Art Therapy for Mothers in the Neonatal Intensive Care Unit

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Abstract

Premature birth affects thousands of families every year. It is common for infants born prematurely to spend extended time in the hospital’s Neonatal Intensive Care Unit while they continue to develop until they’re healthy enough to go home. Having an infant stay in the hospital can put many extra stress on families. Worries about the health and wellbeing of their child, financial stressors, and concerns about cultural differences are just a few of the many aspects of a stay that can affect families. Mothers of neonates are especially susceptible to feeling these stresses in addition to concerns about breastfeeding and bonding while they are physiologically and emotionally recovering from birth. Postpartum mental health is a serious concern for mothers with children in the neonatal units as they are more susceptible to diagnoses than mothers of healthy, full term infants (De Magistris, Conni, Puddu, Zonza, & Fanos, 2010; Horwitz et al., 2015; McIntosh, Stern, & Ferguson, 2004). In an effort to support families of premature infants, hospitals should offer art therapy support groups for mothers of infants in the Neonatal Intensive Care Unit. Group art therapy would provide an opportunity to participate in art therapy-specific directives that encourage processing of emotions, decrease stress, challenge feelings of inferiority, and promote a sense of social interest and belonging within a community. It should be mentioned that because the author has spent significant time as a mother of premature infants in the neonatal units there is inevitable bias in this proposal.
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Art Therapy for Mothers in the Neonatal Intensive Care Unit

Understanding the NICU

On an average day in the United States, one out of 10 infants are born prematurely; and every 90 seconds a baby is born with a low birthweight, or weighing less than 5 1/2 pounds (March of Dimes, 2016). A pregnancy is considered full term at 40 weeks’ gestation, and prematurity is defined by a birth prior to 37 weeks gestation. Many infants born prematurely spend extended time in the hospital’s Neonatal Intensive Care Unit (NICU) or Special Care Unit (SCU) to receive additional medical treatment until they are able to go home with their families (“Premature Babies,” 2013). Before being discharged, infants need to meet specific goals including but not limited to independently regulating their body temperature and blood sugars, eating and breathing without assistance, and consistently gaining weight. Babies born prematurely may suffer from a number of life-long disabilities such as cerebral palsy and developmental delays (“Premature Babies,” 2013; March of Dimes Foundation, 2013). The average NICU stay and medical cost is 13.2 days and $76,000 respectively, but many families do not get to bring their baby home for weeks or months and their bills can skyrocket upwards of $280,000 (March of Dimes Foundation, 2011).

Implications of Hospital Stay

Family Stress

Having a child in the NICU can create a number of stresses on a family. Aside from being worried about the health of the preterm infant, there are often concerns about the physical and emotional health of mom as she recovers from her birth experience (Zimmerman & Bauersachs, 2012). Mothers of preterm babies are especially susceptible to feelings of worry, inferiority, and isolation, all of which can subsequently affect the well-being of an entire family.
system. Life goes on outside of the hospital and parents of NICU infants have to continue to provide for other children, pets, and household responsibilities. The family is continually separated while members take turns being at the hospital and returning home. Families may not have access to what they would traditionally use as coping strategies and it is common for mothers of preterm infants to suffer from postpartum psychological disorders (Carley, 2012).

A NICU stay is also a significant financial burden on families, and it manifests in multiple ways. Families need to plan how they will pay for extra hospital bills and child care for other siblings. Many mothers face the difficult decision of choosing to go back to work very soon after birth so that they can use their maternity leave when the baby discharged, or fear that they may lose their job for taking too much time off to be at the hospital (Cleveland & Horner, 2012). All of these stresses affect more than just mom and partner, they affect every family member and the family system as a whole.

