or some other form of gentle physical contact often quieting them.
3. Maintain a calm voice and avoid sudden, loud noises. The actual words spoken are not as important as the way they are spoken.
4. Because infants can begin fearing strangers as early as 6 months, holding out your hands and asking the older infant to "come over" is seldom successful. If handling is necessary, the best approach is to pick up the infant firmly without using gestures.
5. Infants are usually more at ease when upright and in visual contact with and close proximity to their parents.

Preschool and young school aged children

1. Avoid quick approaches. Let the child make the first move whenever possible.
2. Broad smiles and other facial contortions may appear threatening.
3. Avoid extended eye contact until after the child is comfortable.
4. Position yourself at the child's eye level. You will appear less threatening to the child and the child's smallness will be de-emphasized.
5. Children may be more responsive when remaining close to their parents, such as sitting on a parent's lap.
6. Be direct and concrete with young children because they are unable to deal with the abstract or separate fact from fantasy. For example, young children attach literal meanings to common phrases such as "a frog in the throat" or "hold your horses."

Older school-aged children

1. Continue using relatively simple explanations to facilitate understanding as children get older.
2. Children this age want concrete explanations and reasons for everything, for they rely more on what they know than what they see when faced with new problems. They use knowledge-seeking as a coping strategy. Learning new things about how their bodies work offers children this age an opportunity to master some aspects of the hospital experience.

Adolescents

1. Be prepared to deal with a wide range of emotions and behaviors.
2. Give concrete explanations that focus on the teenager's concerns, even though the adolescent's capacity to think in abstract terms increases with age.
3. It is not necessary to be fluent in teen jargon, but ask for clarification when necessary.
4. To enhance communication, exchange information without using coercive questions. Initially confine discussions to less threatening topics to allow time for trust to develop.
5. Ask broad, open-ended questions before specific questions, such as "How's school?" before asking, "What is the best/worst thing about school?"

NOTE. Adapted from "Communicating Effectively with Young Children," by L. Clutter, C. Hess, K. Nix, J. Rollins, D. Smith, N. Stevens, and D. Wong, 1987, *Children's Nurse, 5*(4), 1–3; and Communicating Effectively with Older Children and Adolescents," by L. Clutter, C. Hess, K. Nix, J. Rollins, D. Smith, N. Stevens, and D. Wong, 1988, *Children's Nurse, 6*(1), 4–8.

X. Relationships with Children and Families

Objectives

- To provide anticipatory guidance to artists to address common concerns of newcomers to pediatric settings
- To introduce artists to a decision-making framework to guide personal interactions with children and families
- To identify artists who may need closer monitoring and/or support

Time

15–20 minutes

Materials

Handout: "Therapeutic Relationships: A Utilitarian Approach"
Flip chart and marker or chalkboard and chalk
Trainer Resource: "Comments on Typical Fears"

Procedure

1. Begin by pointing out the differences in working with adult and pediatric populations (Totka, 1996):

   - The physical boundaries are not the same.
   - In pediatric settings, children can be held, kissed, and nurtured. Under most circumstances, the same does not hold true among strangers in adult healthcare settings.
   - Although the physical boundaries are taken away, it is expected that emotional boundaries remain clear.
   - The struggle intensifies when parents are not available to care and advocate for their children.

2. To help identify artists' needs, desires, and values, explore artists' expectations (Kiely, 1992):

   - Encourage participants to indulge their fantasies, to pretend that their experience with the children is going to be absolutely wonderful in every way; that in this fantasy they will succeed beyond their wildest dreams.
   - Ask: "Someone please give us an example—What would be something that would happen in a wonderful experience here for you?"
   - Responses might include statements like: "I would make a child smile." "A child would be happy to see me." "I would be able to reach a child no one else was able to reach."
   - Write each response on the flip chart or chalkboard. Get as many responses

as possible, and accept them all, regardless of appropriateness. Fantasy means anything is possible.

- Comment supportively, such as "Right. We all need feedback." "We want to feel worthwhile," or "We like a challenge."
- Summarize by stating that we all need and desire a positive result and response for our efforts. Tell artists that "only by recognizing and admitting personal needs can we learn to separate our personal needs and wishes from the needs of the child."

3. Reiterate the fact that artists will learn, through experience, that there may be only small signs that their efforts make a difference. Emphasize that over time they will learn to be proud of what may appear on the surface to be only a very small accomplishment.

4. Next, ask artists about some of their concerns regarding their work with children: "What are your worst fears?" or "What are you most afraid of?" Write the responses on the flip chart or chalkboard. Expect concerns such as

   - "What if I get too attached to a child or family?"
   - "What if I say the wrong thing?"
   - "What if there's a medical emergency?"
   - "What if a child asks me if they're going to die?"
   - "What if a child dies?"

5. Explore each fear briefly by asking the group to probe each fear with questions such as "What does this fear mean? Give an example of what would happen. What would you do? So, how can we prevent this from happening? What resources are available?" Comment on the typical fears using the information outlined in the trainer resource "Comments on Typical Fears."

6. Bring up the issue of self-disclosure—sharing personal information with children or their families.

   - At times such information can be helpful to children and/or their families; other times it is not.
   - Artists need to learn to ask themselves, "What is the purpose of my sharing this information? Whose needs am I meeting?" and be clear that the needs being served by the disclosure are those of the child or family member, not the artist's.

7. Distribute and refer to the handout "Therapeutic Relationships: A Utilitarian Approach." Explain that the utilitarian approach can help artists resolve moral

dilemmas regarding their interactions with children and families. The approach assumes that any interaction with a child has the potential for producing a variety of both negative and positive consequences (McAliley, Lambert, Ashenberg, & Dull, 1996). Emphasize the following points:

- By identifying and weighing the plausible "pleasures and pains" in each of the five domains, the artist is better positioned to determine whether a specific action is likely to foster or detract from a therapeutic relationship.
- The artist may then decide to go ahead with the considered action, to forego it, or to modify it in a manner that avoids or negates the potential hazards.

8. Using an example, demonstrate how to use the model. For example, perhaps a child with limited financial means demonstrates a talent for playing a guitar, and the artist has access to a resource that would provide one for the child. Going through the steps of the model, what would be the impact of giving a guitar on the child? On the other children? Could this be an acceptable thing to do?

9. Point out that children with life threatening illnesses have identified the connection relationship—where the professional sees the child as a person first and as a patient second—as one of the most important factors in helping them cope with the healthcare experience (Rollins, 2005b). A feature of this kind of relationship: professionals sometimes break or bend the rules. For example, a night nurse may let a child who cannot sleep sit with him or her in the nurses' station, even though it might be against hospital policy.

10. Elicit and answer questions.

Comments on Typical Fears

What if I get too attached?—"If you were not capable of attachment, you would not have been chosen for this program. Your human warmth and caring are two of the most important assets you bring to this experience. However, it's good that you recognize that inappropriate attachment is something to watch out for. Asking this question shows that you are aware of one of the most important cautions of working with children, and that is the ability to separate your own needs from the needs of the child. This takes self-awareness, so you need to be aware of this possibility in advance." Ask: "What *could* be some signs of over-attachment?"

- Spending too much time with one child
- Ignoring other children
- Wanting to give special favors to a child
- Thinking too much about the child when you're away
- Feeling that you are the one who best understands this child
- Wanting to maintain the relationship after the child leaves the hospital

"If you find this happening, you may want to talk to one of us about it. It happens to all of us from time to time. We all find ourselves more attracted to some children than others. Some children are more appealing. Pay attention to the kinds of children and behaviors that attract you and those that repel you. Consider the role your own needs play in this attraction or dislike. This helps you set your personal preferences aside and, instead, concentrate on the child's needs."

What if I say the wrong thing?— "What might happen if you did?" (Usually the answer is "I would hurt a child's feelings, or make things worse.") "Wouldn't if be wonderful if we all had a script to follow so we'd never hurt anyone's feelings, or embarrass them or ourselves? Your question shows that you value children's feelings and privacy, so you are the kind of sensitive and caring person we want for our program. With this kind of sensitivity, you are unlikely to blurt out something terrible. Even when your words are not perfect, your caring will likely show through. Sometimes we all believe that if we said the right words we could fix things and make them better. However, what most of us want when we're hurting is someone to listen and not be afraid to be with us in our hurt. Special techniques that will help you communicate with children were covered in the training session "Communicating with Children in Hospitals and Their Families."

