

A Grounded Theory of Liminal Space in Art Therapy:
Between the Paradigms of Clinical and Community Practices

by

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ABSTRACT

In this dissertation, the author examines opposing paradigms within art therapy, and documents research that further unifies the areas of clinical, or private and medicalized, and community, or public and within community settings, art therapy practices. The author proposes a grounded theory of liminal space where both clinical and community practices are linked by common threads. The literature explores the integration of post-modern critical theory and liberatory practices with modern theory, psychodynamic and humanistic practices. Critical theory and liberatory practices examine power hierarchies and limits oppressive power in the therapeutic process. In this study, work within liminal space in art therapy offers both private and community art therapy services in one setting and seeks to help transform clients, art therapists, and art therapy practice settings. The goal of this study was to provide art therapy participants at two sites, A) a daytime homeless shelter and B) an art therapy studio that offers clinical treatment and a community art therapy program, the opportunity to work within liminal space to influence their personal development and sense of connection to community. The author found during the course of critical participatory action research to discover a grounded theory on liminal space in art therapy that in both the clinical and community paradigms, it is necessary to develop the therapeutic relationship, assess, and further secure attachments within participants before they are able to create and connect to community.

Clinical art therapy, community art therapy, liminal space, critical theory, liberatory practices, participatory action research, grounded theory

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CHAPTER 1: INTRODUCTION¹

Introduction

For several years I worked as a professional art therapist in a large group private practice of over 100 mental health therapists. In a staff meeting one particular day, I chose to talk about a depressed 16-year-old client with whom I had discussed bringing her parents into sessions to widen her support network and sense of belonging within her family. My psychoanalytically minded colleagues unanimously cautioned me about jeopardizing the therapeutic relationship with my client by incorporating family members.

I left the staff meeting feeling very alone in my approach to therapy. I was confused— although years of experience as an art therapist had taught me that it is difficult to change a system, disregarding the family and social contexts would not help the treatment of the individual. How could I consider the broader system and connect my clients with their families and communities? I wrestled with what clients needed and what art therapy could do; I wondered about how to continue to see individuals and families without abandoning the education and skills I had developed. As a therapist, I enjoyed my power and ability to diagnose and provide treatment to people, although in my heart I did not want to reduce a person to a psychopathological diagnosis that could be oppressive to them rather than empowering. I realized that I had been romanced into thinking that individual psychotherapy alone could heal; what I saw over time was that many clients who met treatment goals ended up isolated from family and community

¹ Portions of this chapter were published in Nolan, E. (2013). Common ground of two paradigms: Incorporating critical theory into current art therapy practices. *Art Therapy: Journal of the American Art Therapy Association*, 30(4), 177-180.

members who were still considered “unhealthy.” These conflicts began to loom over my practice until I emancipated myself from the large group medical setting and created my own practice.

I had started my doctorate in art therapy and became deeply interested in changing my practice to include a community component. Subsequently, I opened a studio and gallery space in which my art therapy practice now resides. I collaborated with another art therapist, and we both decided to see clients within the space. We agreed our practice would remain with individuals and families, but also would be mindful of social and cultural contexts in which clients lived and the possibilities of emancipatory practice from which they could benefit. In this introduction to my dissertation project I will discuss my struggle to incorporate these intentions into my existing theoretical and clinical orientation. I will consider two major paradigms of art therapy practice—the clinical and the community— and how they can find common ground.

Knowing Personal Framework

My clinical framework was grounded initially in Adlerian art psychotherapy. Briefly, Adler began practice in Vienna, Austria over 100 years ago and brought his practice to the United States in 1932 (Mosak & Maniacci, 1999). According to a review by Mosak and Maniacci (1999), Adlerian theory espouses that every person has a lifestyle, a way in which that person moves through life toward a final unconscious goal. A person’s thoughts, behaviors, and emotions all have a purpose, and that ultimate purpose is in service of the goal. Adler did not agree in diagnosing people with disorders, but rather to identify maladaptive thoughts or mistaken beliefs created through early life

experiences that were repeatedly sought out to confirm the belief system. Mistaken beliefs can be uncovered through early childhood recollections (before the age of 12) to elicit the current belief system; the purpose is not to dredge up the past but to allow the client insight into changes in future thoughts, behaviors and emotions. Adler believed that people could be generally categorized into types, but each person is unique in how that type manifests itself within the personality.

The search for belonging is an essential part of Adler's theory. Part of our goal as people is to have a sense that we are a part of the world we live in, and to play a role within our multiple social and familial groups (Ansbacher & Ansbacher, 1956). This is somewhat tied to what Frankl (1984) existentially theorized as "meaning" in his writing. A person needs meaning in his or her life to feel useful and worthwhile. The meaning one finds in life also addresses the spiritual task that is described in Adlerian theory; it is one of the three life tasks (Ansbacher & Ansbacher, 1956). Frankl's theory focused on the concepts by which people place themselves into context with their group. For example, within the role of the teacher I have professed for myself, I get meaning from being the one who teaches, and it is from this role that I find my place. Likewise, by helping clients create healthy social roles and relationships in which to collaborate with others, together we find their place of belonging. Art therapists use art to look at who the client is and work with what is innately in them; and they do not try to make clients into something that does not support who they feel themselves to be.

In therapy I use the triadic mode of practice (Peven, 1996) where thoughts, behaviors, and emotions all influence each other, but at some point early on I realized that my practice needed a more "intersectional framework" (Talwar, 2011) that addresses

other issues that influence therapy. An intersectional framework considers people in their cultural and social contexts, their race, class, gender, and sexuality. I began to explore other theories, and to learn about and incorporate them into my practice. These perspectives included narrative, attachment, feminist, multicultural, and post-modern. Then I found a theory that made space for all of the psychological, social and cultural elements held within these other theories, which was critical psychology. I continued to work to broaden my Adlerian approach through conceptualizing and practicing how critical psychology could be incorporated into my practice.

Critical theory, as defined by Austin and Prilleltensky, is “a movement that challenges psychology to work towards emancipation and social justice, and that opposes the uses of psychology to perpetuate oppression and injustice” (2001, p. 1). The approach includes questioning what psychology does “to promote social justice and human liberation rather than human suffering and social control” (Austin & Prilleltensky, 2001, p. 2). In this sense, liberation is not intended as something therapists do *to* clients, but rather is a condition and a process—of collaboration *with* clients that empowers them to help themselves.

Oppression can be both internal and external (Austin & Prilleltensky, 2001.) Internal oppression, experienced as thoughts, feelings, and behaviors, can be addressed individually in therapy. An example of this internal oppression can be seen in patients who struggle with body image. The negative thoughts and feelings they have about their bodies are internally oppressive and can cause anxiety and depression. External oppression describes cultural and social contexts that affect a person’s physical and mental health, such as the culture of consumerism, the media, the widening gap between

the rich and the poor, and the impact of globalization (Bezruchka, 2003, 2006). Using the same example of the person who experiences internal oppression from issues with body image, the messages he or she receives from friends, family, culture, and society at large are sources of oppression. Understanding that internal and external oppression are connected makes understanding the treatment that clients ask for clearer and more complete. Individual and social liberation are linked; without one the other is limited (Watkins & Shulman, 2008.) Critical theory is applied when therapists form and sustain the therapeutic relationship while recognizing how cultural and social contexts, experienced as internal and external oppression, impact the issues that clients bring to therapy.

Watkins and Shulman (2008) asserted that modern psychological practice can assume a perspective that is non-oppressive and works toward internal and external emancipation. Liberation from oppressive forces over which the client may have some control often starts with a “rupture” (p.134) from habitual thinking, or from going along with the status quo. This rupture happened for me during the course of my work in private practice. As I considered the role of my clients’ families and communities in their treatment, I questioned the dominant narrative of medicalized psychotherapy practice that I had learned and become a part. I asked questions about the intersecting locations from which I practiced: What is my history? How do my experiences of privilege affect my worldview and the assumptions I bring to treatment? How do they influence my work as a therapist? What about my ethnicity and socioeconomic status? I questioned how I could use my privilege to work within systems and the community to advocate for better mental health and better environments in which to explore creativity and wellness with clients.

It is through these and similar questions that I began to liberate myself from practicing within the dominant narrative I experienced at the group practice and sought ways to integrate my clinical skills into my new community practice. A critical lens involves not only examining one's approach to clients but also those of other clinicians' and administrators' behaviors toward clients and systems. This may mean standing up for patients who are being oppressed by the very institution from which they seek care. Or it may require learning the language of the other therapists in order to dialogue about effective patient care, empowerment, and justice.

Examining Two Dominant Paradigms Within Art Therapy

In art therapy, two fundamental areas of practice exist; one is in the clinical arena with typically private art therapy sessions and one is in the community arena, where the therapy happens within a larger group context but is not considered group therapy. Also in art therapy are clinicians who work in both for profit and not-for-profit hospitals and mental health clinics, therapeutic schools, community agencies, and so forth. In hospital and outpatient settings it is clear that work with clients is aligned with treatment goals, and therefore the practice is clinical in nature. In settings where art therapists work in the community without such treatment goals, the practice can be less distinct with unclear and more diffuse boundaries and goals. Art therapists work with clients to make art, for example, but the purpose isn't necessarily driven by anticipated treatment outcomes. In my study of clinical art therapy and community (or studio or art-based) art therapy I found that they represented two major paradigms in art therapy practice, as will be described later in this paper. Although seemingly dichotomous, the search for common ground between the two paradigms seems essential to make room for another, more

liberating approach. Finding the common ground was important because the on-going development of the field and its purposes can easily become confused or compromised as art therapists continue to expand their work into several different settings. In the clinical setting art therapists must develop clinical skills, but in the community settings art therapists have described more of an artist identity that drives their approach.

Allen (2008) favored the role of the “artist-in-residence” when working with community. The consideration of community in art therapy has largely taken place in art studios, such as Off Center Community Arts (Timm-Bottos, 1996), Open Studio Project (Allen, 2008), and Art Studio (McGraw, 1995). In such environments the commonality between the art therapy client and the art therapist is their shared artist identity (Moon, 2002). When practitioners cultivate an artist’s identity, as is often the case in community and studio practices, it also “makes sense to explore the many different manifestations of this identity in the clinical setting,” as Moon (2002, p. 209) wrote. Art therapists are naturally able to paint, draw, collage, and imagine new pictures; these same skills create new paradigms, find intersections in the practice settings that help individuals to heal, and empower them to imagine and to take action toward their goals. Seen from an artist’s perspective, the “rupture” from habitual ways of being, whether addressed in community or in clinical arenas, ushers in the creative and newly possible:

Making space for the transgressive image, the outlaw rebel vision, is essential to any effort to create a context for transformation. And even then little progress is made if we transform images without shifting paradigms, changing perspectives, ways of looking. (hooks cited in Watkins & Shulman, 2008, p.133)

In the shift of paradigms, an in-between or “loving third” space is created (Watkins & Shulman, 2008, p. 116). In this third space there can be social support, the presence of multiple voices, and fresh perspective. One location at the intersection of clinical and community art therapy is called the *public homeplace* (Timm-Bottos, 1992; Watkins & Shulman, 2008), a hybrid form. There is in fact a multiplicity of ways that art therapists practice and shape the profession. The common ground in which all art therapy overlaps is where people in any setting can experience a personal change through artistic expression; can interact with images and art objects; and can negotiate relationships to the therapist, others, and the environment through art experiences (McNiff, 1998).

Listening for Stories That are Influenced by the Dominant Narratives

Narrative therapy posits that “persons give meaning to their lives and relationships by storying their experience and that on interacting with others in the performance of these stories, they are active in shaping their lives and relationships” (White & Epston, 1990, p. 13). As I began to explore the potential of narrative therapy in emancipatory practice, I found that Watkins and Shulman (2008) had described a narrative as a “cultural nexus with its own particular set of imaginings about the world” (p. 141). Clients come to therapy with stories they may believe to be their own but which contain their culture’s dominant ideologies about addiction, marriage, family, gender, consumerism, and violence, among other concerns. A therapist can find and engage the dialogue between the clinical and community paradigms by listening for dominant narratives. The following example illustrates listening to the client’s dominant narrative and incorporating pieces of a critical framework into clinical practice.

An adult client who had just begun art therapy was hospitalized and diagnosed with bipolar disorder. Her month-long hospital stay and subsequent treatment with me began shortly after coming out as lesbian and breaking away from a heterosexual relationship. Her relationships at work changed as a result; she reported that she felt “picked on” by her superior at work because she was a lesbian. Her anxiety and depression worsened, rendering her unable to function in her daily life and in need of psychiatric hospitalization.

In art therapy I taught her to use cognitive reframing to examine her early childhood recollections. She was able to identify certain triggers affecting her mood swings, to explore the social basis of her mood cycle, and to strengthen her boundaries in personal and professional relationships. Therapy did not stop at this clinical boundary, however; the issues we worked through together over the next two years critically deconstructed the dominant narrative of marriage and family, as opposed to the alternative story she had created. After taking a 9-month leave of absence she went back to work and the intense questioning of her lifestyle faded. Over the course of her therapy, she realized that the “house and picket fence” she wanted in the other story could be a part of the story she lives now.

In this example the client began to build a capacity to understand herself and to advocate for her own ideal, instead of the ideals imposed upon her by society. This was a small, but significant, act of personal emancipation. As her therapist I could have limited treatment to the psychodynamic framework and the culturally sanctioned power that came with its clinical practice. By incorporating aspects of critical theory, which required me to listen more deeply and broadly to her story, our work together deepened

and strengthened her new life.

Creating the Third Space

As I contemplated my interest in changing my practice to incorporate critical theory and community aspects through the course of my doctoral research, an emerging framework not only is evident in my clinical work but also in the environment I have been creating to hold my practice. The clinical and community art therapy space where I see clients is both a studio and gallery space. Clients have the opportunity to exhibit their work to the public four times a year when all local galleries open their doors as a part of a citywide gallery crawl. In sessions before the exhibitions the artists/clients decide whether to display their artwork created in or outside of therapy. They also choose whether to sell their work or only to display it, whether to identify themselves as artists whose work was produced in therapy, and also whether to attend and dialogue about their work with viewers at the gallery opening. In the sessions following the gallery exhibition we discuss their experience at the opening, what it was like to display and talk about their work with others, and any therapeutic issues that may have emerged in these encounters.

The boundaries of our relationship remain clear: I am their therapist and the gallery owner. As a private practice space within a studio, I recognize and continue to be mindful of the power differentials that exist and how the practice operates within the structures so as not to collude with oppressive practices. For example, I could require that the client give over a large part of the money made from the sale of their artwork to the studio, as is typical in gallery operations in order to gain a financial profit. However, acting in this role would be a breach of the therapeutic relationship and my role within it.

Power is negotiated in therapy and claimed in the choices clients make with respect to how and what they will or will not exhibit, will share with the public, or will keep private. Those clients who offer their works for sale choose the price and are aware that, because it is a public gallery, a nominal portion of their sales will go toward administrative costs if not the owner's profit. In contrast the typical clinical space is arranged very differently: the therapist holds the power of the expert in the relationship between the client and clinician. The therapist is given the authority from that role to make choices about what seems to be best for the client, and encourages the client to comply out of the belief in that expertise. Awareness and dialogue about power should be an explicit part of any practice, whether it is for profit or not for profit, practiced in the community or in the clinic.