**Psychological Distress, Breastfeeding and Attachment**

Many mothers with premature babies in the NICU experience adverse psychological effects (Carley, 2012; Cleveland & Horner, 2012; De Magistris, Conni, Puddu, Zonza & Fanos, 2010; Franck & Axelin, 2013; Horwitz et. al., 2015; McIntosh, Stern & Ferguson, 2004; Zimmerman & Bauersachs, 2012). Research suggested that NICU moms experience more maternal distress than mothers with typical or term birth experiences (McIntosh et. al., 2004). Post-traumatic stress disorder (PTSD), acute stress disorder (ASD), postpartum depression (PPD) and anxiety are all more commonly seen with women who have experienced a preterm birth than mothers with full term infants (De Magistris et al., 2010; Horwitz et al., 2015; McIntosh et al., 2004). PPD, the most common of these diagnoses, is also often under reported for fear of
appearing as though the mother isn’t happy about the birth of her child, or that she is unable to fulfill her maternal role (Leahy-Warren, McCarthy, & Corcoran, 2011).

Mothers experience a wide range of psychological symptoms while their child is in the NICU. It is common for women to be obsessively concerned over the well-being of her child, which can cause frequent mood swings, unjustified fears, or even delirium. A mother’s mood can often range from sadness, anger and loss of concentration to hyperactivity, agitation, and talkativeness among many others (De Magistris et al., 2010). Many mothers feel shame, guilt, or both about their circumstances and often blame themselves for being unable to sustain a longer pregnancy or give birth to a healthy child. These perceptions can cause feelings of inferiority and incapability, which can lead to suppression of emotions and discouragement from asking for help. The cause of this discouragement may include fear of not living up to society’s expectations of a mother (De Magistris et al., 2010; Lavoie, 2015).

As many as 19% of women experience PPD during pregnancy or in the first three months postpartum (Borra, Iacovou, & Sevilla, 2015), and the number is higher for women with a child born prematurely. Although breastfeeding has been shown to be protective against PPD (Lavoie, 2015), it is widely acknowledged that mothers suffering from PPD experience more struggles with breastfeeding (Borra et al., 2015; Lavoie, 2015; Zimmerman & Bauersachs, 2012). This is particularly important for premature infants for whom the nutritional and emotional benefits are critical (La Leche League International, 2016; March of Dimes Foundation, 2017). The overwhelming emotional symptoms of PPD can make the struggles a mother faces with breastfeeding feel unbearable (Lavoie, 2015). Lack of sleep, stress and low levels of the hormone oxytocin, which is excreted during maternal-infant bonding, are all factors of a mother’s milk supply (Badr & Zauszniewski, 2017; Feher, Berger, Johnson & Wilde, 1989).
Mothers with children in the NICU are at a unique disadvantage when it comes to breastfeeding because stress is high, and there are fewer opportunities for bonding. Pumping mothers are also waking every three hours or more often, and lack of quality sleep is a significant contributor to PPD (Okun, 2016). It is common for neonates in the hospital to be fed through a feeding tube or from a bottle instead of at the breast, and a breast pump is not as efficient as a baby at removing milk and establishing the mother’s supply in the first days post birth. Even if struggles with breastfeeding are not related to the mother, babies born prematurely may have other health concerns that can interfere with the breastfeeding relationship (March of Dimes Foundation, 2017). According to a study by Borra et al. (2015), mothers who intend to breastfeed during pregnancy and are unsuccessful after birth are at an increased risk for PPD and may need specialized support to process these feelings of perceived failure and inadequacy. The relationship between breastfeeding and PPD is complex as each affects the other. Women with infants in the NICU have a particularly complicated experience around breastfeeding and could greatly benefit from encouragement and emotional support around their success or struggle.