What if there's a medical emergency?—"You are in a hospital and will be surrounded by medical experts. You will be instructed on how to get help when needed."

What if a child asks me if they're going to die?—"If this occurs, it is because you likely have established a relationship of deep trust. The honest answer to the question is that you don't know. However, you might respond by saying, 'I know you have a serious condition. What is it that worries you about dying?' Try to identify the child's specific concern and get permission to share the concern with an appropriate staff person who can talk with the child. You can also say, 'Who could we get to help us answer these questions that worry you the most? I care about you, but I don't have all the answers.'"

What if a child dies?—"What would this mean, for you? What worries you the most? Exploring feelings about death and loss, both ours and those of the children and their family members are an important part of training. If and when this happens, we need to and will support each other."

NOTE. Adapted from *Volunteers in Child Health: Management Selection Training & Supervision* by A. Kiely, 1992, Bethesda, MD: Association for the Care of Children's Health.

Therapeutic Relationships: A Utilitarian Approach

Disengage – ________________________ + _____________________________ Enmeshed

Therapeutic

Consider the potential positive and negative outcomes of the interaction within the following contexts:

Philosophy and policy of the institution—These are significant determinants of action but not necessarily sufficient determinants in and of themselves. In an instance where policy permits or even dictates a specific action, special circumstances may contradict it.

Impact upon desired child/family outcomes—Actions are considered positive if they support or at least do not detract from the achievement of desired goals.

Developmental stage of artist/child/family relationship—The relationship typically progresses through three somewhat artificial phases: (a) the introduction phase, (b) the working phase, and (c) the stage of termination. The artist and child/family have preconceived expectations based on their past experience or lack thereof, which color their interactions, and in part, shape the experience the artist provides as well as the experience the child/family seeks or accepts. One course of action may have different consequences at different stages.

Potential impact on other children, families, and staff—An interaction between a particular artist and child or family might result in other children/families perceiving preferential treatment, or could cause them to have unrealistic expectations of other artists or engender professional jealousies. On the positive side, thoughtful interactions provide the basis for good professional mentoring and project an unbiased, professional caring.

The artist's personal philosophy and values regarding the artist's role and the nature of a therapeutic relationship—This is the most difficult context to address and the one most often overlooked. Artists are encouraged to adopt a system that enables them to make decisions when two equally strongly held personal values conflict or when their values conflict with those of the child, healthcare professionals, or institution. Consequences would be considered positive if they are consistent with the artist's existing personal philosophy and values or contribute to a newly evolving philosophy.

NOTE. Adapted from "Therapeutic Relations Decision Making: The Rainbow Framework" by L. McAliley, S. Lambert, M. Ashenberg, and S. Dull, 1996, *Pediatric Nursing, 22*(3), 199–203; 210.

XI. The Artist's Routine

Objectives

- To orient artists to the routine
- To familiarize artists with the responsibilities they will be assuming
- To emphasize the importance of maintaining confidentiality

Time

15–20 minutes

Materials

Handouts: (1) "The Artist's Routine;" (2) "Session Report"
Communications Book
Sample census sheets

Procedure

1. Review hospital policies re: dress code, where to park, and so on.

2. Distribute the handout "The Artist's Routine." Describe each step. Studio G artists use the following routine as a guide:

   - Each year the Studio G coordinator develops a schedule of the days and times artists would like to facilitate sessions.
     – Most artists work two mornings, afternoons, or evenings per month.
     – Whenever possible, artists try to schedule the same day of the week, for example, every first and third Tuesday.
     – The artist's name is printed on the Studio G calendar that is displayed monthly on the bulletin board outside the Child Life office.
     – The artist notifies the Studio G coordinator and Child Life coordinator of any scheduling changes.
   - The artist plans an activity with built-in flexibility, one that
     – Is adaptable for various ages
     – Can be carried out with a group or individual children
     – Considers the space and/or work surface available—floor, tables, and chairs in activity or playroom for group activities; room size, bedside table surface (approximately 36" X 16"), and art cart for room visits
     – Involves a leave-behind product, when appropriate
     – Considers safety issues, which will be discussed in detail in the following session
   - The artist checks on availability of supplies, or brings or purchases necessary supplies plus a receipt for reimbursement.
   - The artist arrives at the nurses' station to receive census sheets and to ask

which children should not be disturbed and which children would likely benefit most from a visit. Here the artist will learn the age and sometimes the diagnosis of each child. Other details may include

- The child's mood or affect
- How the child is approaching things, both the child's usual style and his or her style today if different
- How the child is responding to events
- What the child is expressing in words/actions, and any confusion or misconceptions
- Family involvement and any significant family issues
- Suggestions and recommendations for working with the child
- Whether or not the child is able to come to the playroom for a group activity.

Stress the importance of keeping all information about children and their families confidential. In addition, artists should be cautioned to not discuss children and their families with other artists or members of the healthcare team while in public places, such as hallways, elevators, the cafeteria, or any place where a conversation may be overheard. Remind them that from time to time all of us may forget; we all have a responsibility to remind each other when this occurs.

- The artist organizes a rough time plan for the session based on how many children may be able to come to a group activity and how many will require room visits, and prepares for the activity, gathering necessary supplies.
- The artist goes to the units, invites children to the playroom or other designated area, conducts a group activity, and assures that children are supervised at all times.
- At the completion of the group activity, the artist asks children who are capable to help clean the area and put away supplies. Children are assisted to their rooms with their art products, when applicable.
- The artist then visits individual children in their rooms, saving the children in isolation for infectious diseases for last to help avoid the possibility of transmitting infection to the other children.
- After finishing room visits, the artist makes notations on the census sheets about the children who participated. These are placed in the communications book. Comments regarding concerns about or recommendations for follow-up for certain children are also emailed to the Studio G coordinator and forwarded to the Child Life specialist when appropriate.

- The artist returns supplies and the communications book to the designated locations.
- The artist refers any serious concerns about a child to the Studio G coordinator, the Child Life coordinator, or the child's nurse immediately. Give some examples of concerns that should be reported.

3. Distribute the handout "Session Report." Explain that within one week after their session, artists will need to complete the report and email it to the Studio G coordinator. The option of phoning and providing an oral report also is available. This data will be used for program evaluation.

4. Elicit and answer questions.

The Artist's Routine

1. Schedule sessions with Studio G coordinator.
2. Plan an activity with built-in flexibility.
3. Check on availability of supplies for your activity, or bring supplies with receipt for reimbursement.
4. Arrive at a designated time to receive census sheets and report.

Keep all information about children and their families confidential.

5. Organize a tentative time plan for the session based on how many children may be able to come to a group activity and how many will require room visits.
6. Prepare for the activity, gathering necessary supplies.
7. Go to the units and invite children who are able to leave their rooms to come to the playroom or other designated area for the group activity. Be certain that children are supervised at all times.
8. Conduct the group activity.
9. After the activity, ask children who are able to help you clean the area and put away supplies.
10. Assist children to their rooms, if necessary.
11. Provide room visits for children unable to come to the playroom.
12. Complete paperwork and put into communications book.
13. Return supplies and the communications book to designated locations.
14. Refer any serious concerns to the Studio G coordinator, Child Life coordinator, or the child's nurse immediately.
15. Complete and email the "Session Report" to the Studio G coordinator within one week after the session.