My partner and I continue to consider ways to collaborate with the community. Because we have created a transitional space within our practice for the clients to interact with the community and to dialogue about their art and experiences, many possibilities of negotiating other community endeavors have emerged. To understand these new possibilities, I chose to research these ideas for my dissertation project, in order to open the therapeutic arena to diverse practices and environments that art therapy can be offered.

Implications for Art Therapy Education, Practice and Research

In my understanding, emancipatory practice does not support the use of diagnosis with clients as a way to reduce their issues and tether their identity to that diagnosis. Some of the language of diagnosis is oppressive; however, clients who have had psychiatric treatment enter therapy with a diagnosis, and clinicians who are working in

managed care settings must use a diagnosis in order to be paid. For me, the diagnosis primarily is a way to manage relationships with the insurance provider. Diagnosis is not promoted in the therapy session or incorporated into our therapeutic relationship as a part of the person's identity. Were I to tie the diagnosis to a patient's identity, it would reduce the complexity that is the patient, and could affect the outcome of the therapy through over-simplification. How to address a clinical psychiatric diagnosis in a community or hybrid practice requires further discourse, in my own practice and also within the art therapy field.

I also teach graduate art therapy courses at a local university where I integrate the theories of emancipatory community practice into the clinical curriculum. I find at times it is difficult for students to understand and conceptualize community work as distinct from "art education in the community." I have heard students use the phrase "trust the process" (McNiff, 1998) as a type of default position, as though they only have to show up to the session, make art with the client, and expect that the client will "get better" as a result. I realize, of course, that students in their early training are naïve to distinctions that make art therapy effective, and are actively learning about what the therapeutic process of change involves. I explain that the phrase "trust the process" actually means that art therapists have to develop treatment plans *with* the patients, trusting that their collaborations will guide them to use the materials of the creative process to find their own solutions and strengths. In no way is art therapy done haphazardly: together the client and therapist negotiate the boundaries of the space where the process can be trusted. For community-based art therapy, this trust also means conscious awareness that if someone is unstable or comes to a group or center in crisis, the art therapist is ethically

responsible for referring the participant to someone whose primary role it is to address those needs.

Approaching art therapy from a stance that is mindful of oppression starts in graduate and undergraduate programs. Students can be challenged to consider who they are, where they come from, and what they have to contribute to the broader community regardless of whether their internships involve work with clinical or community settings (Moon, 2009). Doctoral-prepared art therapists are needed to examine systems of care and to contribute leadership skills that can effect responsible change. Art therapists who assume leadership roles can contribute to the critical discourse on dominant narratives, whether within systems of care, the greater community, or the field of art therapy.

As art therapists, when we strive to negotiate power differences and collaborate with clients we will gain knowledge, and with that knowledge comes power. Able to build upon our knowledge and experience, we can become increasingly mindful of our own oppression to which we contribute. We can acknowledge rupture and work toward empowerment. Dialogue is needed on the commonalities and differences between community and clinical paradigms, and can be achieved through research, conscious action, and reflection on practice. By advocating for ourselves and our clients in practice, research, and education, while not abdicating our power within the systems where we work and live, we can effectively support and create healthier individuals, families, and communities.

Summary

In the following dissertation I will explore how the opportunity to work within a treatment environment that contains both clinical and community-based approaches—

what I call a *liminal space*, between the paradigms— influences a person's development and sense of connection to community. Ultimately, I wish to know how identifying the common ground in clinical and community art therapy practices, creating more in-between art therapy spaces, and further critical reflection of their complexity, affects clients. In Chapter 2, I review relevant literature that supports my research study that combined clinical and community practice. In Chapter 3, I outline the methodology and procedures used for my participatory action research project, which includes the participants as co-researchers, and is used to organize cycles of action and reflection. Participatory action research findings support the foundation for the development of a grounded theory that is generated through practice-based research that explicates my notion of liminal space. My hypothesis was that providing the opportunity to work within a liminal space between the paradigms contributes to personal development and sense of connection to community for those engaged in both clinical art therapy and community art therapy practices. In Chapter 4, I present the results of the research, illustrating the grounded theory with relevant case examples, and discuss outcomes generated from the data. In Chapter 5, I discuss the results and place them in context to support a grounded theory of liminal space, by which I mean therapeutic spaces that are in-between clinical and community practice and how art therapists can work within liminality to develop effective practices with clients.

CHAPTER 2: LITERATURE REVIEW

Introduction

Based on my research I have observed that art therapy that is conducted privately with individuals and groups within the U.S mental health system of care typically attends to a particular diagnosis and therapeutic issues in regard to that diagnosis. Such work is done in inpatient and outpatient settings, including hospitals and private practices (Wadeson, 2002; Vick, 1996). In contrast the community setting may allow for art therapists and community workers to address a variety of psychosocial issues that are not primarily defined by diagnosis or other parameters of the mental health system. Community art therapy work typically is provided in community studios, non-profit agencies and the like, with the people present working collectively to address their concerns rather than only following the lead of the therapists (Allen, 2008). When participants work collectively such practice may differ from society's individualistic values and offer an alternative to traditional mental health treatment (Junge, Alvarez, Kellogg, & Volker, 1993; Watkins & Shulman, 2008).

Currently, in the art therapy literature there is a discussion about both the clinical and the community practice paradigms, but no discourse that puts them together into practice. In reviewing the literature it appears as although community art therapy is viewed as largely distinct and separate from clinical art therapy, the contexts of practice and goals are different. Shifting these paradigms toward a continuum that locates multiple models of practice will provide theoretical grounding for the emergence of a potential new model that might bridge the dichotomy. This evolution of practice is

similar to the historical dichotomy (Wadeson, 2002) that distinguished art therapists who use art psychotherapy from those who practiced art as a therapy in and of itself, which has been reconciled with the understanding that art therapy exists on a continuum from which art therapists can adapt to client needs (Riley, 1996; Vick, 1996; Wadeson, 2002).

Historically, North American art therapy has embraced a theoretical spectrum that identifies two dominant paradigms known as “art psychotherapy” and “art as therapy,” which presumably were grounded in the two worlds of art and psychology (B. Moon, 2008). Naumburg (1987), is widely regarded as one of the founders of the field; she worked from a clinical framework that used art primarily as a tool to facilitate a verbal exchange in the manner of psychology about the client’s issues (Wix, 2000). Cane (1983) and Kramer (1958), in contrast, used artmaking primarily as a process of healing (art as therapy).

An argument since the inception of art therapy has implied that the “cure” in art therapy or site of healing must be located in either one framework or the other (Junge, 1994). With the onset of postmodern theory in the late twentieth century art therapists began to propose that this is not the case and that art therapy can take place in myriad arenas. Wadeson (2002) was one of the first art therapists to espouse a “both/and” position (in 1982), and provided examples of how art therapy can be applied to different settings and populations with differing approaches. Ault also responded to the idea of this dichotomy in art therapy, writing that being an artist and a therapist are “mutually compatible” and that “the process of treatment often parallels the process of artistic endeavors” (as cited in Feen-Calligan, 2008 p. 89). The creative process parallels the therapeutic process (L. Kapitan, personal communication; Robbins, 1987), as I have

witnessed many times in my own work with clients. Vick (1996) wrote about the many dimensions of service to which art therapy skills and training may be applied, and also espoused to a “both/and” position with respect to the question of artist or therapist identities in practice. However, some art therapists have claimed that practitioners who leave behind their personal artistic endeavors are “clinifying” (Allen, 1992) the field of art therapy (Wadeson, 2000; Wix, 2000). According to Allen (1992) art therapists “clinify” the field when they become more invested in developing skills that are modeled by other mental health practitioners while their own investment in personal art making and art skills decline. Art making in this practice is only a means to insight into the problem of the client, with little attention to myriad of artistic materials that could be used to provide a therapeutic effect (Allen, 1992). With the decline of using art in session, art therapists also leave behind their own personal art practice. Gradually art is seen only as a means to elicit psychological information for the purposes of client insight.

Robbins (1994b) validated the struggle to choose one or the other, art or psychology, believing that the choice was rooted in the identity of being both an artist and a therapist. “Trying to maintain one’s identification in both worlds is like having a love affair with two lovers” (Robbins, 1994b, p. 28). Robbins (1994a) further asserted that “the challenge of our profession remains a formidable one: to develop a theory that truly reflects the complex dimensions of psychotherapy without betraying the artistic sensibility central to our work” (p. 45). I have seen this struggle within myself and other art therapists and believe that continued dialogue is still needed to work toward a unified theory of art therapy. However, I assert that art therapists may orient their practice across a continuum of art therapy interventions.

Today the conversation about the polarization of art therapy appears to be regarded as a part of its history (Riley, 1996). When I discuss art therapy with graduate students and peers, the current thought is that this spectrum has become a schema wherein art therapists locate their approaches as their clients' needs indicate. Art therapists no longer need to identify themselves as either a practitioner of "art-as-therapy" or "art-psychotherapy." Approaching each client as an individual and working from the "both/and" perspective allows art therapists to tailor treatment to the needs of the client (Riley, 1996; Vick, 1996; Wadeson, 2000.)

McNiff (1998) summarized the basic working methods within art therapy by writing that people can either experience a personal change, have interactions with images and art objects, and/or negotiate relationships to the therapist, others, and surrounding space through art experiences. This implies movement along a spectrum of interventions and possibilities that is consistent with my own experience in ten years of practice as an art therapist when working with clients and attuning to their concerns.

Through the course of this research study I applied critical theory by taking an emancipatory approach with clients in a non-traditional clinical art therapy setting. In this chapter I will define clinical art therapy and community art therapy more specifically. Secondly, I will conceptualize the notion of liminal space, which I perceive to be a third relational field that may connect the two main art therapy paradigms in support of community and individual art therapy practices. Thirdly, I will define critical theory and emancipatory practice. Lastly, I will explore empowerment of clients and examine of the use of power by therapists within the art therapy literature.

Clinical and Community Art Therapy

Clinical Art Therapy

What I call clinical art therapy is therapy conducted with individuals, families, and couples and mostly in settings that include hospitals, private practices, therapeutic schools, and outpatient settings. Riley (1996) for example, worked with clinical art therapy clients who simultaneously received “medical therapy” provided by a psychiatrist, the latter of whom determined treatment goals, prescribed drugs, and evaluated patient changes based on these medications, without spending much time with the patient. Often clinical art therapists treat clients with a variety of issues that are both medical and psychological in nature (Vick, 1996). Clinical art therapists have used the medical model as a framework to treat clients, including my own use of the model to understand clients within an Adlerian perspective (Mosak & Maniacci, 1999.)

Spaniol (2000) contextualized this paradigm in the field by observing that “most art therapy educators were mentored in the psychodynamic approach based on the medical model” (p. 78). Initially the medical model of treatment referred to an approach that derived from an understanding of disease and illness in bodily functioning, with wellness defined as the absence of disease (Bloom, 1965). The medical model also examines the biological, psychological, and social capacities of functioning known as the bio-psycho-social contributors, but the focus has been on abnormalities within those areas (Bloom, 1965). Recently, Shah and Mountain (2007) updated this definition within psychiatric care to mean “a process whereby, informed by the best available evidence, doctors advise on, coordinate or deliver interventions for health improvement. It can be summarily stated, ‘does it work?’” (p. 375.) This updated definition of the medical

model does not focus on how an intervention works but rather on whether it does work. The onset of post-modern theory has encouraged the development of a non-judgmental stance that moved away from the authoritarian style of previous psychodynamic art therapy practitioners, which is “based on faith in a universal potential for health and the interconnectedness of all living things” (Spaniol, 2000, p. 78).

Riley (1996) is an exemplar of the clinical art therapy approach as it became more contemporary in practice. Riley (1996) discussed the practice of art therapy in the clinical setting and suggested that the art therapy field could be enlivened by “reauthoring the dominant narrative of our profession” (p. 289). Riley offered social constructionism and postmodern theory, (including narrative therapy) to create a pragmatic aesthetic approach to clients, which in turn helps them to re-author the issues they face in their lives. As clients build their own visual vocabulary, art therapists offer interventions and build a relationship with clients based on what the client needs, which contributes to a therapy co-constructed by both the client and the therapist (Riley, 1996). She admitted to diagnosing patients and filling out the necessary paperwork for managed-care requirements, but like me, when the doors to the office close, she attended to the needs of the client in the way that fit them best (Riley, 1996.)

Community Art Therapy

In the past 10 years, the literature has provided examples of art therapy practiced in community art studios, such as Open Studio Project (Block, Harris, & Laing, 2005), Off-Center Community Arts (Timm-Bottos, 1995), as well as social action art therapy projects, such as Cantera in Nicaragua (Kapitan, Litell, & Torres, 2011) and Golub’s (2005) work with survivors of oppressive regimes in Brazil, China, and Denmark.

However, I believe that the current literature has yet to offer a complete definition of community art therapy.

According to Golub (2005,) community art therapy

can be tentative and modest or expansive and organized. Some change begins with the individual who has potential for influencing collective transformation and some develop collaboratively.... [community art therapy] is not about reinforcing the unequal power dynamic between the patient and therapist, it is about the shared power of the community, for the benefit of the [individual and] community. (p. 17)

Kapitan, Litell, and Torres (2011) wrote that in their model of community art therapy the “client” is the entire community. In contrast, I define community to mean the lens with which the client identifies as a member of a larger group. In North America, therapists often regard the individuals within the community as their clients, or community is the site of practice; however, I agree with Kapitan et al (2011) that the collective community is the client. Community art therapy thus has both an individual and a group emphasis. While work with individuals within the community beckons each individual to step outside of social isolation, which contributes to creating stronger relationships. This in turn transforms the community, and I believe this is the key difference between individual art therapy and community art therapy.

Community art therapy takes place when people come to create art together for such purposes as self-expression, acceptance, healing, soothing, escape, and fellowship. In the community participants may be encouraged to see value in each other and to value the work created, and to share their work with others to evoke a social change. One

common way to work within both clinical and community art therapy is the studio art therapy approach (C. Moon, 2002). The studio approach includes using art to build a stronger identity (individually or collectively) orienting practice around the creative process rather than an interpretive framework, using art as a non-verbal facilitator, and a relying on metaphor to connect imagery with meaning.

Borrupt (2006) defined community-based arts as “led by professional artists or amateur practitioners,” which includes “community members in the creation and/or interpretation of theater, dance, music, visual arts, crafts or other artistic forms” (p. 239). Although art therapists may work within contexts known or identified as community-based arts, community art therapy is different because the community-based arts do not use the “language of traditional ‘treatment’” (Elmendorf, 2010, p. 42). Kapitan (personal communication) defined the difference between community arts and community art therapy as one of relationship—therapists are trained to attend to the relationship with the participants; community artists are not. Community art therapy brings forth participants’ social agency when expressing themselves in art and furthers healthy connections within the group.

Social action art therapy. Social action art therapy also takes place within community. Golub (2005) defined social action art therapy as ideally a participatory, collaborative process that emphasizes artmaking as a vehicle by which communities name and understand their realities, identify their needs and strengths, and transform their lives in ways that contribute to individual and collective well-being and social justice. (p. 17)

However, Kaplan (2007) warned against trying to define social action art therapy because any definition will only provide a partial answer. Several art therapists have worked from a social action perspective. Hocoy (2005) felt that social action and art therapy are “naturally fused” (p. 12). As art therapists we treat clients who have been harmed by their milieu and send them out to be re-wounded without considering or treating the collective wounds (Junge, et al, 1993). Clinical art therapy, community art therapy, and social action art therapy offer possibilities to heal not only individuals but also the community, thus effecting a greater social change.