When women are psychologically struggling in the postpartum period, there are many implications for herself, her infant, and her family. One particularly important aspect of these is the effect on parent-child attachment. PPD can significantly affect the maternal-infant attachment (Balbierz, Bodnar-Deren, Wang, & Howell, 2015; Borra et al., 2015; Lavoie, 2015; Zimmerman & Bauersachs; 2012). Even when a mother’s depressive symptoms are not significant enough for a clinical diagnosis, her children are shown to be negatively affected (Goodman & Santangelo, 2011). Postpartum women experiencing depressive symptoms are often less engaged and less interactive in their parenting, less likely to perform daily routines, and show to be less attentive to babies’ cues. Depressed mothers are also less likely to follow
important safety guidelines such as using a car seat and putting their child to sleep on their back (Balbierz et al., 2015). Infant attachment can affect the child throughout their entire life, and PPD can continue to pose a long term risk for a mother’s mental health and the development of her children physically, socially and cognitively (Borra et al., 2015). It is imperative the mother experiencing PPD seeks medical and psychological treatment, as the risks for both mother and infant can be lifelong and potentially life threatening if left untreated (Lavoie, 2015). The extra care to treat these psychological implications may be another financial burden for families as many women need to miss work and find extra childcare during this time (Borra et al., 2015). All of the above consequences can affect the relationship between mother, her partner, and the rest of the family.

Having a child in the NICU can disturb the natural bonding experience between the mother and baby (Zimmerman & Bauersachs, 2012). Many preterm infants cannot be touched or held without permission and assistance from the medical team. Monitors, wires, and IVs make it awkward to comfortably hold and- or breastfeed the baby, and although many hospitals encourage the use of kangaroo care (skin to skin contact between mother and child that affects the biological response between the two), many babies in the NICU typically do not get the amount of temperature regulating and hormone inducing skin to skin time that full term infants do (Zimmerman & Bauersachs, 2012). The hormones released during kangaroo care can also influence the attachment between mother and baby and the success with breastfeeding: two consequences that can affect both mother and child long after the hospital stay is over.

A mother’s experience in the NICU is unique because, in addition to her emotional and psychological adjustment to having a premature infant and the societal expectations around the role of a mother, she is also physically recovering from birth. Regardless of whether a mother
had a natural birth or cesarean section, she experienced a change within her hormones and physical body that is out of her control and adds to her psychological distress. In addition to all of this, a mother’s health influences the health and adjustment of her family.

The effects of a stay in the NICU are significant for infant, mother, and the entire family in both impact and variety. Families face stresses of separation, worries about finances, and what life will be like moving forward. Mothers of infants in the NICU experience all of this in addition to her own feelings surrounding the birth of her child and her physical and emotional well-being.

**Cultural Implications**

Consideration of a family’s culture is imperative for a hospital to provide a successful experience in the NICU (Cleveland & Horner, 2012; De Magistris et al., 2010; Zimmerman & Bauersachs, 2012). It is extremely important that the hospital staff be sensitive to cultural implications such as race, religion, age, housing, and income (Wagner, 2015; Zimmerman & Bauersachs, 2012). Women of color in the United States are at a higher risk of giving birth prematurely. Black infants are more likely to be born prematurely, at a low birth weight, and are more than twice as likely as white infants to die in the first year of life (Carpenter, 2017; March of Dimes Foundation, 2016; Mclain, 2017). Research suggests that the discrimination black American women face throughout their lifetime is to blame for these statistics, and many have legitimate fears of experiencing additional prejudice and mistreatment in the hospital (Mclain, 2017; Wagner, 2015).

Cleveland and Horner (2012) have found that aside from the previously explained universal stresses experienced by families and mothers in the NICU, Mexican-American and Latina mothers feel additional cultural stresses related to language barriers, uncertainty,
involvement, and fear of discrimination. It was concluded in their study that families who receive limited information about their child’s condition and treatment because of these factors put their infants at an increased risk. The two most important factors for the Mexican-American mothers in the study were described as personalismo and familismo, the first meaning a personalized connection between the infant’s family and the nurses and NICU staff and personalized care for their infants. The second is in regards to the profound importance of family support, especially when bringing a baby home (Cleveland & Horner, 2012).

Zimmerman and Bauersachs (2012) expanded on these concerns by explaining a number of specific cultural intricacies they have faced in the NICU. For example, Amish families typically have children at home but will stay in the hospital with their infant in the need for life-saving technology. Somali families practice specific post-birth customs that support mothers, and Arabic, Mexican, and Indian families have specific roles for mothers and fathers that may call for an adjustment in communications.