Session Report

Artist's name: ___________________________________ **Date:** _________________________

1. With whom did you work?

2. What did you do?

3. What were the participants' responses?

4. Any additional comments/concerns?

XII. Safety Considerations

Objectives

- To explore the four primary considerations regarding safety when working with children in hospitals
- To generate thought regarding safety issues to guide planning activities
- To introduce artists to special safety considerations when working with high risk children

Time

15–20 minutes

Materials

Handouts: (1) "Art Materials: Recommendations for Children Under 12;"
(2) "Safety Issues for High Risk Children"

Procedure

1. Describe the four primary considerations regarding safety when working with children who are hospitalized:

   - *Materials*—Toxic substances can be inhaled, ingested, or absorbed through the skin. Exposure to these substances can cause acute or chronic illness, an allergic reaction, or skin damage.
   - *Techniques/activity*—Physical agents, such as noise, vibration, repetitive motion, heat, electrical equipment can cause injury and illness. For example, loud music may further decrease what hearing remains for a child with a hearing impairment.
   - *Child's age and developmental level*—Children under the age of 12 may not understand the need for precautions or carry them out consistently and effectively. Preschool-aged children will sometimes deliberately put things into their mouths and/or swallow them. Habits such as nail biting or thumb sucking increase the risk.
   - *Child's condition*—Exposure to art materials or processes, or participation in art activities that exceed an individual child's physical limitations may place the child, especially a child with disabilities, at high risk for further illness or injury. Many of the hazards can be eliminated or reduced with one-to-one supervision or other appropriate measures.

2. Distribute the handout "Art Materials: Recommendations for Children Under 12." Review some of the examples of substitutions. Emphasize the following points:

- Read the label on art supplies, remembering that nontoxic refers to acute, short term health effects.
- Use your senses. Paint, for example, can get smelly and moldy and should not be used. When in doubt, throw it out.
- However, smell is not a good indicator of toxicity. Some materials (such as markers) can have a strong odor but be nontoxic. Others may have no odor or smell sweet and be toxic (Arts and Creative Materials Institute, 1996).
- Remember that certain odors, even pleasant ones, may bother children who are ill.

3. Distribute the handout “Safety Issues for High Risk Children” and review.

4. Using a specific art activity as an example, discuss some of the safety issues involved and ways you might address them. For example:

   - Is there enough space to carry out the activity?
   - Will people be available to help?
   - How could I safely facilitate this activity in a child’s room?
   - Do the materials and techniques I’m planning to use require one-to-one supervision?
   - Can I substitute different materials or tools—such as blunt-tipped scissors with younger children—and achieve the same results?
   - Will this activity be excessively noisy and perhaps disturb others?

5. Ask artists for examples of activities they are considering using with the children. Generate discussion among the artists.

   - Identify safety issues.
   - Develop strategies to address them.

6. Explain that a purposes of the internship portion of artist-in-residence preparation is to help artists identify safety issues regarding specific activities, and to assist them in developing strategies to facilitate activities safely.

Art Materials: Recommendations for Children Under 12

Do not use	Substitutes
Dusts and Powders	
1. Clay in dry form. Powdered clay, which is easily inhaled, contains free silica and possible asbestos. Do not sand dry clay pieces or engage in other dust-producing activities.	1. Order talc-free, premixed clay (e.g., Amaco white clay). Wet mop or sponge surfaces thoroughly after using clay.
2. Ceramic glazes or copper enamels.	2. Use water-based paints instead of glazes. Water-proof artwork with acrylic based mediums.
3. Cold water, fiber-reactive dyes, or other commercial dyes.	3. Use vegetable, plant (e.g., onion skin's, tea, flowers), and food dyes.
4. Instant paper maches (create inhalable dust; some may contain asbestos fibers, lead from pigments in colored printing inks, etc.).	4. Make paper mache from black and white newspaper and library or white paste, or use approved paper maches.
5. Powdered tempera colors (create inhalable dusts and some tempera colors contain toxic pigments, preservatives, etc.).	5. Use liquid paints or pre-mix paints.
6. Pastels, chalks, or dry markers that create dust.	6. Use crayons, oil pastels, or dustless chalks.
Solvents	
1. Solvents (e.g., turpentine, shellac, toluene, rubber cement thinner) and solvent-containing materials (solvent-based inks, alkyd paints).	1. Use water-based products only.
2. Solvent-based silk screen and other printing inks.	2. Use water-based silk screen inks, block printing or stencil inks containing safe pigments.
3. Aerosol sprays.	3. Use water-based paints with brushes or spatter techniques.
4. Epoxy, instant glue, airplane glue, or other solvent-based adhesives (rubber cement).	4. Use white glue, school paste, glue sticks, and preservative-free wheat paste.
5. Permanent felt tip markers, which may contain toluene or other toxic solvents.	5. Use only water-based markers.
Toxic Metals	
1. Stained glass projects using lead came, solder, flux, etc.	1. Use colored cellophane and black paper to simulate lead.
2. Arsenic, cadmium, chrome, mercury, lead, manganese, or other toxic metals, which may occur in pigments, metal filings, metal enamels, ceramic glazes, metal casting, etc.	2. Do not use these ingredients. Use approved materials only.
Miscellaneous	
1. Photographic chemicals.	1. Use blueprint paper and make sun grams, or use Polaroid cameras.
2. Casting plaster. Creates dust; casting hands and body parts has resulted in serious burns.	2. Pre-mix plaster in a separate' ventilated area or outdoors.
3. Acid etches and pickling baths.	3. Do not use processes employing these chemicals.
4. Scented felt tip markers. These may teach children bad habits about eating and sniffing art materials.	4. Use water-based markers.

NOTE. Adapted with permission from *Children's Art Supplies Can Be Toxic* by A. Babin, P. Peltz, and M. Rossol, 1989, New York: Center for Safety in the Arts.

Safety Issues for High-risk Children

Issues	Suggestions
1. Visual impairment:	
• Possible need to get close to work increases risk for inhaling dust, vapors, or fumes. • Chemical splashes or flying particles entering the eyes, direct exposure to infrared and ultraviolet radiation could damage remaining sight. • Some chemicals can cause eye damage through skin absorption or inhalation. • May not notice hazardous situations because of limited range of eye motion, reduction in peripheral vision, difficulty in focusing for long periods, and dizziness.	• Use proper local exhaust ventilation. • Provide gloves. • Restrict use of certain hazardous materials, when necessary. • Warn about hazardous situation. • Closely supervise, when needed. • Team with another child. • Outfit with appropriate protective goggles when risk of chemical splash, flying particles, or radiation.
2. Orthopedic or neurologic impairment:	
• Poor motor control, lack or coordination, and balance difficulties may increase risk for injuries from machinery or tools, falls, or spills. • Practice of using feet or teeth to make art increases likelihood of ingestion and skin contact with hazardous materials. • Braces, splints, crutches, walkers, and wheelchairs may decrease accessibility to art equipment and supplies. • Sensory problems may affect temperature, pressure, and pinprick sensations. • Hyperactivity, impaired judgment, lack of alertness, emotional swings, short attention spans, and other behavioral difficulties can effect concentration and decision-making ability.	• Use specially built chairs or work surfaces to put work areas within reach. • Evaluate hazardous machinery or tools to determine if child can operate them safely. • Use specially adapted or modified equipment. • Assist and supervise the child with muscle weakness during activities such as lifting. • Under child's directions, carry out operations when child unable to do so. • Minimize chance of spills by avoiding glass containers, having material easily accessible, and using self-closing containers and adaptive devices. • Caution and supervise children who use their feet or mouths for manipulating materials. • Schedule activities to avoid fatigue for the child who tires easily.
3. Intellectual disability:	
• Possible difficulty understanding hazards or inability to learn necessary precautions increases risk for injury from power machinery and sharp tools. • More frequent hand-to-mouth contact, hand-to-eye contact, and ingestion of materials increases risk from exposure to toxic chemicals. • Tendency to use saliva or other body fluids on art materials (e.g., wet clay) increases transmission risk of hepatitis virus and other infective agents from child to child.	• Use only non-toxic art materials. • Avoid machinery or tools that could cause cuts, burns, or more serious injury unless it is determined that the child understands the hazard and is closely supervised. • Evaluate activities of children with contagious diseases to ensure that they could not transmit the disease to other children through contact with wet art materials.