The importance of this study rests in the potential of creating more liminal or overlapping practice spaces within the field where both paradigms can exist simultaneously— where both individuals and communities can transform. As noted earlier the setting in which I currently practice art therapy is located in a studio and gallery, which differs from the traditional psychiatric office environment where private art therapy can take place in. My practice is comprised of individual, private art therapy sessions, but also extends out to the community: we provide art therapy services to a daytime homeless shelter, bring the larger community in for open studios, and create gallery exhibitions. The development of these types of therapeutic spaces should help to shift the polarizations of “only clinical” and “only community” art therapy approaches. Creating such in-between or liminal spaces can potentially increase the number and kinds of people who utilize art therapy to maintain wellness, find community, and heal, create, and connect.

Liminal Space

Liminality

The root word *limin* is Latin for “threshold.” Liminal (Merriam-Webster, 2014) is defined as relating to or being in a threshold, or an in-between or intermediate state or phase. The term liminality was first used in 1909 when Arnold Van Gennep observed indigenous initiation ceremonies that took an adolescent out of his status role and thrust him or her into an “in between state” a preparation for a new role in society (Hall, 1991). As defined anthropologically, liminality exists outside of social structures and hierarchies and is a property of any movement away from a fixed identity (Hall, 1991).

Transitional Object and Phenomena

Although liminality has been described as a social and spiritual experience, Winnicott (1970) a pediatrician turned psychoanalyst, observed this same phenomena in the infant-mother dyad. The infant, in the process of individuating from the mother attaches to a transitional object, which is a blanket or toy that comes to “represent a freedom for the self” (Eigen, 1991, p. 68.) The transitional object is liminal in that it represents the first thing that is both-and: *not mother* and *not me*. The object is used in the first experience of play, which helps the child to begin to separate from the mother. Play, too, exists in the intermediate zone between self and reality (Cwik, 1991.)

Within transitional phenomena, rituals and play are processes whereby a person is able to move between “inner” and “outer” realities (Eigen, 1991, p. 70.) The child is able to bring fantasy into reality, which helps to achieve congruence between one’s inner and outer worlds (Cwik, 1991). “Between” in this sense is a developmental concept whereby the totality of a person is not bounded by the “inner” and “outer” alone; transitional phenomena contributes to an area of experience that feels free of imposed structures

(Eigen, 1991, pg. 70.) As the developing child senses a division between the boundaries of the self and the mother, play and other transitional phenomena helps to bridge separations of one or another state of being in the process of becoming a fully formed self (Eigen, 1991).

Winnicott (1970) regarded the therapeutic relationship as two people playing together often in the liminal space of between. The relationship between the therapist and client serves as an attachment relationship (Mikulciner, Sharver & Berant, 2012) with the therapist and client working together to bring congruence to the client's inner and out realities. They work together to orient the sensations and impulses that emerge from the client's unconscious as real (Cwik, 1991), and in this way helps the client regulate affect (Franklin, 2010).

Jung recognized active imagination and symbols brought forth from the unconscious as a primary means of movement from what Winnicott referred to as ego to ego-relatedness (Cwik, 1991). As the thoughts and feelings from the client's unconscious are brought forth, and the therapist "holds" the material until the client is able to do so. Gradually clients develop a capacity to hold material relating to their own inner and outer worlds and also to mediate between the two (Cwik, 1991; Eigen, 1991).

Liminal Space

What I have surmised from the anthropological and psychological descriptions of liminality is that space itself can be understood as both internal and external in human experiences. Internal space denotes an area within a person's mind of experiencing, which can be psychological; external space indicates a physical location or a place where events occur. In between the two areas is the liminal. Liminal space is a threshold that

emerges for a person after feeling some rupture, whether from development or society, or from habitual ways of being (Watkins & Shulman, 2008.) People tend to live their lives in ways that maintain a sense of comfort, and to create patterns that keep their equilibrium and comfort intact. A threshold is the transitional phase between the patterns of comfort and transformation. This threshold can be a physical space, such as a doorway, but as well as an internal psychological space, such as the liminal process of identity formation.

Moore (1991) believed that a steward who has an intention for transformation is needed to create a liminal space. In the context of my research, such as steward is an art therapist. The steward creates liminal space in a ritualized way such that it creates a boundary that allows for movement from one to another state of being (Moore, 1991.) The ritual and boundary creates the safety necessary for participants within the liminal space to grow a capacity for selfhood and community. The traditional hierarchical power of the therapist and client is suspended as both step into the liminal space, as though echoing the indigenous rituals noted by Genep in 1909.

Kapitan (2009) asserted that “the liberating meditation that is art promotes and empathic relationship between self and inner and outer realities seeking validation” (p. 151). Refuting the notion of a single most effective paradigm, art therapists can create liminal spaces in both community and clinical environments. Through ritual and setting boundaries while making art, therapists and participants work together toward connection, healing, and transformation. By bridging clinical and community practices to create transitional spaces of client and community collaboration, art therapists can help people create connections to themselves, their families, and their communities. In so

doing we create new paradigms to practice within and evolve art therapy in tandem with the needs of the changing world. The idea of liminality in the context of this research, thus is important in moving from a fixed identity for art therapists to a “both/and” clinical and community practice orientation.

As humans we strive for significance and belonging; we naturally want to belong and connect in the community (Johnson-Migalski, 2013, p.6). By helping clients grow the capacity to create healthy relationships, together we find belonging. I believe that art therapy practice that integrates clinical and community art therapy likely draws on a kind of liminal space that can contribute to both personal development and empowerment, as well as begin to help people make connections to community and find a place of belonging. Personal agency is promoted by providing opportunities for participants to experience success and to change their beliefs about themselves and the power they hold in their lives.

From this review of liminality, I understand that my practice is liminal. As a steward I invite individuals and families who utilize clinical services to interact with community in order to grow the capacity to connect to one another in open art studios, and community art exhibitions. Open art studio is a format that allows participants to freely use art materials in a group for personal expression, and also as a means to ritualize art therapy in the creation of liminal space. However, we invite community in only at certain studio times, which draws the boundary needed to create a protected liminal space. As will be described later, my practice provides open art therapy studios at another community site where art therapy takes place with the intention of developing a sense of community within a community of homeless people. There is a rhythm to the

community art therapy of which I am a part. This rhythm is similar to the rhythm in the infant-mother dyad that creates conditions for the child to move from the oneness of symbiosis to the separateness of individuation and eventually to freedom. My hope is that art therapy participants and clients will develop similar freedom to connect to others, and that art therapists will move away from a fixed *either* clinical *or* community practitioner/therapeutic environments identity within art therapy.

Critical Theory and Liberatory Practices

Emancipatory practice has been used in community settings to examine oppression among community members and to empower the group to take action, thereby shedding light on the structures of oppression in certain domains (Austin & Prilleltensky, 2001; Freire, 1970; Watkins & Shulman, 2008). Emancipatory practice draws from Leonard's (1990) definition of critical theory as the critique of existing social and political systems and practices. This critique is used not only to illuminate injustices but also is a critical viewpoint and language used as a pragmatic imperative to transform society. Critical theory attends to the social role of science (Thomas & Bracken, 2004) and is a valuable lens in therapy because it "challenges psychology to work towards emancipation and social justice" and "opposes the uses of psychology to perpetuate oppression and injustice" (Austin & Prilleltensky, 2001, p. 1). Kapitan (2009) acknowledged that the art therapy world can be confined by oppressive practices and colonized by distorted influences. Oppression of all types exists within institutions, communities, and cultures, and art therapy and the mental health system are not immune to oppressive practices.

While other post-modern theories may bridge the clinical and community paradigms, such as narrative (Riley, 1996) or feminist theory (Burt, 2012; Hogan, 2012), for the purposes of my study a critical emancipatory approach was selected because it incorporates those theories into critical and liberatory dimensions. Emancipatory practice and critical theory can benefit the integration of art therapy paradigms because it envisions the liberation of art therapy practice from current working models as the field expands with globalization (Kapitan, 2009). The liberation of art therapy from confining models can occur through therapists' reflective practices, their critique of treatment initiatives, and creation of new paradigms in which to practice art therapy.

Examples of emancipatory ideas in the literature include C. Moon's (2002) "relational aesthetics," which uses art primarily as a means of building a relationship to one's self and others, and Thompson's (2009) notion of "artistic sensibility" that can be developed in clients to inform new identities. Applied to psychiatric patients, artistic sensibility relies less on identity steeped in what a person's diagnosis may be, and leans towards developing a more a positive and capable identity that supports strengths, beauty, and creativity.

As another example of liberation in art therapy Wix (2009) recounted the story of Dicker-Brandeis, a teacher of art therapist Edith Kramer, who taught art to children in a concentration camp from 1942-1944. Dicker-Brandeis taught the children to feel into an object in order to paint or draw it, which developed their "aesthetic empathy" (Wix, 2009, p. 154). The artwork served as an intermediary to connect the children and their observing selves with the object, holding open a liminal space for beauty even in

desperate times. Aesthetic empathy served to free the children from some of the overwhelming oppression they felt in their daily lives and ultimate fate.

Social action initiatives have positioned art therapy “within an individual therapeutic encounter while also opening up the possibility of service to the wider community” (Potash and Ho, 2011, p. 75). Some of these social action projects have already been discussed, however, it appears that a common goal of the projects is to transform communities through psychosocial connections fostered through art making. Considering the social contexts of the participants in both ArtStreet (Timm-Bottos, 1995), Cantera (Kapitan, et al 2011), the work with survivors of oppressive regimes was at the forefront of developing the social action initiatives in art therapy.

Social-Cultural-Historical Contexts

Huss (2013) recognized that the social, cultural, and historical contexts of the client’s life need to be at the forefront when forming and sustaining the therapeutic relationship in any treatment. Thus, a recognition is fostered of how an oppressive context influences the issues the client faces during the entire therapeutic process. Huss (2013) noted that within her social action work with Bedouin women in Israel, social workers naturally considered these contexts. Visual anthropologists also recognized that images are often understood as illustrations of social processes, she commented, but art therapists often do not. Huss (2013) wrote that this limitation exists because art therapists tend to view the art image a person creates as “an inherent statement from within the unconscious or conscious layers of the self, decontextualized from social surroundings” (p. 71). Clinicians will have more effective practices when they understand the contexts from which the clients and their art emerge, and examine power dynamics with self-

reflective practice. Clinicians also must understand their own social positions, and cultural and historical influences in relation to their clients (Huss, 2013.) Any social transformation that develops must also do so *within* the context in which the art therapy takes place.

Therapists who use a critical framework view objectivity as a myth or illusion. Modernist scientific and psychological theories contend that clinicians need to maintain objectivity, yet practitioners create most measures to determine objectivity based upon their own subjective experiences (Thomas & Bracken, 2004). In therapy therapists may oversimplify clients and the concerns they bring, which negates the actual complexity of people and their issues (Austin & Prilleltensky, 2001; Thomas & Bracken, 2004; Watkins & Shulman, 2008). Oversimplification happens when people are reduced to identities steeped in diagnosis or are regarded as broken, with little regard paid to the social embeddedness that contributes to their diagnoses (Ansbacher & Ansbacher, 1957.) Therapists use a critical and emancipatory framework to approach clients by consistently reflecting on their complexity and richness within the therapeutic process.

I believe that an emancipatory approach will promote transformation for participants within liminal space. The work within liminal space is intended to aid in the development of a person's relatedness to self, their art and to others. This group development of personal agency then expands an individual's capacity to free him or herself and create transformation. Generally emancipatory practice has not been used as an approach in the clinical setting with private psychotherapy and art therapy consumers. However, it seems appropriate when considering that an oppressive act is one that prevents a person from being human (Freire, 1970). Moreover, individual psychotherapy

should take into consideration the wider contexts that contribute to an individual's mental health, such as the historical, cultural, socioeconomic, and spiritual domains of a person's life. "Without this transgression of disciplinary boundaries, an individual is unable to ferret out the ways in which his symptoms speak of the effect of larger contexts that create sufferings for others as well as himself" (Watkins & Shulman, 2008.) Adding a positive dimension to mental health treatment can help people to understand their own strengths and to build personal agency.

Personal agency refers to the choices a person is able to make freely about his or her life (Corey, 2009). A key component in developing self-agency is personal efficacy or the beliefs people have that they can make a change in their lives (Bandura, 2001). Once people develop their belief systems to include the ability to make personal and collective change, they can act to do so. Art therapy experiences paired with positive psychology can also help to develop personal agency through engagement with people's strengths (Chilton & Wilkinson, 2013). Chilton and Wilkinson (2013) suggested that using art therapy assessments to identify client strengths could potentially, in turn, establish art therapy as an effective means of increasing creativity and capacity for attachment.

Empowerment

Critical theory and emancipatory practice examines oppression and power. As a mindful practitioner it is therefore essential to examine the proper use of power within therapeutic relationships. Franklin (2010) defined mindfulness in the therapist as "present-focused" with a non-judgmental awareness that "supports the development of an attuned relationship [with the client] because it helps clear the inter-subjective field of

unrelated cognitive debris ” (p. 162). A general definition of power is the “possession of control, authority, or influence over others or things” (Merriam-Webster, 2014). To liberate my practice I needed to examine the power I hold in relationship to my clients and make sure that I am not influencing them or other therapeutic factors that may contribute to their oppression.

In the therapeutic space therapists and participants are afforded the opportunity to examine and utilize power not as a binary but as a matrix (Tew, 2006.) The matrix (Table 1) illustrates oppression as the power people can have over others and power people can have with others, which is then set against protective modes of power and limiting modes of power. Tew’s (2006) matrix worked well for the creation of liminal space in this study because it examines power on a continuum, and therefore may bridge the clinical and community paradigms. However, there are other ways to look at power, including the seminal references of French and Raven (1958a; 1958b) *Group Support, Legitimate Power and Social Influence*, and *Legitimate Power, and Coercive Power and Observability in Social Influence*.

Tew (2006) conceptualized oppressive power in terms of liberatory practices and its usefulness lies in using it to work with people who are struggling with mental health issues. Tew identified four types of power: oppressive power, protective power, collusive power and co-operative power. Oppressive power excludes others to enhance personal position and to exploit the client’s differences, whereas protective power is used to provide safety despite that it also can prohibit people from moving forward to reach their own potential. My understanding of oppressive power within the therapeutic relationship would be to refer to clients as their diagnoses, without regard to the diagnoses as just an

aspect of who they are. Protective power, on the other hand, could potentially benefit the client if they were in personal danger, such as attempting suicide or remaining in a violent relationship. Protective power would include dialogue with the client to determine what necessary actions could be taken to help the client out of the dangerous situation. For example, I have had clients who were suicidal and as a protective act of power, I encouraged them to go to the hospital for care. I also have had clients in dangerous domestic violence situations where I encouraged them to develop a plan for escape.

Collusive power occurs in groups when certain people are excluded from the majority and internal and external ‘otherness’ is suppressed. Co-operative power is shared action, dialogue, and support through valuing what people have in common as well as their differences (Tew, 2006). In both examples of protective power described earlier, I could have colluded with family members or psychiatrists to get the client to comply, instead of dialoging with the client to determine the best course of action. When the client and the therapist co-create treatment plans and art therapy directives this illustrates collaborative power. Both have a stake in what is best for the client and both parties determine what is best.