The aforementioned examples just touch on a few of many of unique populations that deserve care that is conscious of their cultural experiences, beliefs, and practices. Being aware of, becoming educated on, and incorporating these cultural concerns into the NICU experience is not only beneficial for both mother and infant; it is imperative. By participating in an art therapy support group, mothers would have an opportunity to incorporate their cultural concerns, practices, and customs into their hospital stay.

**Supportive Practices**

**Family Support**

Research has shown that it is crucial for mothers and caretakers to receive emotional support while they are in the NICU. When a parent feels elevated levels of stress and anxiety, it
is harder to focus and retain information about their child and the care plan (Reichman, Miller, Gordon, & Hendricks-Munoz, 2000). Franck and Axelin (2013) found that NICU parents perceive almost all of the support they received in the hospital is given by the nursing staff.

From the author’s own experience, having two children born prematurely and spending extra time in the hospital’s neonatal units, it was observed that the nursing staff takes on a surprising amount of responsibility in serving the infants and families who stay in the NICU. NICU nurses care for multiple infants at one time and typically perform or oversee an almost never ending list of cares. Nurses coordinate the feeding, weighing, bathing, checking of vitals, and administration of medications to their neonatal patients while answering to beeping machines and rushing to babies who struggle to breathe, maintain their temperature, or regulate their blood sugar. They answer phone calls from concerned parents, attend meetings with doctors and care teams, and coordinate with other departments within the hospital (such as lactation support, social workers, etc.). To include providing the majority of the emotional support of mothers and families as part of a NICU nurse’s job description is risky because it might not always be possible to fulfill every one of their responsibilities. Studies by Tubbs-Cooley, Pickler, Mark, and Carle (2015) and Turrill (2003) focused on the neonatal nurse’s workload and have found that not all infants in the NICU receive adequate care due to the pressures and the number of responsibilities placed upon nursing staff. Turrill (2003) specifically cited the need for “the introduction of non-nursing support roles” in order to improve conditions for nurses and subsequently, infant outcomes. Nonetheless, Franck and Axelin (2013) concluded that the families of infants in the NICU do need to receive support from hospital staff as well as suggested that the nurses and physicians in the NICU be critically aware of how they show their support in an attempt to align with and fulfill a parent’s perceived needs. Parents who
do not feel supported by the staff in the NICU reported that they felt ill-informed and missed out on opportunities to bond and form a relationship with their newborns (Franck & Axelin, 2013). All aspects of care for NICU infants and families are of utmost importance, and it is not realistic or responsible for the nursing staff to be expected to provide adequate emotional support to families in addition to the care of an infant. An art therapy support group for mothers with children in the NICU run by art therapists with a degree in psychology or counseling as well as specific art therapy training would be the best way to ensure family support.

The research on what works best to support families of NICU patients has provided insight into the complexity of the experience. Parents and families go through a significant adjustment around the birth of a healthy, full term baby. Not surprisingly, the numerous complicating factors around a premature birth can significantly impact this integration and adaptation (Zimmerman & Bauersachs, 2012). Many hospitals are currently opting for family centered care where parents are included in the development of care plans and in the care-taking of their infant (Zimmerman & Bauersachs, 2012). Providing these supports to mothers and families goes beyond emotional benefits to family and infant in that it can also support neurological organization and physiological stability in the infant (Bowden, Greenberg, & Donaldson, 2000). Parents reported having a better experience overall when they were asked about their culture, thoughts, and feelings around their circumstances, are well informed of their child’s care, and developed a trusting relationship with the care team. It is seen as the hospital’s responsibility to not only care for the preterm infant but also encourage bonding between infant and caretakers, provide education, promote coping skills to alleviate stress, and support families in their preparations to bring their infant home (Zimmerman & Bauersachs, 2012).
The event of having a child in the NICU is often unexpected and can cause a frightening sense of uncertainty around the health of the infant for the parents, and mother especially (McIntosh, 2004). A mother’s disposition, optimism, and use of coping strategies can have a significant impact on both mother and child during and following the hospital stay (McIntosh, 2004). It is incredibly important that mothers have opportunities to express and process their emotions so that they can come to terms with their experience. Focusing on concrete events and recognizing parenting milestones can combat a mother’s avoidance or denial she may experience as a result of her distress (Carley, 2012). Lavoie (2015) suggested that to successfully support women struggling with psychological symptoms or diagnoses postpartum, care providers should use the Five Es in their approach: encouragement, empathy, education, engagement and evaluation. In using these strategies, providers get an understanding of the mother’s feelings and can positively influence her experience, her coping skills, and her concerns around breastfeeding. Mothers benefit greatly when they are educated on the symptoms of PPD, are aware of what types of treatment are available to them, and when to seek help. It is in the best interest of the hospitals, families, and infants for mothers to be provided with this information and support.