Issues	Suggestions
4. Hearing impairment:	
• At very high risk for further hearing loss if exposed to noisy situations, even at noise levels that would not affect most people. • May be unable to hear audible warning signals.	• Require a hearing evaluation before participation in noisy activities, such as hammering or activities that use loud machinery. • Use appropriate hearing protectors (ear plugs, ear muffs, and helmets) in noisy environments. • Closely supervise and use visual warning signals, clearly displayed signs and written materials, sign language, or an interpreter to communicate hazards of art techniques and suitable precautions.
5. Emotional/behavioral disorder:	
• May deliberately eat, inhale, or otherwise abuse art materials, particularly solvents. • Possible self-destructive or violent behavior increases risk for injury to self or others around dangerous machinery, tools, and hazardous chemicals.	• Evaluate thoroughly before allowing use of hazardous machinery, tools, chemicals, or processes. • Carefully supervise.
6. Asthma, allergies, severe scoliosis, cystic fibrosis, and other respiratory problems:	
• Tend to be very sensitive to molds, dusts, spray mists, and other airborne contaminants. • Some asthmatics are very sensitive to the sulfur dioxide produced in clay firing, and from fixing baths in photography.	• Wet mop to reduce dust levels. • Use dust masks. • Avoid chemicals that are irritating to the lungs. • Provide ventilation.
7. Heart and circulatory conditions:	
• High concentrations of some solvents can cause heart arrhythmias.	• Avoid exposure to solvents found in many aerosol spray products. • May need to avoid high activity levels or high heat situations such as foundries, gas-fired kiln rooms, and glassblowing studios.
8. Liver or kidney conditions:	
• Previous damage to organ increases susceptibility to further damage from chemicals, especially organic solvents and heavy metals.	• Avoid exposure to organic solvents.

NOTE. Adapted with permission from *Teaching Art Safely to the Disabled* by M. McCann, 1987, New York: Center for Safety in the Arts. Check with the child's physician about any questions regarding art hazards for a particular child.

XIII. Infection Control

Objectives

- To prevent the spread of infection
- To prepare artists to work safely with children who are in isolation
- To provide an opportunity for artists to express concerns regarding potential hazards of working in a pediatric setting

Time

30 minutes

Materials

Handouts: (1) Your hospital's policy/guidelines on infection control and isolation;
(2) "Age-Related Responses to Isolation and Immobilization"

Masks, gloves, gowns

Other

Note: Hospital volunteer orientation, which some hospitals require artists-in-residence to attend, typically includes content on infection control. Consider inviting someone from your hospital's infection control department to present this session.

Procedure

1. Emphasize to artists that if they follow certain precautions, working in the pediatric setting should not be hazardous to their personal health and well-being.

2. Distribute and review your hospital's policy guidelines on infection control and isolation.

   - "Standard Precautions"—to be used for the care of all patients in hospitals regardless of their presumed infection status.
   - "Transmission-Based Precautions" for isolation—based on routes of infection transmission: airborne, droplet, and contact.

3. Demonstrate proper handwashing technique.

4. Discuss the psychosocial/developmental issues involved when children are in isolation:

   - All stressors associated with hospitalization are increased:
     - Further separation from familiar persons
     - Perceived threat from mask and gown
     - Additional loss of control

  - Added environmental changes, such as sensory deprivation
  - Greater impact on a child's orientation to time and place
  - Depersonalization from reduced interaction with the environment and the people in it
- Immobilized and isolated children may have fewer coping strategies available to them.
- The child's age influences his or her reaction to immobilization and isolation.

5. Distribute and discuss the handout "Age-Related Responses to Isolation and Immobilization."

6. Discuss the need to plan activities for children in isolation that address the following goals (Hart, Mather, Slack, & Powell, 1992):

   - Provide sensory stimulation
   - Stimulate kinesthesia
   - Promote orientation to time and place
   - Encourage social interactions
   - Reduce depersonalization

7. Ask artists for examples of expressive activities that meet the criteria above.

8. Give artists an opportunity to ask questions and to try on isolation masks, gowns, and gloves. Discuss the routine and the importance of introducing themselves and letting the child see their faces before donning a mask.

Age-Related Responses to Isolation and Immobilization

	Issues	*Responses*
Infants	Separation anxiety	Become visibly upset when parents and significant others leave the room or bedside
Toddlers	Difficulty understanding the reason for their restraint or isolation	Regression and restlessness
Preschoolers	Guilt	Less exploration of environment
Schoolagers	Loss of control	Initially—angry and hostile Later—usually one of three behavior patterns: responsibly independent, passively dependent, or manipulative
Adolescents	Body image and fear of being different from peers Developing independence challenged	Initially—acting out, regression, anger, denial, and hostility Later—possibly boredom and apathy

NOTE. Adapted from *Therapeutic Play Activities for Hospitalized Children* by R. Hart, P. Mather, J. Slack, & M. Powell, 1992, St. Louis, MO: Mosby Year Book.

XIV. Cultural Issues

Objectives

- To help artists evaluate their degree of cultural competence
- To provide an opportunity for artists to learn more about their personal cultural values and beliefs and how these may influence their interactions with people different from themselves
- To offer artists some strategies for working with culturally diverse children and their families

Time

30–45 minutes

Materials

Worksheets: (1) "A Multicultural Checklist;" (2) "Exploring Your Cultural Heritage"
Handouts: (1) "Contrasting Beliefs, Values, and Practices;" (2) "Hints for Effective Cross-Cultural Communication"
Flip chart and marker or chalkboard and chalk

Procedure

1. Remind artists that not since the early 1900s has America experienced more diversity than in the last two decades. Point out that according to statistics from recent Census data, a demographic shift is taking place.

2. Explain that the challenge is to ensure that people become interdependent, have mutual respect, and maintain major parts of their cultural identity.

3. Distribute the worksheet "A Multicultural Checklist." Point out that the activity is simply for artists to evaluate where they are in the process of achieving cultural competence. No one will know their answers unless they choose to share them.

4. Discuss the concept of cultural competence as a process, a continuum. Meanwhile, draw a horizontal line on the flip chart or chalkboard and add six intersecting points: (a) cultural destructiveness; (b) cultural incapacity; (c) cultural blindness; (d) cultural pre-competence; (e) basic cultural competence; and (f) advanced cultural competence. Use the example below as a guide:

+	+	+	+	+	+
Cultural Destructiveness	Cultural Incapacity	Cultural Blindness	Cultural Pre-Competence	Cultural Competence	Cultural Proficiency

5. Provide an explanation for each point on the continuum (Cross, Bazron, Dennis, & Isaacs, 1989):

   - *Cultural destructiveness*—actively carries out activities that destroy or disrupt cultural beliefs or practices.
   - *Cultural incapacity*—represents cross-cultural ignorance; often characterized by support of the status quo.
   - *Cultural blindness*—well-meaning but misguided "liberal" policies and practices based on the belief that if only the dominant cultural practices were working properly, they would be universally applicable and effective for everyone.
   - *Cultural pre-competence*—reflects a movement toward the recognition that there are differences in individuals, families, and communities, and a willingness to begin to try different approaches to improve service delivery.
   - *Cultural competence*—acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models to better meet the needs of non-dominant populations.
   - *Cultural proficiency*—at the most positive end of the scale, characterized by actively seeking to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, publishing and disseminating the results of demonstration projects, and so on. In other words, advocates for cultural competence throughout the system and improved relations between cultures throughout society.

6. Read the following list of phrases and ask artists to guess what cultural roots these sayings likely represent (Hanson, 1992):

   - All men are created equal.
   - Where there's a will, there's a way.
   - A penny saved is a penny earned.
   - Do unto others as you would want done unto yourself.
   - Time is money.
   - If at first you don't succeed, try, try again.
   - Tomorrow is a new day.
   - The early bird catches the worm.

7. Confirm that these sayings represent families with Anglo-European roots, the dominant culture of the healthcare community. These beliefs, values, and practices are reflected in following cultural courtesies and customs:

- The notion that all people are more or less equal:
  - Females and males are treated with equal respect.
  - People providing daily services (cabdrivers, waitresses, secretaries, sales clerks) are treated courteously.
- People freely express their opinions:
  - Freedom of speech is major characteristic of the culture.
  - However, some topics (sex, politics, religion, personal characteristics such as body odors) typically are not openly discussed, particularly with strangers.
- Persons are greeted openly, directly, and warmly:
  - Not many rituals are associated with greetings; maybe a handshake, particularly among males.
  - People usually greet each other and get to the point of the interaction.
  - Eye contact is maintained throughout the interaction.
  - It is considered impolite to not look at the persons to whom you are talking.
- Social distance of about an arm's length is typically maintained in interactions:
  - People (males, in particular) do not expect to be touched except for greetings such as shaking hands.
  - People walking down the street together typically do not hold hands or put their arms around one another unless they are involved in a more intimate relationship.
- Punctuality and responsibility in keeping appointments are valued:
  - Time is valued and most people expect punctuality.
  - It is considered rude to accept an invitation to someone's home and not show up, or to make an appointment with someone and not keep it.