Table 1. *Matrix of Power Relations* (Tew, 2006)

	Power Over	Power Together
Productive Modes of Power	Protective Power	Co-operative Power
Limiting Modes of Power	Oppressive Power	Collusive power

As therapists use the power matrix they may acknowledge that people can be involved in more than one type of power relation simultaneously, as well as understand the complexity of the situation. Tew (2006) gave the example of an interpersonal relationship that may “offer opportunities to co-operative power while simultaneously retaining aspects of oppressive inequality in how it is structured” (p.40). Even as therapists co-create treatment plans with clients, any tendency to rescue the client rather than work collaboratively may undermine the client’s own potential and contribute to feelings of oppression (Tew, 2006). Art therapists engaged in self-reflective, emancipatory practice can use this matrix to guide their decision making when working with clients in either the clinical or the community setting. Understanding the dialectics of power operating within the client’s life can aid the therapist in determining how to proceed by identifying the modes of power in place and dialoging with the client about the potential actions that they can take, while ultimately leaving the choices up to the client.

As I understand the hierarchies of power and overlapping power relationships that exist, I gain a means to further empower clients through identifying and offering choices without colluding with other professionals or undermining clients’ attempts to reach their potential. I agree with Tew (2006) who observed that by “using the matrix, it may be possible to generate more lateral strategies for dealing with situations of powerlessness, rather than such a head-on approach of directly contesting oppressive power” (p. 42). As I look at and examine power on a continuum or matrix, I see that this parallels creativity as something that is fluid and moving, which are qualities that contribute to creating liminality.

To help achieve the goals of my study, I used Tew's matrix in reflexive practice to critically consider the power within all of the relationships that were present in liminal space. This procedure was important in maintaining equalized participant relationships whereby each participant maintained an active role in shaping and creating knowledge relevant to his or her needs and life; no one person held expert status over others. As I formulated my hypothesis for this research I also questioned how the language of diagnosis fits into emancipatory practice in the clinical setting. Some of this language is oppressive, (i.e. referring to a client as their diagnosis) despite that clinicians in the medical managed care setting have to use a diagnosis to sustain a practice financially. When treatment includes a psychiatrist and the client enters therapy with a diagnostic identification in place, the diagnosis is a function of the service the psychiatrist provides.

I have decided that diagnosis is a way to manage relationships with the insurance providers and it is not to be promoted in the therapy session or our relationship as a part of the person's identity. I now see diagnosis as a dialogue between the patient and me, and between managed care providers on behalf of the client. I don't view this as collusive power, but rather is a protective power that also can be co-operative. Riley (1996) described wither compliance with managed care requirements in order to help the clients obtain the services they sought. However, when she worked with clients in therapy that paperwork did not affect her ability to work with the clients in sessions. Riley (1996) wrote, "I found a way to focus on the family's need for treatment and translated it into language that satisfied stipulations but still gave me the freedom to provide the therapeutic services that my clients required" (p. 290). Within therapy I

discuss with the client the unfair implications the diagnostic label places on them, as well as ways a label can sometimes be helpful to the client.

As an example, one client who I saw regularly for art therapy over three years had been assessed as having a diagnosis of bipolar disorder. Her symptoms were severe and she was unable to keep a job. Her family blamed her instability on innate tendencies and her diagnosis was wrapped into their and her own perceptions of her self. Working in the studio during individual art therapy sessions, she began to explore other facets of her identity. These included her creativity, her womanhood, her willingness to care for others, and her sense of humor. After working for a while together, and exploring the ways her bipolar diagnosis played a role in her life, while being separate from her identity, she began to see a possible benefit to diagnosis. She was eligible to be part of a program at the department of vocational rehabilitation that helped her find a job that would accommodate her needs.

At times a diagnosis can indicate the presence of disease. However, when therapists and doctors diagnose mental health clients it is important to distinguish disease from illness and to determine wellness. Disease refers to abnormalities within “the structure and function of bodily organs and systems,” (Helman, 1981, p. 548) or “a pathophysiologic process,” (Green, Carillo, and Betancourt, 2002, p. 142). In art therapy Vick (1996) referred to the disease model as an indication of “helplessness” (p.97). In contrast,

illness refers to the subjective response a person has to being unwell, how he, and those around him perceive the origin and significance of the event; and how it affects his behavior and relationships with other people; and the step he takes to

remedy the situation. (Helman, 1981, p. 548)

The differences between disease and illness illuminates illness as a psychological, social and cultural phenomena, whereas disease refers to abnormalities within tissues, organs, and body systems.

When practitioners examine the concept of mental illness, this includes consideration all of the factors included in the person's subjective response these must incorporate social and cultural contexts as well as the practitioner's own views of that patient's diagnosis. Clients and their treatment providers who co-create treatment plans can make sure that the goals of the treatment are aligned in order to elicit positive outcomes (Mosak & Manniaci, 2003). This is the case for medicine as it is for therapy and art therapy.

Using the lens of critical theory, therapists analyze what criteria constitute a diagnosis and who decides whether that criteria is purposeful. An example of how medical doctors read a diagnosis of hypertension can illustrate this critical process. In the medical diagnosis of hypertension, blood pressure is composed of the joined measurements: systolic blood pressure (pressure when the heart beats) and diastolic blood pressure (pressure at relaxation). A reading of 135 systolic results in the diagnosis of hypertension. The actual threshold or cut off number was concluded through the research of several doctors, independently verified, and now accepted as the appropriate number to indicate a disease.

A systolic blood pressure reading of 120 or higher is now understood to constitute a risk for the disease hypertension. (S. Nolan, personal communication, January 5, 2013). Already considering the numbers of people with hypertension— more than half the U.S.

population—if the criteria for this illness were changed and lowered to a threshold of 115, the increase in people who are considered to have this illness would be drastic (Figure 1). Thus, the determination of the boundary between health and illness, or degree of intervention necessary, has ethical and political implications. Over-diagnosis, in this example, might result in a larger market for drug companies.

When examining the power clinicians hold in diagnosis; the use of critical theory and emancipatory practice helps therapists determine whether the clients understand the conditions, meanings, and the treatment of their illness. Therapists should consider how the person understands his or her illness and how his or her social and cultural contexts contribute to this understanding. Therapists who reconcile their own notions of illness and wellness that are constructed from their own cultural and social contexts are better equipped to understand how this is so for clients as well. By examining power and utilizing self-reflective practice, clinicians will be better suited to develop relationships with clients in ways that allow for clients to connect to communities.

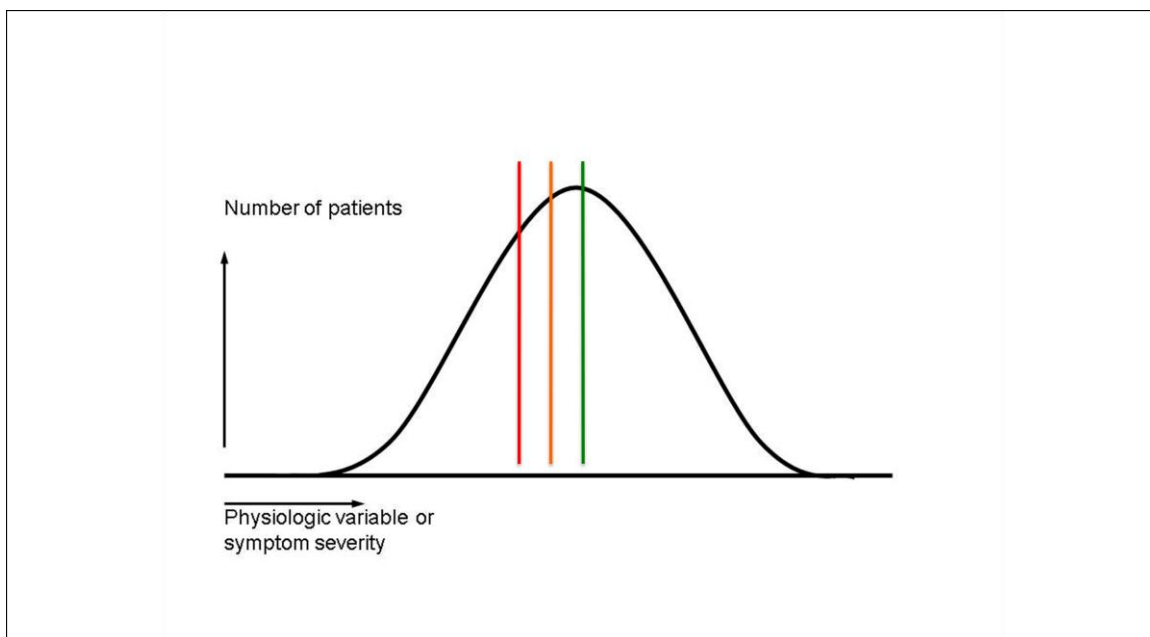


Figure 1. Hypertension in the medical model, red line indicates 115 systolic, yellow line indicates 120 systolic, and green line indicates 135 systolic. (S. Nolan, Personal Communication, January 5, 2013)

Conclusion

In conclusion, I have argued in this review of the literature that extending the clinical offering of art therapy practice into the community is possible for addressing the multiple ways that treatment can occur. By bringing community into the clinical art therapy space we offer additional ways for individuals to use the private art therapy space to connect to the community. People who live narratives outside the norm can be encouraged to utilize and access treatment for all issues of health including mental illness, and be empowered to continue to live lives with a sense of belonging and purpose, thereby increasing social agency. The integration of clinical and community art therapy practices creates areas where treatment itself resides outside the dominant narrative; thus, more people can benefit from services (Watkins & Shulman, 2008).

This study is important to demonstrate that the bio-psycho-social medical model of art therapy can incorporate the social-cultural-historical contexts of emancipatory practice, which functions within liminal space to create a therapeutic environment that is not a clinical nor a community facility alone, but a “both/and” space. This is a space that hosts and provides both clinical private art therapy sessions and community art therapy practices. A space where more people will be able to utilize art therapy to create and maintain wellness, and connect to community. As described in the following chapters this study was designed to explore whether such a space leads to integrated community

and clinical art therapy practices, generates opportunities for participants to develop agency and feel empowered, and creates opportunity for people to connect to community.

CHAPTER 3: RESEARCH METHODOLOGY

Introduction

When I began my doctoral studies, I went through a process of moving away from using psychodynamic tenets and toward facilitating a greater change in clients and systems by considering not only the bio-psycho-social but also the historical and social contexts of art therapy and mental health care. I began to implement community art therapy practices at my site, which already hosted clinical art therapy, and sought to study the effects and implications of integrating the paradigms. My purpose in this study was to transform art therapy, art therapy practices, and art therapy practice settings. Because I sought transformation, I utilized participatory action research (PAR) as the primary methodology. The values inherent in PAR align with the social transformation ideal (Kemmis, 2006; McIntyre, 2008). Change is the purpose of PAR. Through the voices of the participants in decision-making and their contribution to the creation of knowledge and actions, we all were co-researchers.

Research Objectives

I will more clearly define PAR later, however, the general purpose of action research is change, and within participatory action research “strategies are identified and used with deliberate intention to develop new insights that will effect change and thereby improve practice” (Kapitan, 2010, p. 97). Action research consists of developing a plan of action, implementing the action, observing the effects of that action, and then reflecting on the outcomes of that action to determine further planning, or a course of new actions and reflection through repeating cycles (Herr & Anderson, 2005; Kapitan,

2010; Watkins & Shulman, 2008; etc.). Outcomes from the action research provided knowledge on which a grounded theory could be developed.

The objectives of this study were as follows:

- (1) To integrate community and clinical models of art therapy practice within a location of the in-between space that may transform existing dialects of art therapy;
- (2) To generate opportunities for participants to develop agency and to feel empowered;
- (3) To create opportunities for participants in both the clinical and the community arts practice settings to connect to others and to their communities.

Research Question

The core question examined in the study was the following:

How will the opportunity to provide a liminal space for therapy influence the personal development and sense of connection to community for those engaged in clinical art therapy and community art therapy practices, respectively?

Hypothesis

If art therapists provide the opportunity to people to make art in liminal space, the participants will feel personal empowerment, create new pathways to make connections to others, and create community, all of which can be transformational in their lives.

Research Design

Participatory Action Research

Participatory action research, or (PAR) involves a collective commitment to investigate a social concern; reflection to gain clarity about the concern; a joint decision to implement action to create a solution that benefits the collective and collaboration between the researchers and participants in the planning, interventions, and dissemination of the research process (Herr & Anderson, 2005; Kapitan, 2010; McIntyre, 2008; Watkins & Shulman, 2008; etc.). The implementation of PAR in this study relied on the use of co-facilitators and participants who actively engaged in critical dialogue and collective reflection as co-researchers (McIntyre, 2008). Participants who engage in critical dialogue and collective reflection understand that they are stakeholders in the research and its outcomes; what emerges is a dialectical process that transforms researchers, participants and the situations they are investigating (McIntyre, 2008). This approach empowers ordinary people to be participants in the production of knowledge that considers them to be experts in their own lives and needs (Kapitan, 2010).

Examples within the art therapy literature of PAR include research with communities in Nicaragua (Kapitan et al, 2011) and with art therapy practitioners in dialogue with people diagnosed as having mental illness (Spaniol, 2005). In Nicaragua, in context of devastation by hurricane, oppressive political practices, and poverty, community leaders use the creative arts to transform their society; over time their efforts were able to provide a “multiplying effect” that disseminates knowledge gained from creative practices to transform their local communities (Kapitan et al, 2011). The community leaders were regarded as co-researchers in this work, and they held an egalitarian role in the research (Kapitan, 2011). Together the co-researchers (both outside facilitators and community mentors) developed practices that were culturally

sensitive and applicable to the people and the locale. As another example, Spaniol (2005) conducted PAR to generate a non-hierarchical dialogue between consumers of art therapy and art therapists. Both the dialogue and art made together served to unite art therapists and consumers, and offered new knowledge to transform practice. Participants who are empowered by the process of being active researchers, and view themselves as the experts of their lives, can transform themselves and also have a transformational impact on their marginalized communities.

Researchers guided by critical PAR can examine how psychological experiences (e.g. depression, anxiety, the grief process, etc.) can be understood in their social and historical contexts (Watkins & Shulman, 2008). One component of PAR is the critical understanding of people's social and emotional concerns, which the co-researchers reflect upon and use to initiate emancipatory action (Watkins & Shulman, 2008). Golub (2005) advised the use of Freire's questioning process (p. 18) first by "naming" the problems in their lives, asking if they should be this way and if not, how should they be. Secondly, by "reflecting" on why the problems exist, and who or what might be to blame, which includes one's own role in the situation. Thirdly, by "acting" on what can or should be done to change the situation, and what has been done already or will be done. An example of emancipatory action could be how a client re-authors the dominant narrative within his or her life rather than conform to what has been created or idealized by society. Knowledge becomes "critical" when self-reflective practice replaces a modernist approach to issues of power (i.e. the therapist holding expert status) and unfolding ethical concerns of process such as dual relationships (Herr & Anderson, 2005; Kapitan, 2010; Watkins & Shulman, 2008). This means that practitioners might create new knowledge

that does not necessarily maintain the status quo in treatment but, if necessary, ruptures and transforms it. Practitioners implement treatment salient to individual and collective needs through the process of reflective practice, mindful of how the dominant narratives or societies ideals influence participants and their situations, and usher participants towards the creation of their own narratives, such as living by their own ideals.