Social Support

Social support for mothers suffering from PPD has been shown to effectively decrease depressive symptoms (Goodman & Santangalo, 2011; Leahy-Warren, McCarthy, & Corcoran, 2011). The NICU is a part of the hospital that cares for many of the most vulnerable infant patients. The rooms in this unit are required to be sterile and quiet and are often kept dark in order to protect the infant and provide an environment conducive to developing as though the neonate is still in the womb. Many NICUs now offer private rooms (as opposed to an open ward) for each infant where his or her health and privacy are well protected, a decision that also
separates the family and caretakers from others going through similar experiences. Mother-to-mother support groups have been shown to be successful in influencing a woman’s perception around her family’s current situation, as well as introducing breastfeeding techniques and assisting in making informed decisions about care for herself and her infant (Horwitz et al., 2015). Offering a support group to the mothers of infants in the NICU not only gives a platform to do that, it creates a community of women that can normalize the feelings that come with the experience and begin an important conversation. Many NICU mothers do not know other women who have experienced having a child prematurely, and spending much of their time in a private room at the hospital discourages them from speaking with other families who share their experience. Social isolation detracts from a mother’s sense of community feeling, or her feelings of empathy and belonging. This could exacerbate her emotional struggles and affect her ability to make proper decisions (Mosak & Maniaci, 1999). Lavoie (2015) suggested that providing a holistic environment in which mothers can also participate in therapeutic activities and gain support can positively influence the coping and recovery of PPD and other psychological impacts.

**Art Therapy**

Although research is lacking on the use of art therapy for NICU mothers, a study conducted by Mouradian, DeGrace, and Thompson (2013) found that an art-based occupation group was successful by producing a clinically significant reduction in anxiety for parents in the NICU. Parents who participated in the group made scrap books about their hospital experience, and reported that they enjoyed the experience and felt more relaxed.

There is evidence to suggest that art therapy is beneficial in treating depression, as well as women who struggle with infertility and other issues surrounding their reproductive health. The
use of visual imagery and creative self-expression allows for visual communication and expression that is challenging to verbalize. Based on psychological testing, group art therapy has been found to significantly reduce participants’ feelings of hopelessness and depression (Chandriaiah, Anand, & Avent, 2012). Hughes (2009) explained that when working with women experiencing psychological effects from infertility, he saw a decrease in stress, anxiety, and hopelessness by providing an opportunity to participate in an art therapy group with other women experiencing similar struggles. Art therapy offers an advantage over verbal based therapies in showing the participants and therapists the thoughts and feelings that may be otherwise hidden. In Hughes’ 2009 study, the participants rated their satisfaction with the group as extremely high. After starting with some inhibitions about creating art, the women quickly discovered the benefits of art therapy including stress reduction, an increase in self-awareness, an increase in self-esteem, and having a safe place to explore what they may perceive as negative emotions. Hughes (2009) found that every art therapy group of this kind he witnessed created such a bond between participants that they have left with contact information to stay in touch with one another.