8. Distribute handout: "Contrasting Beliefs, Values, and Practices." Pick a few of the values and ask artists for examples.

9. Distribute and ask artists to complete the worksheet "Exploring Your Cultural Heritage." Again, mention that no one will know their answers unless they choose to share them. After everyone has finished, ask the following questions:

   - Because no human being is born with racist, sexist, and other oppressive attitudes, what would happen if no one said anything to children about differences? Would children notice? The answer is yes because:
     - Early on, children notice differences and mentally organize these observations into categories. This is how young children make sense of their ever-expanding world.
     - Attitudes about "us and them" are learned and reinforced in the home, school, church, and through the media.

  - By 3 years, children have learned to categorize people into "good or bad" based on superficial traits such as race or gender.
  - Children 2 years or younger learn names of colors, then begin to apply these names to skin color.
  - By 3 years or even earlier, children can show signs of being influenced by what they see and hear around them. They may even pick up and exhibit "pre-prejudice" toward others on the basis of race or disability.
  - Children of 4 and 5 years may use racial reasons for refusing to interact with others who are different from themselves; they may act uncomfortable around or even reject people with disabilities.
  - By the time children enter elementary school, they may have developed prejudices. Stereotypes remain until personal experience or someone attempts to correct them.
  - Open mindedness increases with age.
- What has been your experience as a person having or lacking power in relation to
  - Ethnic identity?
  - Racial identity?
  - Class identity?
  - Sexual identity?
  - Professional identity?
  - Within the family?
  - Handedness?

10. Distribute and review the handout "Hints for Effective Cross-Cultural Communication."

11. Elicit and answer questions.

12. Remind artists that although much literature exists about various cultural beliefs, values, and practices, there is always the danger of overgeneralizing or stereotyping. Cultural groups should be viewed as a collection of individuals who share a common cultural heritage. There are many intragroup differences as well as intergroup dissimilarities and similarities.

A Multicultural Checklist

1. I have actively sought out information to enhance my own awareness and understanding of multicultural diversity.

   No   Yes   Intend to   Do not intend to

2. I have consciously pondered my own attitudes and behaviors as they either enhance or hinder harmonious multicultural relationships.

   No   Yes   Intend to   Do not intend to

3. I have evaluated my use of terms or phrases that may be perceived by others as degrading or hurtful.

   No   Yes   Intend to   Do not intend to

4. I have suggested or initiated workshops or discussions with friends, co-workers, social clubs, or church groups about multicultural diversity.

   No   Yes   Intend to   Do not intend to

5. I have openly disagreed with racial, cultural, or religious jokes, comments, or slurs.

   No   Yes   Intend to   Do not intend to

6. In my work setting, I have used appropriate occasions to discuss the multicultural climate in the organization with my colleagues and with institutional administration.

   No   Yes   Intend to   Do not intend to

7. When I see a broadcast, advertisement, or newspaper article that is racially, culturally, or religiously biased, I have complained to the author or sponsor responsible for it.

   No   Yes   Intend to   Do not intend to

NOTE. Adapted with permission from "Personal Reflections on Death, Grief, and Cultural Diversity" by K. Lundquist, & V. Nelsen, 1993, In D. Irish, K. Lundquist, & V. Nelsen (Eds.), *Ethnic variations in dying, death, and grief*. Washington, DC: Taylor & Francis.

Contrasting Beliefs, Values, and Practices

Anglo-American Values	*Some Other Cultures' Values*
Personal control over environment	Fate
Change	Tradition
Time dominates	Human interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Self-help	Birthright inheritance
Competition	Cooperation
Future orientation	Past or present orientation
Action/goal/work orientation	"Being" orientation
Informality	Formality
Directness/openness/honesty	Indirectness/ritual/"face"
Practicality/efficiency	Idealism/theory
Materialism	Spiritualism/detachment

NOTE. From *Cross-cultural Counseling: A Guide for Nutrition and Health Counselors* by United States Department of Agriculture & United States Department of Health and Human Services, 1986, Washington, DC: Author.

Exploring Your Cultural Heritage

The following questions have no right or wrong answers. They should help you clarify your attitudes and beliefs and the ways in which they influence your ability to work with people from cultural backgrounds different from your own.

1. What ethnic group, socioeconomic class, religion, age-group, and community do you belong to?

   ____

   - What about these groups do you find embarrassing or would like to change? Why?

     ____

   - What sociocultural factors in your background might be rejected by members of other cultures?

     ____

   - What did your parents and significant others say about people who were different from your family?

     ____

2. What do you believe or value?

   ____

   - How do you define health, disease, illness?

     ____

   - Are you usually on time? Early? Late? ______________________________
   - How do you feel when others are late? Frustrated? Angry? Not respected? Fine? Philosophical?

     ____

   - What are your views on children's education? ______________

     ____

- Are you comfortable with physical contact (touching, embracing)? How much and with whom?

  ____

- What are your religious views and biases? Do you adhere to religious rituals?

  ____

- What are your feelings on childrearing practices (including nutrition, discipline, play, roles)?

  ____

  ____

3. What experiences have you had with people from ethnic groups, socioeconomic classes, religions, age-groups, or communities different from your own?

   ____

   - What were those experiences like?

     ____

   - How did you feel about them?

     ____

4. What personal qualities do you have that will help you establish interpersonal relationships with persons from other cultural groups?

   ____

   ____

5. What personal qualities may be detrimental?

   ____

   ____

Hints for Effective Cross-Cultural Communication

1. Speak slowly and clearly.
2. Pause more frequently.
3. Use simple sentences.
4. Use active verbs.
5. Repeat each important idea.
6. Use visual measurements such as graphs or pictures.
7. Act out and demonstrate.
8. Focus on non-verbal behavior.
9. Remember that silence is communication. Listen.
10. Check comprehension.

XV. Death and Dying

Objectives

- To help artists gain personal insight into their thoughts and feelings regarding death
- To familiarize artists with a developmental approach to children's perceptions of death and dying
- To offer artists some strategies for supporting children and their families who are facing a life threatening condition and/or death

Time

30 minutes

Materials

Handout: "Children's Perceptions of Death"

Procedure

1. Read the following statements to the artists and ask whether the statements are fact or myth:

   - Young children do not grieve. (Myth)
   - Because of cultural influences, family members grieve in the same way. (Myth)
   - Religious beliefs influence the way people respond to grief. (Fact)
   - Grieving people need to stay busy to heal. (Myth)
   - Unresolved grief can accumulate over time. (Fact)
   - The way in which a person dies has an impact upon the grief that survivors experience. (Fact)
   - Death is the sole cause of grief. (Myth)

2. The artists will likely answer all or most of the questions correctly. Explain that answers to these questions can provide insight regarding personal attitudes and an understanding of the attitudes of others toward grief.

3. Ask artists to think about why the death of a child is different from that of an adult. (The death of a child breaks the natural order of life where the old die and the young carry on. When you lose a parent, you lose your past; when you lose a child, you lose your future.)