Critical PAR aims to improve practice outcomes, including the self-understanding of practitioners, and helps them to critique their work settings. “This kind of action research aims at intervening in the cultural, social and historical processes of everyday life to reconstruct not only the practice and the practitioner, but also the practice setting” (Kemmis, 2006, p. 95). For example in Nicaragua, PAR contributed to a change in the North American view of how art therapy can be conducted, by modeling how the creative arts could be adapted for transformation within a culturally different community (Kapitan et. al, 2011.) One assumption that was critically challenged was that a master’s degree and professional credentials always are a requisite to practice. Given the general lack of access to higher education, this assumption would mean that art therapy in Nicaragua could not be utilized. Thus, PAR in Nicaragua contributed not only to a change in the local communities who gained new knowledge from art therapy but also to a change in the dominant narrative of how art therapy itself can be conducted (Kapitan, et al, 2011.) Change in all these—the practitioner, the practice and the practice setting through critical PAR allows the practitioner/researcher with new potential to shift existing patterns of systemic and daily mental health care away from the status quo, which otherwise could contribute to further oppression.

Researchers who use PAR methods formulate a hypothesis from the research question, and then look for dialectics, or living contradictions, within the problem that may be interacting within the problem situation (L. Kapitan, personal communication, February 13, 2014). The dialectics identify assumptions the researcher is operating with and also serves to create grounded ideas that test these contradictions against the researcher's hypothesis. When the researchers reflect deeply on the dialectics, the therapist opens up options that are caught up in opposing forces at work within the situation under examination. For example, a therapists who explores why a school does not offer art therapy services to students may automatically assume it is because the school does not have a budget for an art therapist. However, upon closer examination and deeply reflecting on the opposing forces at work within the problem, the therapist may discover that not only does the school have a limited budget and cannot hire an art therapist, but also that school officials may not have an awareness of what art therapy is and what it can do for the students. Therefore, the researcher can use this emerging knowledge to guide actions to test the hypothesis and change assumptions.

The art-based elements provided by the co-researchers for data collection in PAR projects further illustrates ways that art can be incorporated into art therapy research, and how the research outcomes can be reflected upon through art. Art is not only created as something we do with clients, or that they do in session, but also something art therapists do to explore and inform them of steps to take with clients (Kapitan, 2010). Art therapists can also gather data about participants and personal development and experiences. Results of PAR can also provide data that supports the creation and construction of grounded theory (Herr & Anderson, 2005).

Grounded Theory

Grounded theory is “the discovery of theory from data systematically obtained from social research” (Glaser & Strauss, 1976, p. 2). Glaser and Strauss (1976) developed grounded theory out of their observation that most academic researchers at the time were applying existing theory to research questions. The authors came to believe that theory could be generated naturalistically from data that emerged when studying the phenomena in question, and the resultant theory could be more relevant than those conceptualized by researchers who are removed from actual practice. I was drawn to create a grounded theory of liminal art therapy paradigms based on its practical and applicable components. In doing so I was valuing research for the sake of its application to practice and not research solely for the sake of research.

Combining PAR with Grounded Theory

PAR also has a practical intent, which is to influence and shape existing practices. Like PAR, grounded theory also requires systematic iterative processes to obtain data (Glaser & Strauss, 1976; Kapitan, 2011). Researchers who generate grounded theory use a specific format (described later) to open up data and reflect on them in order to determine operant themes (Glaser & Strauss, 1976). These themes are then used to determine possible answers to the dialectics determined within PAR, and are then incorporated into a developing theory (Herr & Anderson, 2005). In the case of my research the PAR and grounded theory served to develop a theory on liminal space within art therapy, which I conceptualized as an in-between space that not only integrates clinical and community paradigms but also is transformational for clients in creating connections to others and to community, art therapists, and art therapy practices.

Methods

Participants

PAR was conducted at two sites, the features of which are outlined in Figure 2. The action research took place at two sites: a) art therapy sessions at Site A, a daytime homeless shelter; and b) Open Studio at Site B, a studio, gallery and clinical space. Participants at Site A were members of the homeless shelter who had been invited to engage in art therapy as part of the services offered at the shelter. Anyone who was present at Site A could participate in the study.

For site B, I asked art therapy clients of and recent art therapy professionals if they were interested in participating in a community art therapy program. Participants at Site B were selected based on their interest in participating regularly in community art therapy. In total, 5 people were selected: a recent art therapy graduate, (hereafter referred to as “new professional”) 3 people who were private art therapy clients and an art therapy student intern from a local university. Open studio at Site B was open to the general public, included private art therapy clients as well as eventually participants at Site A. To recruit participation I sent marketing materials to local area non-profit organizations that advertised the open studio opportunity.

All participation in this study was voluntary. Clients at both sites signed consent forms for both art therapy services and research, and clients were able to withdraw from either at any time. The data from each participant was kept confidential and secured in the same manner as clinical files, which was in a locked file cabinet housed in a locked closet. Names of participants were not attached to the data in the files.

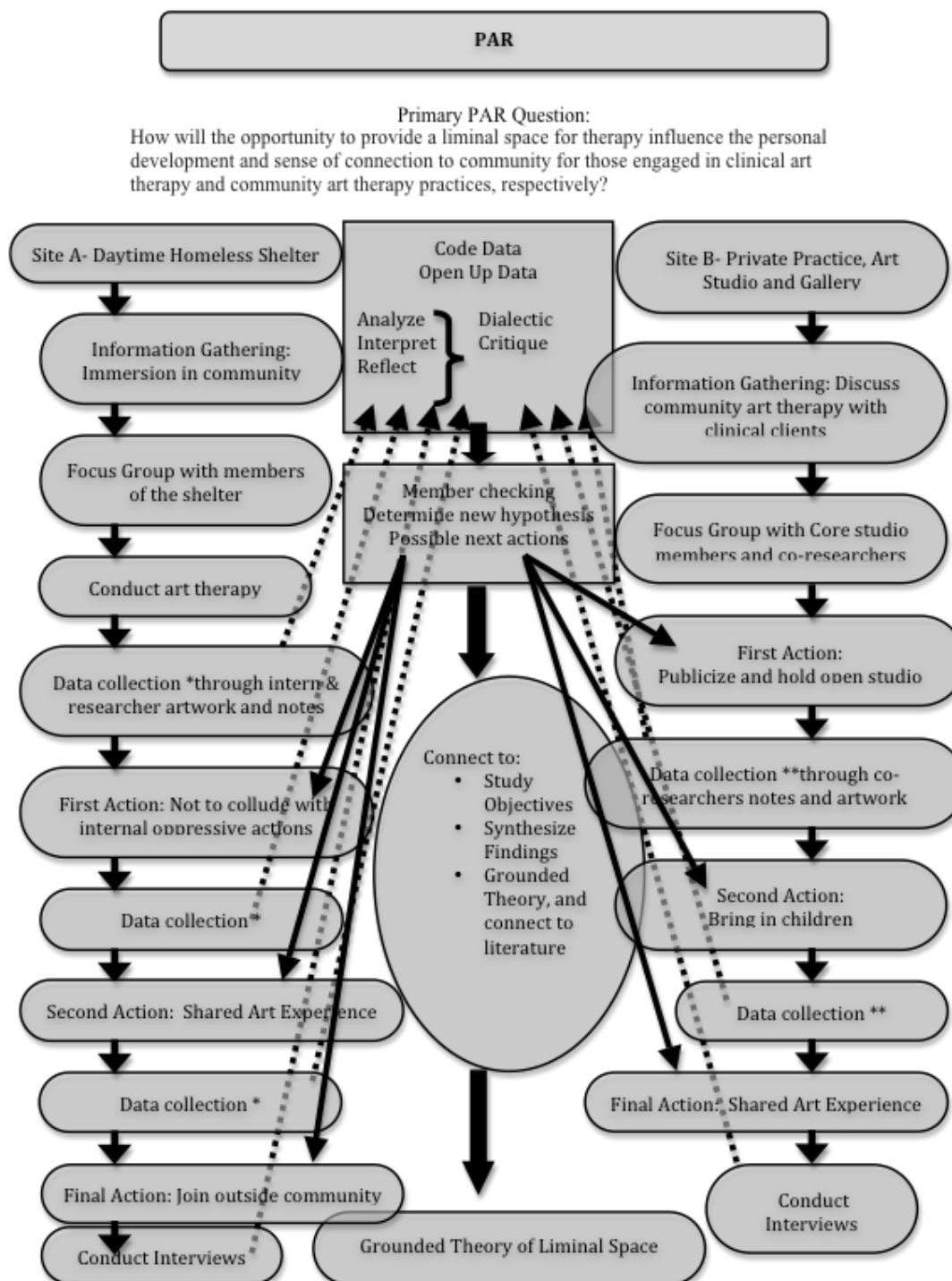


Figure 2. Research Flow Chart: The Participatory Action Research Cycle *indicates that data collection came through intern and researcher artwork and notes, ** indicates that data collection came through co-researchers notes and artwork

The proposal for my research went through a process of approval by the Institutional Review Board of Mount Mary University. I conducted the research once the review board approved the proposal.

The Action Research Cycle

To begin the PAR, first I developed a “problem set” (Kapitan, 2010) by describing completely what I wanted to change. I had identified from a review of art therapy literature that clinical art therapy and community art therapy had been operating primarily in separate environments, within two different paradigms. I reflected on the underlying assumptions that situated both paradigms as separate approaches (Kapitan, 2010.) Then I examined the possible dialectics that were operating within the problem. From the research question I determined that a set of three dialectics might be operating in my problem.

1). Either people don’t have the opportunity to use art to feel personally empowered or, people don’t want the opportunity to use art to feel personally empowered.

2). Either people don’t have the opportunity to connect to others or, people don’t want to connect to others.

3). Either people don’t have the opportunity to create community or, people don’t want the opportunity to create community.

In PAR methods, the data emerge from the co-researchers’ implemented actions and the outcomes that result are evaluated in relation to the hypothesis (Herr & Anderson, 2005; Kapitan, 2010; Watkins & Shulman, 2008; etc.). Emergent data not only are

present in PAR, but also exist in other qualitative designs when researchers make connections from patterns that exist within the data as it collected (Richards, 2008). As the data comes forth, researchers analyze it for relevance to the issues they are living. The emergent data is then used to test the hypothesis against possible answers to the dialectic critique.

Once the first cycle of data came forth from artwork, field notes, and responses, I coded the data to identify when it was created and who created it. I analyzed the formal elements of the artwork and written material, and reflected upon them and after analysis of the dialectics that I hypothesized, I brought the data back to the group. The group then reflected on the data and together we developed a new course of action. For example, when the artwork and responses at Site B presented themes of feeling connected to one another, I brought that data back to the group and as a result they decided they wanted to create a large art piece together to carry the theme of connectedness into transformation. After the action was implemented, we reflected on what we observed in order to determine the outcome that developed from the dialectics we observed and then hypothesized possible future research actions. Interviews with all co-researchers and core participants took place after the final research cycle.

Contexts of Practice Sites

Practice Site A was a daytime homeless shelter in Milwaukee, WI. The shelter offers a daytime democratically run center that is governed by the people who used the shelter themselves. According to its website, the shelter aims to restore “the security and dignity of profoundly marginalized people and empowers them to create solutions to homelessness through a constellation of free programs and services, including a free

medical clinic.” The center serves 70 to 150 adults each day, and as many as 2,500 to 3,000 individuals per year. Also according to its website,

Our homeless constituents are not passive ‘clients’ or ‘guests’—rather they are active ‘members’—of a community of homeless persons in transition to the mainstream. Members prevailingly develop a sense of ownership in the Center, help ensure a positive environment, and have a voice in the self-determination of the site’s community. Our member-community not only created the Community Rules that govern their Center—their ‘constitution’—but they also enforce them. The agency values the participatory framework present in the methods and ideals of my study.

Members of the shelter can come in and rest, get a meal, and take a shower. They can also obtain clothes for job interviews and receive job coaching through programs at the shelter. Some of the members elect to take on job roles within the community such as site security, front manager, and food preparation assistant. When someone walks into the facility, he or she enters into a space called the living room. This is where a majority of the members sit through out the day. The site holds prayer in the space and someone leads a daily reflection. This space is also where people outside of the shelter community give lectures to the site’s members.

Important to the study goals, Site A is a place that fundamentally functions as a liminal space. That is, it is experienced as in-between space of transformation for its members, bridging them from a state of homelessness to one of home dwellers. Members of Site A are active in shaping their own lives in their use of the site and its services. With the help of their community they are encouraged to empower themselves to gain

employment and to establish a stable lifestyle. The site and its programs aids in the members' personal transformation.

Practice Site B. Site B is a private clinical practice located within a gallery and studio. The space houses an open studio space with tables and chairs for small groups to create artwork together, walls that display the gallery work, and two private clinical areas with couches and a table and chairs for individual and family sessions. The practice currently serves children and adults, ages 5-60, as well as families, couples, and groups. Diagnoses of clients utilizing the private practice services include autism-spectrum, eating disorders, post-traumatic stress, depression, anxiety, and bipolar disorder. Currently at Site B, participants have a choice to use the gallery to display the work they create in and out of therapy sessions and take part in a neighborhood-wide gallery night. This component offers each client the opportunity to share their work as an artist, and interact with the community if they choose to write an artist's statement or attend the opening.

In the goal of creating liminal space we created an open studio program for two hours a week, inviting the clients and the community at large to come in and create art for a suggested small fee of \$5, with a collection container available to drop the donation. This open studio was facilitated by a new professional who was earning experience hours toward art therapy credentials, a graduate intern, and three community artist volunteers who were also private clients. The client community artist volunteers were individuals who had been seen in individual art therapy sessions and wanted to be a part of the open studio as core participants.

The studio at Site B operated with the help of the 5 co-facilitators/co-researchers. All of the co-facilitators, or core participants, facilitated the open studio work. After each open studio, they were asked to document their experiences from that day in the form of art responses and field notes that described both the co-facilitators' subjective experiences and the events that had taken place. Response art is another way to extract and interpret meaning of lived experiences using an aesthetic framework, and is utilized not only art therapy but also in arts-based research (Kapitan, 2010). At the end of the research study, each co-facilitator took part in an ethnographic, semi-structured interview to describe and reflect on the study outcomes. Questions during the interview included how their felt sense of community had changed during the course of the research and ways in which they may have felt empowered.

Open Studio. Open studio is a format first articulated by Allen (1995) as a place where people come to make art collectively and artistically thrive on the energy created without explicit therapeutic roles and directives. All people who participate in the studio are active in artmaking. As an approach, open studio is viewed as “art as therapy” on the art therapy continuum of practice. The approach we used at both sites was a modified open studio process, adapted from the Open Studio Project (Block, Harris, & Laing, 2005). This modified format directed the participants to hold an intention in their minds about what they wanted to create each week, to witness each other's artmaking, and to share and write about the experience if they chose to do so, but not to critique each other's creations. The art therapists and intern also took on the role of artists and made art alongside other participants as fellow artists, a practice that sought to create egalitarian relationships within the studio space.