Currently, art therapy in the NICU is offered at few hospitals around the country. There are programs at Riley Children’s Health at Indiana University, Children’s Hospitals of Philadelphia and the Children’s Hospital of Wisconsin shares an art therapy healing photography project of a NICU mother on their website (Burns, 2017; Children’s Hospitals of Wisconsin, 2016; Children’s Hospitals of Philadelphia, 2017). This suggests that the shift into providing a more creative and supportive environment for moms in the NICU has begun. There is much room for improvement and expansion, but it is promising to see that some progressive
institutions have taken the steps to improve the lives of their most vulnerable patients and their families.

**Art Therapy for Mothers in NICU**

The proposed art therapy program for mothers of infants in the NICU is a way to provide emotional support where mothers want to be: near their child. From the author’s experience, it seems that many women are reluctant to seek help outside of the home or hospital because they don’t want to be away from their children. In addition to feeling discouraged and overwhelmed, it is common to feel inadequate in their role as a mother. Taking the time away from their infant or other children to seek professional help can exacerbate these feelings. Because of the high probability of NICU moms to suffer from PPD, PTSD, ASD, among other psychological diagnoses, the support program needs to be facilitated by a trained art therapist. It would be irresponsible, as well as unethical, to have a person not trained in mental health and art therapy to process the art and the myriad of complicated emotions surrounding the NICU experience (Art Therapy Credentials Board, 2016). Mental illness is a potentially life threatening disease, and a trained mental health professional should be the only person providing therapeutic services to someone suffering from a mental health diagnosis. In addition, art therapy is a specific and complex field, and a trained art therapist understands the psychology behind the creative process, use of specific art materials, and how to process art work along with addressing emotional health. The art therapist facilitating this program should also be sufficiently educated in childbirth; understand the risks and the effects on both mother and child when a birth doesn’t go to plan, as well as general knowledge on NICU practices, preterm infant health, and postpartum practices and diagnoses.
Carley’s article (2012) on journaling as support for NICU families does a very thorough job explaining many specific emotions that parents in the NICU feel and one way they can process their feelings and concerns. Through journaling, parents are able to acknowledge their struggles and successes, channel their emotions into a creative and productive expression, and connect with others through sharing their story. Art therapy also encourages all of these things and takes it further by building on an individual’s creativity, providing guidance and encouragement for coping skills and self-esteem, and facilitating a deeper conversation between therapist and group members. The art therapist and participants can align their goals for therapy and facilitators will be able to suggest art directives that cater to the specific needs of group members based on their unique situations.

Though sometimes it is suggested that the process of creating art is the most important part of the art therapy experience, having a physical piece of work to hold and honor a profound experience can be incredibly healing and transformative. This gives mothers an opportunity to revisit an event without holding the emotional weight of it. For example, when mothers create a container to hold the tiny socks, hat, and hospital band that they’re given when sent home from the hospital, they affirm the incredible impact that the NICU stay had on their life and on their family.

Creating and working on art directives can channel the energy that is often caused by feeling an emotional dissonance between the struggles and joys surrounding the birth of a premature child. Working through those conflicting thoughts and feelings helps with a mother’s understanding of her experience. With this, she can move forward rather than find herself stuck in a psychologically unhealthy place. When humans experience complex and confusing emotions, it is often hard to accurately verbalize them. By creating a piece of artwork, mothers
are able to release their feelings first and begin to process and understand them after. This opens up the potential to uncover something they may not have otherwise known and gives an opportunity for expression even if they’re not ready to discuss their experience. With this insight, participants can allow for reframing or begin to see ways that their time in the NICU can positively influence their own life, the lives of their family members, and the community they are a part of.