4. Before delving into the issue of death, help artists explore the reaction of the child and family to life threatening illness, using cancer as an example. Wong (1995) describes the phases children and their families experience as follows:

- Phase 1—Revelation and Dawning Reality: Diagnosis and Treatment
  - Child—Often feels angry and frequently directs anger toward parents. Treatment usually means loss of hair. Baldness has little significance for young children. School-aged children's reactions largely depend upon their preparation for the loss and their parents' adjustment. Adolescents typically are angry and fear rejection from their peer group.
  - Parents—Initially are concerned with the diagnostic tests, treatments, and their effects. After induction therapy, families commonly react with anger, depression, ambivalence, and bargaining.
- Phase II—Reprieve: Remission and Maintenance Therapy
  - Child—Overprotectiveness and "special" treatment increase their fears concerning serious illness and failure to recover. Can become very frustrated, unhappy, and demanding.
  - Parents—React to this long period of hope for an eventual recovery and fear of a possible relapse with heightened vigilance by overprotecting the child, encouraging dependency, and liberalizing discipline.
- Phase III—Recovery: Cessation of Therapy and Possible Cure
  - Child—Psychosocial problems may surface. Adolescents may be particularly concerned about fertility and sexuality.
  - Parents—Have mixed feelings of grief, ambivalence, uncertainty, and concern for the future. May question the physician's decision to terminate treatment at this time, characteristic of the grieving for the loss of security afforded by medical intervention and the need for adjustment to the hazards of "waiting it out" again. A resurgence of the need to overprotect and isolate the child is often seen.
- Phase IV—Recurrence: Relapse and Death
  - Child—May fear isolation and loneliness. Some children experience anger at the unfairness of their situation. They may also be concerned about their parents' feelings. They see their parents' sadness, and try to hold on to life as long as possible in an effort to spare their parents further pain.
  - Parents—Reactions of depression, anger, loss of hope, fears of death and pain for their child, and possibly acceptance mark this period of intense anticipatory grieving.

5. Distribute and review handout "Children's Perceptions of Death."

6. Discuss unhelpful things to say to parents and helpful things to say (Kessler, 2000; Wong, 1995):

Unhelpful Things to Say	*Example*
Advice	You need to be strong for your family.
Cheerfulness	Cheer up, you have other children.
Interpretation	It's better now because she's at peace. There is a reason for everything.
Reassurance	I know how you feel.
Argument	You should be glad his suffering is over.
Ignoring loss	It could be worse; he could have lived with severe brain damage.

Things That Might Be Helpful to Say	*Example*
Feeling-focused	I am so sorry for your loss. I wish I had the right words; just know I care.
Nonjudgmental questions	Can I be of any help?
Clarification	I'm not sure I understand. Could you tell me more about....
Explanations	You can touch her and hold her if you wish.
Concern	Your daughter's birthday is near. That must be painful to deal with.
Support, empathy	It sounds like you have been doing some painful thinking.
Support, silence	Hello (touch, silence). Saying nothing, just being present.
Assessing coping and support	Is there someone who can drive you home?
Validating loss	You have been through a very tough time. He was a special boy. I will miss him. My favorite memory of ____ is…

7. Elicit and answers questions.

Children's Perceptions of Death

Age	*Concept*	*Comments*
Infant and Toddler	No concept of death but reacts to loss	Sleep-wake patterns and "peek-a-boo" games reflect infant's awareness of existence and nonexistence Infants become very dependent and bonded to primary caregiver (usually mother) and cry or fuss when she moves out of their line of vision; loss is the absence of this security, her person Parent's grief keys the infant to sad circumstances
Preschooler	Death is temporary and reversible Death is seen as a departure or separation	Perceives death as a departure or sleep that can be reversed Believes that some bodily processes go on in death (eating, breathing, hearing) Views self as living and therefore views the world in a state of livingness, which includes lifeless objects and dead people
Schoolager	Death is irreversible but not necessarily inevitable Death may be personified and viewed as destructive Explanations for death are naturalistic and physiologic	Personifies death often as a frightening clown, angel, or someone who has already died, but "if you run fast enough and lock the door you may be able to beat it" Holds impression of death as a composite of contradictory paradoxes surrounded by the unknown By the age of 9, understands that death is final, inevitable, irreversible
Adolescent	Death is irreversible, universal, and inevitable Death is still seen as a personal but distant event Explanations for death are physiologic and theologic	Most difficult of all age groups to face death Wavers between experiencing a sense of total invulnerability to having a catastrophic sense of doom A time when concern about body image is at its height

NOTE. Adapted from *Whaley & Wong's Nursing Care of Infants and Children* by D. Wong, 1995, St. Louis: Mosby; and "Facilitating Grieving," by B. Redding, in D. Smith (Ed.), *Comprehensive Child and Family Nursing Skills,* 1991, St. Louis: Mosby.

XVI. Stimulating Creativity

Objectives

- To help artists explore the basic concepts of stimulating creativity with children who are hospitalized
- To generate thought among artists about individual enhancers of creativity
- To offer artists some strategies for stimulating creativity with children who are hospitalized

Time

10–15 minutes

Materials

Handouts: (1) "Development of Drawing;" (2) "Talking to Children About Their Art" by Linda Carson, which can be downloaded from http://www.bigblackpig.com/howtotalk.html

Procedure

1. Distribute the handout "Development of Drawing." Explain the four key points to keep in mind when working with children who are hospitalized:

    - First, and above all else, children who are hospitalized are children.
    - Many children regress somewhat when hospitalized.
        - Refer to handout and discuss how this is often visible in their artwork.
        - Ask artists what might indicate regression in other expressive modalities.
    - Avoid assuming a child cannot do something.
    - Let the child do as much as possible; avoid interfering with the process.

2. Discuss some techniques for encouraging creative thinking:

    - *Reversal/looking at things in a different way*—Jenner's discovery of a vaccine for smallpox by studying people who did not get smallpox (milkmaids) instead of those who did.
    - *Quotas*—Generating a certain number of ideas before making a decision:
        - Ask artists to think of ways they could get from where they are to a nearby location.
        - Continue to elicit responses until they get beyond "I could walk...skip... hop" to more imaginative ways such as "I could shrink myself and get into your pocket and have you take me there."
        - Point out that when many ideas are generated, solutions typically are more creative.

  - Even when people choose an earlier idea, they still benefit from learning to explore many possibilities, an important skill in problem solving.

3. Review the basic concepts of facilitating creative expression with children:

   - Offer children a wide range of media to explore, remembering that they may never arrive at a finished product.
   - Erase the lines between modalities, such as using music during a visual art activity.
   - Encourage children to consider as many details as possible by asking questions about their work, such as "Who lives in that tree?"
   - Provide suggestions for activities, such as a list of things they might want to draw, or for songs, ideas such as making up a singing telegram to be delivered to their doctor or nurse.
   - Respect the importance and uniqueness of a child's emotional life.
     - An opportunity to engage in an expressive activity can bring out all sorts of thoughts, concerns, and feelings. Some children may be reluctant to share them.
     - Children can be given a sketch book and a supply of paper clips. They can express these thoughts and feelings through writing and drawing, then clip together the pages they do not want others to see, maybe not now or maybe not ever. They have still experienced some benefits from expressing them.
   - Accept the feelings, any honest responses, or fantasies that children express symbolically or verbally, no matter how unexpected, bizarre, regressive, or messy—as long as there is no realistic harm.
   - Be an extension of and for the child who is physically unable to do all or parts of an activity or project.
   - Encourage any special interest or talent in the arts by suggesting or providing books, tools, or referring the child to a particular artist or artist's work.
   - Help children celebrate their art by displaying it, having festivals, and so on.

4. Explore personal enhancers of facilitating creativity by asking artists the following questions:

   - What kinds of things stimulate ideas for you?
   - Where is it easiest to process these ideas?
   - What medium is best for expressing these ideas?

5. Point out that a child's creative process can be assisted by awareness of his or her personal enhancers. For example:

- Ideas may come and/or be processed when looking at something, engaging in a particular activity, hearing something or in silence, touching something, and so on.
- If the idea is stimulated visually, it may be easiest for the child to express it visually; if it is stimulated from a sound, it may be easiest to express it through music; if it is generated through the sense of touch, it may be easiest to express it through pottery or weaving, and so on.
- When the artist is aware of the child's personal enhancers, he or she can help create an environment that assists the child's expression. For example, the artist can provide a CD player for the child who best processes ideas to or with music, or suggest a quiet place for the child who works best in silence.
- The artist can suggest that the child mix modalities or use different modes of expression for different ideas.

6. Offer the following suggestions for working with children with special needs:

   - Help the child get started, if necessary.
   - Avoid interfering with the child's creative process.
   - Learn to rethink time when working with certain children.
   - Address the unique needs of individual children.