As illustrated in Figure 2, the open studio was a format utilized at both site. At Site A, two days a week for four hours was scheduled for open studio, and was implemented and maintained by the student intern. The open studio at Site B took place each Saturday for 2 hours, for 12 weeks concurrent with the art therapy open studio sessions at Site A. As described earlier, an art therapy “new professional,” an intern, and three client community members co-facilitated the sessions at Site B. This configuration of individuals made up the core participants of the open studio, and allowed the studio to run regardless of other, possibly transient, weekly participants.

Safety and Ethical Issues. Before the sessions began Rachel, (name used with permission) was apprised of the requirements of Site A, which included professionalism and how to handle safety concerns. She attended Site A two days per week, for 4 to 5 hours each day. Weekly supervision sessions with me (the lead researcher) occurred and Rachel also was supervised at her university via an academic supervisor.

Part of this research studied whether or not the implementation of these formats for community art therapy would benefit the private practice Site B. However, in no way was this study associated with a drive for increased revenue. The intention also was not to generate referrals to private art therapy sessions at Site B, although this could have happened once awareness spread of what art therapy is and what programs were available. Had referrals occurred, an art therapist who was not involved in the study was identified in advance to serve as a referral for the individual as a client, or as an alternative the client would have been referred to another local art therapist.

Measurement and Data Collection

The intern and I collected data in of the design of new actions and a grounded theory that would emerge from fieldwork notes, art inquiry, and the semi-structured interviews. We recorded field notes and observations each week from Site A; the intern, new professional, and community participants, and I also took field notes after open studios from Site B. I then coded the field notes to determine the themes or emerging data within the images and written notes. In doing so the data illuminated the process and outcome efficacy of the program. In daily life people participate and observe in on-going activities; it is only one more step to record those observations in the form of a field note (Richards, 2005).

The raw records (actual hand written notes) were stored with information about who recorded the data, when it was recorded, what the content was within the data, what was the context of the event that was recorded and what the context of the record was made in (Richards, 2005). I then “opened-up” the data record to extract from it noteworthy material that collected into themes (O’Reilly, 2009). The process of *opening up* the data included asking necessary questions about the particular phrases, repetitions, or statements that seemed noteworthy, given their repetition, occurrences, and locations. Those questions included:

In what conditions would you likely hear this statement?

What are the consequences of such an attitude or idea?

What will this mean for strategies and interactions within the research? (Richards, 2005, p. 72.)

Opening-up the data is a strategy used to enrich data on the way to creating grounded theory (O’ Reilly, 2009; Richards, 2005). After I initially analyzed and opened

up the data as a first round of data analysis, I then included the intern, co-researchers, and my advisor in the process for participatory purposes. Finally, I utilized member checking to validate the themes against the participants' experiences (Richards, 2005).

I examined the notes using a qualitative phenomenological strategy to collate emergent common themes. Specifically, after the data was *opened up*, I coded it *descriptively, topically, and analytically* (O' Reilly, 2009; Richards, 2005). I cross-examined the data and emergent concepts with research goals and dialectics to determine whether the research goals were met and to confirm or disconfirm the study hypothesis as well as expand other possible ideas or theories (O' Reilly, 2009; Richards, 2005). I created a catalogue of themes from the notes and artwork, which were then categorized and coded.

Art-Based Components of Research. According to Kapitan (2010, p. 162) "art based inquiry can be defined as the creation of knowledge using visual means within a research perspective." Art-based inquiry and responses were important to this study because they roused, confronted, and shed light on emergent ideas that came forth from the PAR's implemented actions. I aesthetically examined my artwork, as well as the intern's, new professional's, and Site B's community participants. The works were *opened-up* in the same manner as the field notes, and categorized. I analyzed the artwork phenomenologically to determine formal elements and patterns that existed within the set of images, such as color, line, shape, or a specific use of an element (Kapitan, 2010). I cross-examined the themes within the artwork with PAR research goals and dialectics to determine which goals were met through out the course of the research. I then brought the findings back to the research team. Using the team approach and its diverse

perspectives on the analysis ensured greater research validity. New themes that emerged from the artwork played a role in developing subsequent cycles of action.

Interviews. Ethnographic interviews took place as the final step of the PAR research cycle. It was important in this study to craft interview questions carefully so that they could be communicated in the language of the participant as a natural extension of his or her culture rather than using researcher language (Kapitan, 2010). To facilitate this communication, questions significant to program efficacy were developed from the focus groups before the research began, in order to determine if the fit of the language and questions asked were pertinent and relevant to the study objectives (Richards, 2005). The use of the focus group earlier in the PAR, comprised of participants from both sites, created an opportunity for dialogue about what questions fit best. It also kept the study validity in check and the control of the study outside the sole responsibility of the primary researcher. The data from the interviews were recorded and analyzed in the same manner as the field notes.

The participants at Site A could attend art therapy as they wished. Initially, no members of the shelter identified that they would consistently attend. Because of the transient nature of the participants I elected not to ask for responses from them as a form of data. However, the 2 most consistent participants in art therapy at Site A were interviewed at the end of the research.

The semi-structured interview for those 2 participants of art therapy at Site A were:

- 1) What connections to people did you make as a result of participating in art therapy?

- 2) How do you feel empowered by the art you made during art therapy?
- 3) How have you changed as a result of the work that you did in art therapy?
- 4) How has this changed your experience being at [Site A]?

The semi-structured interview for participants of the open studio at Site B were:

- 1) How have you changed as a result of participating in Open Studio?
- 2) In what ways do you feel empowered by the work you did within the group?
- 3) What sense of connection do you have to the community here at [Site B]?
- 4) What sense of connection do you have to other communities now that may not have been visible before?

The final results of the study were brought back to all of the co-research participants in order to ensure that they agreed with the documentation and the portion they contributed to in the final outcomes. This is in line with the participatory action research philosophy of limiting hierarchical power, in that all co-researchers had a say in how outcomes were articulated in relation to their experiences.

Action Research Cycle at Site A

Before Rachel implemented art therapy at Site A, she oriented herself to the culture there. She sat with the members in the large room that is known as the living room. After a few days of being there, Rachel facilitated the PAR focus group, comprised of members who were present at the site that day, organized by the executive director who invited participants' feedback on what they thought would be most beneficial in terms of art therapy. During the focus group session, the participants said they would like a private room off the living room and a sign on the door that stated, "Art

therapy in session.” They also wanted to sign up to see Rachel individually. They agreed that the art therapist could bring in a variety of basic materials to use in creating artwork. Rachel set up her area in this manner and individually greeted and invited people in the living room to come in and make art with her. Although, participants did not utilize the individual sessions precisely as they indicated they would in the focus group, they did return again and again, and gradually the program self-organized into an open studio that was similar to what was offered at Site B on Saturdays. Rachel took feedback about what materials the participants wanted to use and would get the supplies from Site B to use during her two days at Site A. She began to bring in rulers, stencils, and books, in addition to the other basic art materials such as markers, pencils, acrylic paints, and oil pastels. Rachel discovered that the participants needed structure to begin their pieces and the rulers and books helped them to get started.

First Action

During this time, Rachel was also meeting with me for weekly supervision and we would discuss what the next actions for the research cycle would be. She would share what happened the week before at both sites and we would discuss the implications of the experience and how next to proceed. During this time, Rachel noticed ways that the agency of the homeless shelter seemed to exert oppressive power over the participants. For example, when she invited participants into the makeshift studio, the lead volunteer would yell at them to “go to art therapy.” She reported that he badgered them, saying, “We have these services available to you, she is back there waiting and I BETTER SEE SOME OF YOU GOING BACK THERE TO UTILIZE YOUR SERVICES, PEOPLE.” Rachel did not know how to address this behavior within her role as an intern, and felt

uncomfortable with the manner in which people came to participate. We discussed the power matrix (Tew, 2006), observing that she did not have to collude with the volunteer worker. Rachel told him politely to let her ask the people to participate, and if they wanted to come they would on their own accord. Consequently, people began to go to art therapy without the volunteer's prompts.

Second Action

During one of our weekly supervision sessions, Rachel discussed feeling isolated in the room where she held art therapy. After the studio sessions, she often remained to listen to the various community speakers who came in and gave lectures to the participants. Rachel felt uneasy about the messages that were given to the participants about the speaker's and the participants' experiences of homelessness. She heard statements like, "pull yourself up by your boots straps," "success is a personal choice," and "there is a gateway to change" (Figure 3). She felt that people seemed to come in and drop messages on the people who were experiencing homelessness, and after the outsiders delivered the message they simply left. Rachel wanted to provide a way for the participants to process these messages offered to them in these lectures. We brainstormed possible ways for the group to better understand the messages and decided to implement an experiential that I developed called a shared art experience. The art experience helped the group to process the information and remained in the large space for people to add to as they needed.

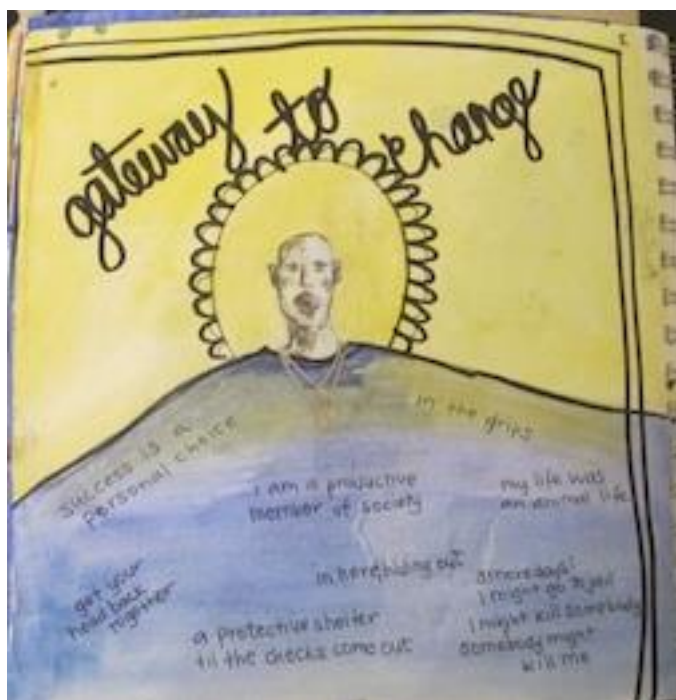


Figure 3. Gateway to Change

At Week 7 Rachel began to implement the shared art experience. First, a few people painted on the board, but they reported that they didn't know what to do. The following week, Mark (pseudonym) painted on the board and informed Rachel that the board wasn't the group's but rather was his. He claimed the piece by painting his name on it. During the third week, Mark began to talk to Rachel about his anger and his rage-like outbursts; together, Rachel and Mark painted the entire board black. Later Mark wrote an artist statement on the board and had an insight that the color black was a symbol of his anger. After working with Rachel on the board, Mark began to answer questions from the book *How You Do Anything Is How You Do Everything* (Huber, 1988) and painting his answers on the board.

Because Mark took over the board that had been reserved for the group and no one seemed to mind, the shared art experience at Site A appeared to be a bust. Rachel and I considered the implications of these dynamics, and also realized that we were not

entirely following the PAR principles in that we were not including the community members to help us decide the next action, but were deciding it ourselves. We had exerted our power and the action had failed. However, we were able to glean from the experience an indication that perhaps the group at Site A did not want to join together or connect to one another in a community of participants who identified as homeless. This dialectic was confirmed later when a participant from the homeless shelter told Rachel directly that he and his peers did not want to connect to each other on site; rather, they wanted to connect to a community outside of the shelter.

Final Action

At one of our next supervision sessions, Rachel discussed her desire to bring the Site A art therapy sessions out into the “living room” to re-join the larger group that usually gathered there. She had tried to do this earlier with the shared art experience and we knew that this should be the next action, but she did not know exactly how to facilitate this process. Then, Rachel called me after a day at Site A, saying that the local art museum had its monthly free day that week, and some of the participants expressed a desire to go. Could she take them? We discussed the logistics of taking a group of people from the daytime shelter to the museum. It would be best to take the public bus and leave from the Site A bus stop together. Rachel would provide bus passes only to those people with whom she had built a relationship with and who wanted to go with to the museum.

On the day of the museum trip various people at Site A seemed to be excited about the art therapy group going to the museum. Rachel heard people say that it was “so cool they were going,” “no one ever took people out of the shelter,” and maybe they

would go next time. Clearly this was the participatory action we were waiting for and our instinct was right about the group members wanting to rejoin the larger community; however, the action had to come from the participants and not the so-called experts. Two women from the shelter went to the art museum with Rachel. On the way to the museum, one woman carefully held onto half of a sandwich to give later to the raccoons she took care of, while she talked about being raped at another nighttime shelter over the weekend. Rachel was surprised at how casually the woman disclosed the rape, but Rachel did not exert her expert therapist role at that point. Instead, she listened. Rachel reported that the women saw “every inch of the museum.” They seemed to like and connect most with the realistic artworks. They told Rachel they didn’t understand abstract art and didn’t see the point. At the end of the day they rode the bus back to Site A, and parted ways. Rachel created an art piece to aesthetically process her experience (Figure 4). She imagined the woman going back to her self-made shelter at the abandoned bus station, feeding the raccoons that she held in her care.

A few weeks later, Rachel offered to take some of the art therapy participants from the shelter to the open studio at Site B. Mark and another participant agreed to go and rode the bus with Rachel the morning of the open studio so that she could guide them across town to the Site B. This trip to Site B in conjunction with going to the art museum was the last action of the research cycle at Site A. At this time, Rachel identified the two participants at the Site B open studio as the most consistent participants of art therapy, and I interviewed them at that time.



Figure 4. Feeding the Raccoons

Action Research Cycle at Site B

For the initial open studio session at Site B we conducted a focus group to determine the group's preference for how the format would be arranged. The group consisted of five core members: a new art therapy professional (Caitlyn, real name used by permission); an art therapy intern, (Rachel); one woman who was formerly a private art therapy client, (Cathy, a pseudonym); one woman who currently was in private art therapy sessions, (Roxy, a pseudonym); and one male, (Jon, a pseudonym), who also was in private art therapy sessions at the studio.

The group decided on art materials and processes. They determined they would like the freedom to explore their own concepts with the basic materials that were available and the option to use other materials if they chose. They would utilize color pencils, watercolors, acrylic paint, oil pastels, brushes, paper, and masonite boards. They also were all in favor of opening the studio to other participants from the public. As the

lead researcher, I would not be a core participant of the open studio, but could utilize the studio as a general public participant on the weeks when I wanted to participate. The core members signed consent forms to take part in the studio, to participate in the research study, and to have all other participants who attended also sign consents.

The group agreed to take part in the research during the 12 weeks of PAR. During the course of the open studio and PAR research they would have the option to discontinue at any time either the studio and/or the research. Their obligations to the program consisted of participating weekly in the studio, completing a response both in art and words that indicated what their experience entailed that day and, at the end of the cycle participate in an interview.

First Action

The first action was to open the studio to the public each Saturday, which was attended by the core members. The studio was publicized to various agencies throughout the local area via a flyer that each intern at the local university's graduate art therapy program distributed, as well as posted to Site B's Facebook page. During some weeks, people from the public did attend and for other weeks only the core members of the group attended.