For mothers whose cultural background plays an important role in their definition of motherhood, art therapy can provide an opportunity to incorporate cultural and spiritual beliefs and practices into their child’s hospital stay. When we look at a mother holistically, we see that no part of her life is fully separate from the rest. Being aware of and incorporating culture into therapy is an important way to support her and her family. For example, Cleveland and Horner (2012) found that the large extended family was very important to Mexican-American and Latina mothers in the NICU. One strategy mothers used to cope was to leave part of me with baby. They brought bibles, blankets, clothing, and photos from home to keep with their child in the hospital. They expressed feeling some relief knowing that parts of their family and their culture were there when they could not be. Art therapy provides a safe space to discuss cultural beliefs, rituals and traditions and how they affect the individual families while in the hospital. The therapist and mother can then come up with ways to incorporate these important elements as a way to relieve some of their stress and increase their sense of connection.

Mothers who feel isolated by spending time in their infant’s quiet room and who are not getting enough connection and social support from outside the hospital can benefit greatly from attending art therapy support groups. Sharing a mother’s experience and learning that her reactions, feelings, and doubts are common can help normalize something that otherwise feels
foreign and uncertain. Being a part of a group encourages feelings of safety, significance, and belonging (Ansbacher & Ansbacher, 1956); it fosters an environment where women can receive and give support to other struggling mothers. Having the ability to help another person and engage in social interest promotes an increase in the mother’s self-confidence as well. When she is able to create something and give it to another mother or infant in the NICU, she builds a relationship, she spends her time being productive, or on the useful side of life (Mosak & Maniacci, 1999), and she proves her own competence to herself. When engaged in these groups of support, women can see their self-worth, improve their own emotional health, and the emotional health of other group members. That positively affects the health of their infant and their entire family.

**Discussion**

There are risks and limitations to this program, as there are for all therapeutic groups. It should be mentioned that not all mother’s in the NICU may feel comfortable with joining a group to create art and share their story with other women. This group does not address the needs of mothers with physical and/or cognitive disabilities, adoptive parents or same sex couples. This proposal also does not specifically address the need for grief and loss counseling, and some families may need separate or follow-up support after the death of an infant. An art therapy group for NICU moms would require a private space with quality art materials which would be accessible to women who visit the hospital during the day and at night. There is also a risk for secondary trauma of other group members and staff facilitating, and a further need for managing emotional responses.

The author presented the information about the needs of NICU mothers and how art therapy could support them to social workers and child life specialists at Children’s Hospital in
St. Paul, Minnesota in May of 2017. According to the evaluation surveys, all of the staff and visitors who viewed the presentation stated that information presented had a positive influence on their support for this type of program and it raised no concerns for them. Attendees noted that they took away valuable information about the importance of art and creativity in their current practice and the strong need for women in the NICU to receive support and have opportunities to connect with other moms. Suggestions for improvement included giving more specific examples of art directives and visuals of what this type of group would look like. In the future, it would be helpful to share the example of a mother’s photography project which is public on the Children’s Hospital of Wisconsin’s website.

Although the author has bias because she has been a NICU mom, hospital staff seemed to agree that there was a strong need of support for this population. Two women who attended the presentation were already doing work with families in the NICU, one specifically running a program for NICU moms after their child is discharged. Going forward, future research is needed for more scientific evidence to support the claims of art therapy as treatment for depression, anxiety, postpartum disorders and for the specific population of NICU moms.

**Conclusion**

Having an infant in the NICU is a complicated experience for families; especially for mothers. Worries about the health and safety of her child is only one of many stressors women face when they cannot bring their infant home after birth. NICU mothers are overwhelmed with concerns about bonding with their infant, their own health, their finances, breastfeeding, specific cultural implications and their relationship with the hospital staff. Although it is the responsibility for NICU nurses to provide support for families to an extent, nurses do not have the time or training to emotionally support NICU mothers as they should be supported. The risk
for serious mental illness is too high, and the emotional reactions to a NICU stay are too complex. If hospitals provide an opportunity for mothers to participate in art therapy support groups, mothers have an opportunity to connect with and support others in a socially interested way and thus create an opportunity for self care so that they can provide for themselves, their infants and their families.
References