7. Encourage artists to ask the question "Why not?" do a particular activity that they believe will be exciting for the children, rather then merely asking "Why?" After exploring all the reasons and checking safety precautions, if they cannot come up with a good answer to that question, they should proceed.

8. Review the handout "Talking to Children About Their Art."

9. Elicit and answer questions.

Development of Drawing

Approximate age (years)	*Characteristics of drawing*
0–1	The infant has a reflex response to visual stimuli. The crayon is brought to the mouth, but the infant does not draw.
1–2	At approximately 13 months, the first scribble appears: a zig-zag. The infant watches the movement of the crayon leaving its marks on the surface.
2–4	Circles appear and gradually predominate. The circles then become discrete. In a casually drawn circle, the child envisages an object. A first graphic symbol has been made, usually between 3 and 4 years.
4–7	In this stage of intellectual realism, the child draws an internal model, not what is actually seen. The child draws what is known to be there. Transparencies, such as showing people through walls and hulls of ships, are commonly produced. Drawings at this age are expressionistic and subjective.
7–12	During this stage of visual realism, subjectivity diminishes. The child draws what is actually visible. Human figures are more realistic and proportioned. Colors are more conventional. The child distinguishes the right from the left side of the figure drawn.
12+	With the development of the critical faculty, most children lose interest in drawing. The gifted tend to persevere.

NOTE. Adapted from *Interpreting Children's Drawings* by J. DiLeo, 1983, New York: Brunner/Mazel.

XVII. Art Activity/Adaptations

Objectives

- To help artists effectively adapt their creative modalities to some of the most common physical limitations of children who are hospitalized
- To provide an opportunity for artists to explore the use of medical supplies as material for creative expression
- To offer artists a creative break

Time

60 minutes

Materials

IV arm boards and supplies needed to attach them to artists (cling, tape); eye patches

A mix of traditional art supplies (such as glue, paint, construction paper, glitter) and medical supplies (such as syringes, gauze, tape, waterproof disposable pads, cotton applicators, cotton balls, medication cups)

Optional Trainer Resource: *Arts Activities for Children at Bedside* by J. Rollins, 2004, Washington DC: WVSA arts connection.

Procedure

1. Explain that certain creative activities can incorporate medical supplies in their process or product. Emphasize the following points:

    - Using medical supplies can help these objects become familiar and therefore less feared.
    - Children may recreate an experience when these supplies were used on them to achieve mastery of the experience.
    - Traditional art supplies should always be available to offer children a choice.

2. Spread the art materials and medical supplies in the center of the table, explaining the medical supplies and their uses.

3. Invite artists to create something using the materials.

4. As they work, equip artists with IV boards on their non-dominant hand. (Although IV boards are not used as often as they were in the past, they never the less help simulate the experience of having an IV to contend with.)

5. After each artist has had this experience, move the board to the dominant hand. Some artists may also want to try out eye patches.

6. Note your observations and the comments artists make while working.

7. Allow artists to work until the session comes to a natural close and then ask them to describe their experiences and the ways they adapted their methods to meet the challenges. When appropriate, note your observations and the comments you heard.

8. Elicit questions regarding adapting specific activities and ask for suggestions from everyone. Explain that the children themselves often have effective solutions.

9. Optional: Refer artists to book *Arts Activities for Children at Bedside* for activity ideas.

10. Remind artists that children who can not participate physically still benefit from making important decisions in the creative process.

XVIII. Review of Internship: The Next Step

Objectives

- To familiarize artists with the purpose of the internship
- To provide artists with details of paperwork that must be completed prior to internship
- To describe the internship process

Time

20 minutes

Materials

Hospital forms

Contact information

Procedure

1. Using the information in STEP 3 Internship, page 91, describe the purpose and format of the supervised internship.

2. Explain that each artist will shadow a veteran artist at least once and then will facilitate a minimum of three internship sessions. After that time the artist may request or the supervisors may recommend that the internship period be extended.

3. Distribute the forms the hospital requires for employment, health clearance, and so on.

4. Elicit and answer questions.

XIX. Summary/Questions and Answers

Objectives

- To summarize the training sessions to offer a sense of closure
- To provide a specific opportunity for artists to ask questions
- To clarify details

Time

10–15 minutes

Procedure

1. Briefly summarize the topics covered in training.

2. Emphasize the fact that training is just the first step:

   - Artists will feel more confident at the completion of the internship.
   - It usually takes about 6 months to really feel comfortable in the pediatric setting.
   - There will be opportunities, such as at staff meetings, for ongoing learning and support.

3. Elicit and answer questions.

XX. Evaluation

Objectives

- To offer an opportunity for artists to provide feedback
- To provide information needed to improve the training program
- To identify future inservice topics

Time

10 minutes

Materials

"Studio G Training Evaluation"

Procedure

1. Explain the purposes of evaluating the training program:
    - To improve future training sessions
    - To identify topics for ongoing education
2. Distribute "Studio G Training Evaluation."
3. Ask artists to complete the evaluation, emphasizing that previous evaluations have helped shape their training sessions.
4. Encourage them to be as honest as possible; they do not need to sign their names.
5. Thank the artists for their participation and indicate a designated place to turn in their evaluations when completed.

Studio G
Artist Training Evaluation

1. What is your overall rating of this training?

   Excellent *Very Good* *Average* *Fair* *Poor*

2. What did you like *most* about the training?

3. What did you like *least* about the training?

4. Was too much or too little time spent on any of the topics?

5. Can you think of any additional topics that should be included in future training sessions?

6. What other comments do you have about the training?

STEP 3
Internship

Each artist intern will shadow a veteran artist at least once and then will facilitate a minimum of three 3-hour sessions under the supervision of the Studio G coordinator and the Child Life coordinator.

Purpose

The internship serves three main purposes. It provides:

- An opportunity for the artist to practice their art in the pediatric setting under supervision
- An opportunity for the artist to evaluate whether or not this is the kind of work they want to do.
- An opportunity for the Studio G program coordinator and the Child Life coordinator to evaluate the artist's work and provide support and guidance when needed.

Format

Artist interns are encouraged to follow a veteran Studio G artist for a session or two. Many interns have found this very helpful and our veteran artists seem to enjoy the mentoring role. These sessions do not count toward the minimum of three internship sessions.

Artists sign up for three unpaid internship sessions under the supervision of the Studio G program coordinator or the Child Life coordinator. Both coordinators have an opportunity to work at least once with each artist. This provides greater input from complementary yet different perspectives to evaluate each artist's progress.

The supervisor walks the artist intern through each step of the artist's routine. As information about the children is presented, the supervisor helps the artist identify the relevant issues and develop strategies to address them. The internship also provides an opportunity for the artist intern to observe the supervisor role model appropriate communication skills with children and their families.

At the completion of the three sessions, the supervisors and artist intern evaluate the need for more sessions. In most cases, there is agreement that interns are ready to be "turned loose" on their own. In situations where an extended internship period is needed, usually only one or two extra sessions are required.

Once the internship is complete, the artist schedules sessions with the Studio G coordinator. Artists choose two days or evenings a month that fit into their schedule. For ease in remembering, they typically choose a particular day. For instance, a storyteller works every other Thursday, and a musician works the alternate Thursdays. This practice also simplifies scheduling.

STEP 4
Ongoing Learning and Support

Formal and informal mechanisms are in place to provide opportunities for problem solving, continued learning, mutual support, and growth.

Purpose

We provide ongoing learning and support for a number of reasons. First, the field of arts medicine is rapidly evolving. We want keep our artists updated on the latest in the arts in healthcare and complementary and integrated medicine practices.

Further, in the current healthcare climate, pediatric healthcare is defined by change. Healthcare team members, including the artist-in-residence, struggle to delivery quality pediatric care within a time frame that seems to shrink daily. Sharing personal strategies as well as resources from others enables us to better serve our children and their families.

Working with children and families who are dealing with difficult issues surrounding illness and hospitalization can drain artists emotionally. The mutual support we provide to each other enables all of us to keep moving forward and to grow.

Staff Meetings

We have a regular staff meeting every other month. It is typically held over dinner, with each artist bringing a dish to share. The meetings usually last about three hours. Because we value our artists time, we strive to pay them for attending when funding permits.