Second Action

A few weeks into the open studio program, I began to make art about what I perceived might be the next action for the study. What emerged for me was a picture of my son kissing me on the cheek (Figure 5) adjacent to an image of watercolors in intersecting planes. In fact I had considered attending the open studio with my children. I wanted to fully explore the boundaries of liminal space as defined by this research



Figure 5. Louie (pseudonym) and Me

project and to test the experience personally as a community member. The core members had agreed to allow members of the public attend and my children were considered members of the public. Therefore, after careful consideration, I brought my two sons (ages 8 and 4 years) one week and my daughter (age 7) the next.

My sons said that they felt at home in the studio; they had been there many times before, but were excited to attend with other artists. Each boy took a turn creating a painting on the easel. When my older son noticed that the other paintings in the gallery had price tags on them, he decided he wanted to exhibit his painting, *Starry Ocean* (Figure 6) and sell it in the gallery for \$13. My younger son witnessed his brother pricing and hanging his work, and wanted to join in. He priced his painting *Seagulls, Seagulls, Seagulls* (Figure 7) at \$16 and hung it next to his brother's piece. A citywide gallery open house took place that next Friday evening where their work was displayed. The next week I brought my daughter to the studio. She had her own visual journal to work in but like her brothers was allured by the easel and began to work on a



Figure 6. Starry Ocean



Figure 7. Seagull, Seagull, Seagulls

painting. Other co-participants Jon and Roxy (pseudonyms) did not attend that week; as it happened it was only women in the studio that day. A 14-year-old girl, Emma (pseudonym), came to the open studio to work on a painting she had begun that week in her individual session with another art therapist. She asked for help in blending some

paint on her canvas and I showed her how. Emma began to talk about the several different high schools she had attended in the past year and how she had been kicked out of more than seven. While she talked, my daughter interrupted to show us her painting, and we followed her to the easel. Emma then asked my daughter if she would like to see all of the work Emma had made. My daughter followed her to where she kept her artwork and smiled as she looked at Emma's paintings. Caitlyn later remarked to the group that she felt like a female role model that day. However, Emma didn't attend the studio again; we heard from her family that she had run away. My children also did not attend the studio again.

Final Action

The open studio continued over the next few weeks with people other than the core participants filtering in and out. Seven weeks into the 12 week research cycle the core group decided to create shared art experience for the open studio, which comprised the next action of the research cycle. A masonite panel was primed and displayed on the easel in the studio, ready for anyone during the open studio to come and contribute an image, medium, or any technique they chose. This piece continued to evolve over the course of the next 5 weeks, with each participant adding to it weekly (Figure 8). This shared art experience was the last action of the research cycle.

During the last week of the open studio, we had two male participants attend from Site A. Rachel had mentioned to the participants at Site A at several points that they could attend the Site B studio if they wished. This week, two men came and took part,



Figure 8. Shared Art Experience.

making art with the rest of the artists. They left the studio with a smile on their faces and one said he would be back to participate again. On this day, I interviewed the core members of the studio as well as the two participants from Site A.

Summary

In this chapter I have outlined the research methodology that was used for my culminating research project. I defined grounded theory and participatory action research. I also discussed how the safety of the participants was ensured during the research and how confidentiality was maintained. I described the participatory action research cycle and discussed the data collection and analysis procedures used to determine the themes within the research. In the following chapter I will explicate the results of the study.

CHAPTER 4: RESULTS

In this chapter I will describe the results from the 12-week PAR cycle that took place at both sites, and put the research themes into context with two case examples. The research problem for this project is: how will the opportunity to provide a liminal space to work within influence the personal development and sense of connection to community for those engaged in clinical art therapy and community art therapy practices? The research implemented and examined within this dissertation focused on providing people the opportunity to work within liminal space. This involved examining the influence of personal development and sense of connection to community for those engaged in both clinical art therapy and community art therapy practices. Within these results I will provide a case example that is representative of each site and discuss themes that were deduced from the artwork, responses, observations, and field notes recorded during the course of the action research.

Case Examples

Mark

Seven weeks into the art therapy program and research at Site A (a daytime homeless shelter) Mark (pseudonym) began to attend sessions facilitated by Rachel, the art therapy intern. He attended his first session with a friend, and reported that his ex-girlfriend was pregnant with his child. He also said that he intended to take responsibility for the child, despite that he and the mother were no longer together. He used graph paper and stencils to draw a house and the letter “C.” The letter “C” meant *crazy*, he said, and how “everything is crazy.” He told a childhood memory of holding his hand

over his brother's nose and mouth while his brother slept, such that his brother woke up and thought he was drowning. Mark disclosed that if he were to enroll in school it would be for "criminal justice to protect people who aren't protected."

The next session Mark attended was a week later. He came into the art therapy room immediately after Rachel arrived. When she asked him what he wanted to work on in the studio that day, he reached for the book, *How You Do Anything Is How You Do Everything* (Huber, 1988.) With pencil and paper he answered questions he found in the book. While he worked on these questions from the book, he reported that he was still staying at a local overnight homeless shelter. He talked about his family and reported that they weren't close. They hadn't been communicating in the past but were currently able to talk. He and Rachel discussed lying—he reported that he wished he could stop lying and be "real." He said that he had lied to the mother of his child, to "hide his feelings," but now he planned to tell her how he really felt. He realized that he laughed in order to hide his anger, and discussed why he gave so much "attitude." Mark brought the shared art experience from the shelter's living room to the studio to work on it. He added to the panel in paint, deciding that it should have a theme of "things from the past" because it was a theme everyone would be able to relate to. In acrylic paint he created an image of his family that he labeled "me and my family bein[g] distant." He reported that sharing his thoughts and feelings with Rachel was an expression of "being real."

The following week Mark reported that his ex-girlfriend had had their child, but also had placed a restraining order on him because of a fight he had with one of her relatives. He also had been removed from the overnight shelter due to an altercation with another resident. Using a compass to create a series of circles on paper, he named each

circle with an event where he had been angry and acted out his anger inappropriately. He said that he found it difficult to express his emotions or to tolerate unpleasant feelings. He reported that he was sad and mad that he couldn't see a picture of his daughter, and that his life was "falling apart." Together with Rachel, Mark painted over the masonite board, first in blue and then in black. Mark said that the board felt "black," "dark," and "new," but it needed "light." Rachel encouraged Mark to write a "manifesto" or artist statement about the work. With red paint he wrote on the board, "My statement is being angry all [the] time and trying to hide it" (Figure 9). He then wrote "Mark's board" on it, saying that this was a "big statement."

Two days later, Mark added to the board by writing his responses from the book in white oil pastel. The other members of the group encouraged Mark by telling him his work was great. He reported that he felt cautious about sharing his work with others, but that it felt good to have others see it. He agreed to let Rachel take the board to Site B to hang in the gallery.

After the first few sessions, Mark came consistently twice weekly and always waited for Rachel to arrive. He stayed the entire 4 hours the studio was open, worked diligently, and didn't talk very much. He mostly kept his head down and wrote down answers to the questions he found in the book. However, at times he also made sure to get Rachel's attention and seemed to compete for it around other participants. Rachel sensed that he felt a connection with her because he tried often and consistently to get her attention. During one week, he was barred from the agency but came back the following week to participate in art therapy and to socialize with the other participants. He began to



Figure 9. Mark's Board

boast that he was the most loyal art therapy participant and the most productive artist in the group.

On the last day of the research study, Rachel met Mark at the agency and with another male participant took the bus to the open studio at Site B. Mark and the other participant worked in the studio alongside the other artists.

I interviewed Mark at that time with questions that were geared toward the art therapy program at Site A. The first question I asked Mark was, "What connections to people did you make as a result of participating in art therapy?" Mark reported that he had made a lot of progress in art therapy. He was able to meet new people. Mark clearly indicated that he felt a connection to Rachel, saying "Rachel's cool."

The second question I asked Mark was, "How do you feel empowered by the art you made during art therapy?" Mark stated, "I feel like I can show everybody the art that I made." He indicated that showing his artwork to others "expresses a lot." We discussed how showing his work to others could be both a feeling of strength and

vulnerability at the same time. He agreed, saying that he was proud but also did feel vulnerable. Mark was able to feel emotionally safe within the art therapy space in order to be able to express his emotions, such as his anger and his vulnerability.

The third question I asked Mark was, “How have you changed as a result of the work that you did in art therapy?” When Mark answered that question he stated, “I don’t yell at people like that no more.” I asked him to clarify, did he not get angry anymore? “No” he said, “I do get angry” but that he expressed his anger differently and felt better about himself. Mark was able to use the creative process to express himself and feel personally empowered.

When I asked him, “How has this changed your experience being at the Site A?” He stated, “That place is like a reality show. People cool there, though.” It was like a reality T.V. show because he witnessed a lot of drama from the other members. He reported some people were “cool,” meaning that he liked them but they weren’t at the shelter all of the time. I made the connection between his use of the descriptor “cool” for Rachel and I asked him about it. I asked, “Is art therapy the reason you go back to [Site A]?” He indicated that while he liked art therapy, he really liked art therapy with Rachel. This is another indicator that he was able to create a connection to Rachel, and this connection aided in his ability to attach to a healthy person.

After the interview and his time participating in the open studio at Site B, Mark left the studio and Rachel reported that he had been mad at her for not taking the bus back with him and the other participant. The following week he attended art therapy with Rachel at Site A, but he gave her a hard time. He wouldn’t talk to her or answer her when she spoke to him. His body language was guarded and stiff towards her. The first

day after his visit to the open studio at Site B, Rachel reported that he acted like a child; he sat in the room and put his head down on the table. He was angry with Rachel. Periodically, Rachel would check in with him to make sure he knew she was there and wasn't angry with him, but for a time he sat there and seemed to sulk. Eventually, he participated in art therapy again. Mark's response was similar to the response of a child who is angry with a parent. When the consistent healthy parent repairs the rupture and continues to check in with the child, the child is able to resolve the feelings and move on, showing the development of a healthy attachment style. For Mark this behavior indicated signs of developing a healthy attachment to Rachel. Mark was able to trust Rachel, she was reliable and always there when she said she would be, and she was attuned to Mark's needs. Rachel and Mark had developed a healthy therapeutic relationship during the course of art therapy.

Later on, Mark also helped Rachel to display the work of the artists in an art exhibition at Site A. He helped her to organize and hang the work; he also made posters to advertise the event to the other shelter members and art therapy participants. Mark's dedication to showing the work the group made is an indicator that Mark was proud of the work that he and the others did in art therapy. Mark had found a place of belonging within the group and made progress toward developing community within art therapy participants at the shelter. In liminal space Mark was able to move between his internal reality and his external reality using art therapy with Rachel as transitional phenomena to mediate between the two realities and senses of identity. What occurred for Mark is that he was able to develop his capacity to be with other people, to express his anger appropriately, and ultimately to work towards personal transformation.

Jon

Jon came to Site B's open studio 8 out of the 12 weeks of research, and continued to come to the open studio beyond that. Originally, I did not ask Jon to be a part of the research because I had not had contact with him in clinical art therapy. However, he attended the focus group with his girlfriend Roxy and subsequently I decided to ask whether he wanted to participate because his attendance would diversify the gender of the core group of co-researchers. He also brought a new energy to the group. He talked a lot during the focus group and shared many ideas. His talk seemed to be generated by a nervous energy, and he jumped from topic to topic. Jon attended individual therapy sessions with another therapist at Site B prior to his involvement at the open studio. He had a history of drug use in his teen years and had gone to a rehabilitation center at that time, and he underwent intensive personal therapy.

A few things happened at the start of the open studio with Jon that were noteworthy. First, Jon had recently moved out of his parent's house and into his own apartment with Roxy. He made it very clear that he did not have a good relationship with his parents. He described them as very wealthy and driven by success, which they seemed to measure by their wealth. He felt he did not meet their expectations and they constantly reminded him that he didn't "measure up." Second, he talked about his 3-year-old son by another woman, and the guilt he felt for not being the father he wanted to be. He didn't see his son very often; his relationship with the boy's mother was strained. He had asked for a paternity test just to be sure the child was his. The test came back to reveal that Jon was not the father. On the Saturday after he found out, he attended the open studio without Roxy.

Jon described himself as an introvert, and so both Rachel and I were surprised when Jon attended the open studio without Roxy. That week he spoke to the group about what had happened. He wasn't the father. At the end of the studio that day, Jon created a reflection piece (Figure 10). Jon wrote the following response with his artwork:

Harmonious non trying
How am I? I am.

The waves can be crashing on the shore.
How magnificent.

The silence IS.
The storm goes on
But there is no boat to be sunk

Why so cryptic?
Why not.

It seems as though Jon was trying to let go of control, to accept and to allow the natural course of his life to progress. He seemed to want to do so by accepting that the child was not his, and that he was not responsible for not being a part of the child's life—he is not the father. And unlike his own father, he would not sink the boat. Through his attendance in the studio that week, Jon confirmed the need to express himself as an artist, and also reported that he felt like this was a group he could feel emotionally safe within.



Figure 10. Harmonious

Jon came to open studio every other week for the next four weeks. Roxy his girlfriend mentioned that because he had moved out, Jon's parents had cut him off financially. He had worked for them as a custodian at one of their fitness gyms, but they did not pay him enough to survive on his own. They used to pay for his lunches, gas for his car, and his individual therapy treatment, but since he moved out they had stopped providing this for him. Jon had little extra money for gas to get to open studio.

However, when he could attend he did, and he contributed verbally to the discussions of the studio while he worked on his own art. Five weeks into the studio and research, Jon created a reflection at the end of the studio time (Figure 11). He wrote,

Don't really know word wise
I enjoyed the harmony of the different energies in each person
It allows me to dance between them and look in astonishment at how wonderful the
dance between people is. Thank you.

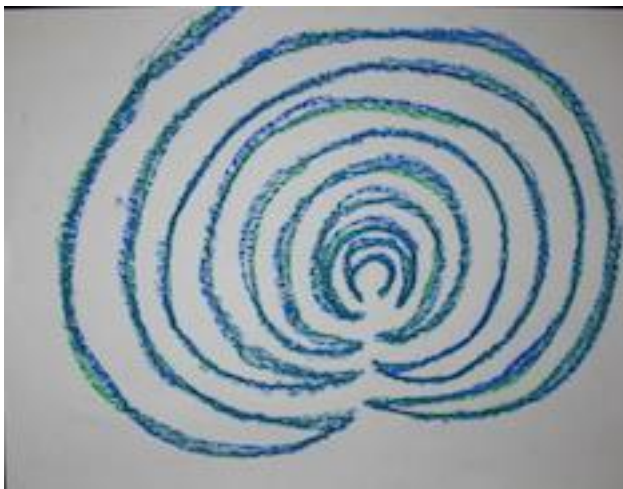


Figure 11. Dance

This is the second reference to harmony that Jon made and he identified a feeling connection to the others in the group. Jon also referenced the energy between people, which indicated he felt like he was in a liminal state or space.

The next week, he attended again and contributed in the same way through art making and initiating conversation. The other members of the group always responded to Jon's ideas positively, but he certainly was the driver of the conversations. He created another reflection, which included a small pen drawing (Figure 12), and wrote,

Unexpected wonder

Like being tapped on the shoulder and humbly reminded

That it's everywhere and everything and everyone that makes this all worthwhile.