An announcement and tentative agenda for the next staff meeting is emailed to each artist about a week in advance. Although each artist has an agenda slot, artists are invited to submit items they wish to have addressed by the group added to the agenda.

Each meeting typically includes a mini-inservice on a topic either the Studio G coordinator, the Child Life coordinator, or the artists themselves have identified as important to learn more about. Identifying such topics has helped shaped future

artist training sessions. For example, after identifying the need for providing a mini-inservice on therapeutic relationships, "Relationships with Children and Families" was added to training in 1996.

Meetings provide an opportunity for artists to hear what others are doing. Artists also discuss upcoming plans and arrange to work together on certain special events. This is also a time to share information and resources, and to simply enjoy each other's company.

Evaluation

After artists have been part of the Studio G program for a year, they are asked to complete an "Artist Post-Training Questionnaire" (see p. 94). The questions are identical to those on the "Artist Pre-Training Questionnaire."

Data are used to evaluate the effectiveness of all of the program components—training, internship, and ongoing learning and support. This self-evaluation allows artists to identify their strong areas as well as their weak ones. We also use responses to identify topics that need more attention during training and inservices. In addition, we provide further educational development and resources to individual artists when needed.

Individual Support

The time spent getting to know one another through training sessions, internship, and staff meetings has paid off. A high level of trust and respect is evident in the ease with which everyone involved in the Studio G program freely asks for, offers, and anticipates the need for support.

Over the years we have shared small triumphs and large ones. We have laughed together; we have cried together. We all seem to agree that this rewarding personal and professional experience, like fine wine, seems to grow richer with time.

Studio G
Artist Post-Training Questionnaire

Name ____ *Date* ___________________________

Please rate your current knowledge about the following topics using the scale below:
1 = I know nothing about the topic.
2 = I know a little bit about the topic.
3 = I probably know as much as the average person knows about the topic.
4 = I probably know more than the average person knows about the topic.
5 = I know a great deal about the topic.

1. The special needs of children in hospitals — 1 2 3 4 5
   Comments:

2. Child growth and development — 1 2 3 4 5
   Comments:

3. Communicating with children — 1 2 3 4 5
   Comments:

4. Hospitalization's impact on a child's family — 1 2 3 4 5
   Comments:

5. The role of families in hospitals — 1 2 3 4 5
   Comments:

6. Safety considerations when using the arts with children who are ill or disabled — 1 2 3 4 5
   Comments:

7. Grief issues for children and families — 1 2 3 4 5
   Comments:

8. The ways in which the arts meet the psychosocial needs of children who are hospitalized — 1 2 3 4 5
   Comments:

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Appendix A
Organizations

Child Life Council
11821 Parklawn Dr., Suite 310
Rockville, MD 20852-2539
Phone: 301-881-7090
Fax: 301-881-7092
Web: http://www.childlife.org/

Established as a nonprofit organization in 1982, the Child Life Council represents a group of trained professionals with expertise in helping children and their families overcome life's most challenging events. The Child Life Council membership is composed of nearly 4,000 individuals representing more than 600 organizations worldwide. Members include child life specialists, child life assistants, university educators and students, hospital administrators and staff, school teachers, therapeutic recreation specialists, and others in related fields.

Institute for Family-Centered Care
7900 Wisconsin Avenue, Suite 405
Bethesda, Maryland 20814
Phone: 301-652-0281
Fax: 301-652-0186
Email: institute@iffcc.org
Web: http://www.familycenteredcare.org/

The Institute for Family-Centered Care provides leadership to advance the understanding and practice of patient- and family-centered care in hospitals and other health care settings. The Institute serves as an information resource center for patient and family leaders, clinicians, administrators, educators, researchers, and facility designers who are interested in advancing the practice of patient- and family-centered care.

The Institute provides consultation, training, and technical assistance to hospitals, clinical practices, educational institutions, architecture firms, community organizations, and agencies at state, provincial, and federal levels. The organization offers a wide selection of resources, including printed materials such as guidance publications and self-assessment tools, videos, DVDs, and CD-ROM and MP3 Audio CDs.

National Center for Complementary and Alternative Medicine
National Institutes of Health
9000 Rockville Pike
Bethesda, MD 20892
Email: info@nccam.nih.gov
Web: http://nccam.nih.gov/

The National Center for Complementary and Alternative Medicine (NCCAM) is the Federal Government's lead agency for scientific research on the diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine.

NCCAM sponsors and conducts research using scientific methods and advanced technologies to study CAM. CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. NCCAM has four primary areas of focus:

- *Advancing scientific research*—NCCAM has funded more than 1,200 research projects at scientific institutions across the United States and around the world;
- *Training CAM researchers*—NCCAM supports training for new researchers as well as encourage experienced researchers to study CAM;
- *Sharing news and information*—NCCAM provides timely and accurate information about CAM research in many ways, such as through their Web site, information clearinghouse, fact sheets, Distinguished Lecture Series, continuing medical education programs, and publication databases; and
- *Supporting integration of proven CAM therapies*—NCCAM research helps the public and health professionals understand which CAM therapies have been proven to be safe and effective.

Society for the Arts in Healthcare
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The Society for the Arts in Healthcare is a non-profit 501(c)3 corporation in Washington, DC. Founded in 1991, the Society for the Arts in Healthcare is dedicated to advancing arts as integral to healthcare by:

- Demonstrating the valuable roles the arts can play in enhancing the healing process;
- Advocating for the integration of the arts into the environment and delivery of care within healthcare facilities;
- Assisting in the professional development and management of arts programming for healthcare populations;
- Providing resources and education to healthcare and arts professionals; and
- Encouraging and supporting research and investigation into the beneficial effects of the arts in healthcare.

The Society for the Arts in Healthcare welcomes members from the U.S. and abroad. Membership includes professionals, students, and organizations in both the arts and medicine. Benefits of membership include access to an online membership directory; eligibility to apply for grants and awards; a subscription to the Society's professional journal *Arts & Health: An International Journal for Research, Policy and Practice;* discounted registration rates for the annual conference, regional meetings, online trainings, and consulting services; access to a listserv, e-newsletter, news article briefings, research, model programs, best practice, and tools; and opportunities to join Special Interest Groups and Arts in Healthcare Networks.

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VSA arts is an international nonprofit organization founded in 1974 by Ambassador Jean Kennedy Smith to create a society where people with disabilities learn through, participate in, and enjoy the arts.

VSA arts showcases the accomplishments of artists with disabilities and promotes increased access to the arts for people with disabilities. The organization also provides educators, parents, and artists with resources and the tools to support arts programming in schools and communities.

Appendix B
Artist Folder Contents

1. Agenda
2. Artists roster
3. Pad of paper
4. Photocopy of Appendix A
5. Optional: Figures 4–8 (Total Healing Environment) and 5–2 (Typical Sound Pressure Levels for Common Sounds) from "Innovations in Healthcare Design," by S. Marberry (Ed.), 1995, New York: Van Nostrand Reinhold.

About the Authors

Judy Rollins, PhD, RN, coordinator of Studio G, is a nurse with a fine arts degree in the visual arts, an MS in child development and family studies, and a PhD in health and community studies. She is president of Rollins & Associates, a research and consulting group in Washington, DC, and an adjunct assistant professor in the Department of Family Medicine and the Department of Pediatrics at Georgetown University School of Medicine. She serves as associate editor of *Pediatric Nursing* and North America regional editor for *Arts & Health: An International Journal for Research, Policy and Practice*. Dr. Rollins consults, writes, and researches on children's issues, with a special interest in the use of the arts for children in healthcare settings and a focus on children with cancer and their families.

Carmel Mahan, MSEd, CCLS, is former coordinator of Child Life services at Georgetown University Hospital, and currently serves as an early intervention specialist with the Baltimore County Public School System in Baltimore, MD. She has a BS in human development and family relations and a MSEd in special education. Ms. Mahan has over 25 years experience as a Child Life specialist in a variety of acute care settings. She and Dr. Rollins have collaborated on a number of projects to benefit children and families in healthcare settings and to educate the professionals who care for them about their psychosocial needs.