Here again, Jon referenced connection, being tapped on the shoulder. The eye that he drew seems also to reflect his own awareness in allowing himself to connect with others, and the "unexpected wonder" he referred to, indicating that he was again able to enter into liminal space, which transcends "everywhere and everything."

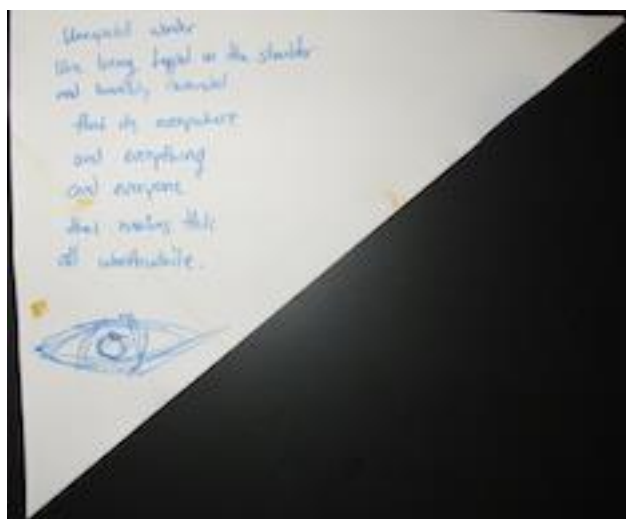


Figure 12. Wonder

During the next few weeks Jon contributed to conversation but seemed to hold back at points, and almost seemed reflective in the conversations he started and what he shared. In particular Jon seemed to hold back on his contribution to the studio conversation in a uniquely more calm or contented way, while being aware of his contributions. He reflected that day (Figure 13) and wrote:

Like two bubbles of mercury getting closer and closer together, then all at once, becoming one.

Yet again, Jon indicated connection through his words and in his art. It seems as though he had referenced the cohesiveness of the group, the feeling of community. “Becoming one” designated that he was able to enter into a liminal space within the group, and to contemplate his internal and external realities.

The next week when Jon returned, the energy in the entire studio seemed quiet and tense. Jon added the least amount to conversation in the group, being more reserved



Figure 13. Bubbles

and quiet. Rachel and I noticed and during supervision discussed the possibility that Jon was becoming more self-regulated each week and therefore able to ease the anxiety he admittedly felt, rather than to use words to release the anxiety.

Jon attended the second to last studio during the research, and seemed to hang out in the studio, rather than making much art. At the end of the day, he created a reflection that indicated this, (Figure 14) writing:

Didn't do much
Talked a lot
Loved the time

Going on with my day
Freer than I was

This response indicated a release and transformation. Jon felt a sense of freedom being a part of this group and he was accepted for who he was no matter what art he made and no matter what he talked about in the studio.

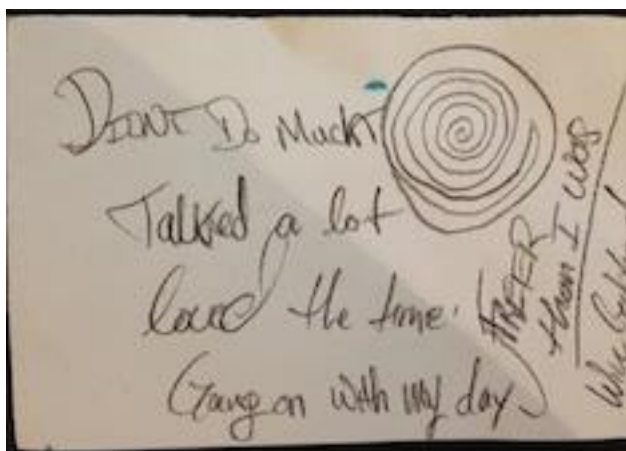


Figure 14. Freer

The last week of the studio, Jon did not attend. The participants understood that they would be interviewed at the end of the 12 weeks. In the following session Jon and I discussed his experience as a participant in the open studio at Site B. I asked Jon, “How have you changed as a result of participating in open studio?” Jon answered by admitting that, “I’m hermit-like and keep to myself.” He went on to say that this is a small community that he has been able to participate in weekly. The community was not something that he normally would have sought out. He had changed because he now participated at least weekly and that was a step for him in connecting to others and creating community.

“In what ways do you feel empowered by the work you did within the group?” I asked. When Jon answered he reported that attending the group empowered him to have

the confidence to talk to people and share his “unique world-view” that he was “normally self-conscious about.” He shared that he thought and felt that he could “let it out” in the studio; people in other places, like his family, were not accepting or understanding of his views.

I asked him, “What sense of connection do you have to the community here at [Site B]?” He said, “this is an unpressured environment... to connect to others in; even though we are from different areas and are different ages we have things in common, and have universal experiences.” John was able to express what he needed in a safe and structured environment, which contributed to his ability to connect to others and to create community.

Finally, I asked Jon “What sense of connection do you have to other communities now that may not have been visible before?” He discussed this question after first stating, “This is a jumping off point for me.” He realized that this was his beginning step toward engaging with others. I found this interesting, because while I noted that Jon attended the studio regularly, I didn’t realize that he felt so alone and isolated. I remembered at the beginning of the open studio program at Site B that Jon had attended individual therapy sessions. He stopped because his parents refused to pay for his treatment after he moved out. It seemed to me that Jon began to actively use the open studio as a more accessible alternative to individual treatment. Research participants weren’t asked to pay the suggested five-dollar donation, and because he was so financially strapped his ability to forgo the donation allowed him the opportunity to participate.

I asked Jon about the differences he experienced between his work in individual therapy and the community open studio. He reported that he had had a lot of experience

with individual treatment in the past. He thought that individual therapy kept him in a “monologue” with his issues and kept him focused on “one thing.” However, in the group setting he felt an asset in that the connection to others didn’t isolate him to one problem. He was able to see outside of his own issues and connect to others in their shared anxieties. He could feel like he was not the “only one” and this, in and of itself, he reported, reduced the anxiety he felt. His ability to connect to others around his own source of insecurity, his anxiety, helped him create community.

I asked about the ways that he had experienced a reduction in his anxiety. He reported that he still had daily panic attacks. While those panic attacks happen everyday, his response to them has changed. He doesn’t give them power by having anxiety about his panic attacks, how long they will last, and when they will arise. Instead, he allows the panic to move through him. He attributed this to the “basic level of acceptance” that he felt by the group at the open studio. He reported that he no longer felt like, “I am flawed, or something is wrong with me.” The experience at the open studio allowed him to continue to come back to open studio weekly and not avert from the studio because of his inner feelings and thoughts of being personally damaged. He has been able to move toward transforming feelings of being personally damaged into thoughts of acceptance and belonging.

He went on to articulate that his experience at open studio had been a “good enough,” counter argument to what he was taught, both in actions and words about being accepted by a group or community. In his family he was taught that there is no community. He spoke about his history with his family, particularly his relationship with his father. He reported that his father was extremely afraid of death and isolated himself.

The family lived in a large house, on many acres of land, isolated from their nearest neighbors. His father is only concerned about his personal security, which secures by making as much money as possible so that if something happens he will have the monetary means to address the issue. The open studio, Jon reported, has given him the ability to see that his needs can be met otherwise; community and connections to others can offer what money can't; he stated it is like knowing that “the *word* water doesn't quench my thirst.” In the open studio community people accept him for who he is, and this was confirmed to him through both actions and words— an experience he reported that he had never had before.

Contextualization of Themes

In this section I will identify the dialectics of the research problem and place each theme into context (see Figures 15, 16, 17). Together with the co-researchers' confirmation, I deduced the themes or areas of significance within the research data from outcomes that were observed after the implementation of actions during PAR (Table 2). I used data from the intern's artwork, as well as mine, and observations and field notes from Site A, I also used with the weekly response artwork from the co-participants at Site B and their written reflections. The themes emerged as a result of cross-examining what we saw within all of the data and the dialectics. At Site A the themes were: a) self-soothing and refuge, b) physical and emotional safety, c) structure, d) expression as a luxury, e) healthy connection to individual or attachment. At Site B the themes were: a) expression as important to people who identify as artists, b) emotional safety, c) freedom to create, share or not share, d) connection to others within the group, and e) the feeling of community or family within the studio.

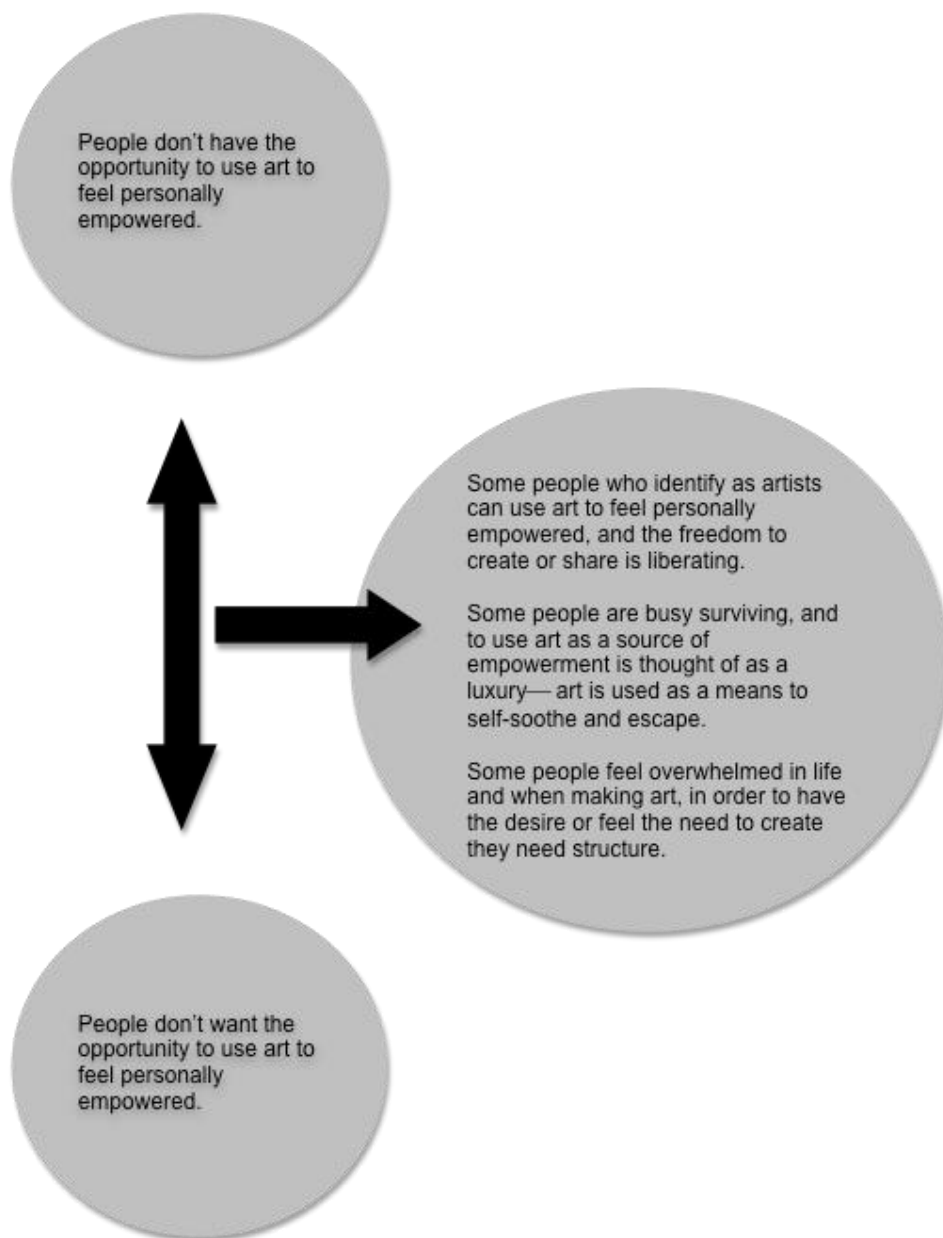


Figure 15. Dialectic 1: Art for Empowerment.

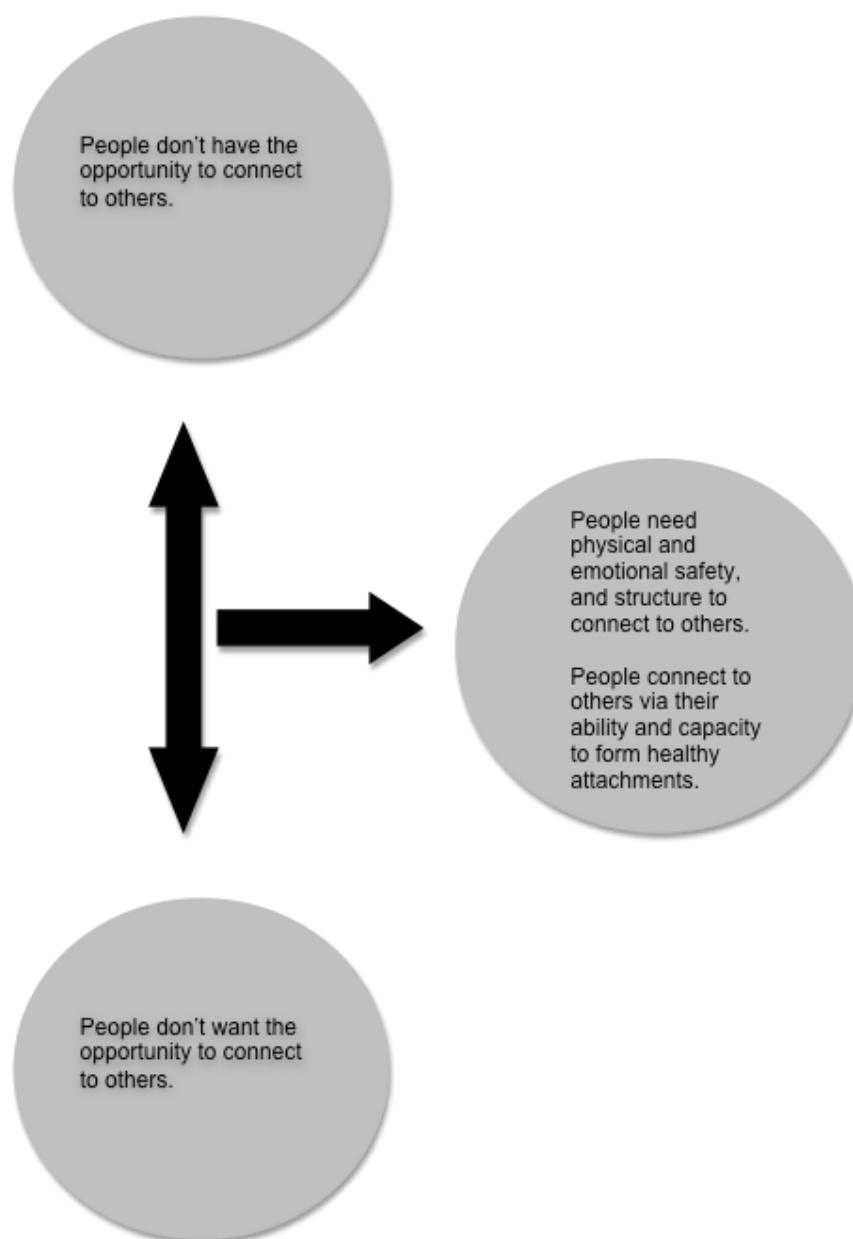


Figure 16. Dialectic 2: Opportunity to Connect.

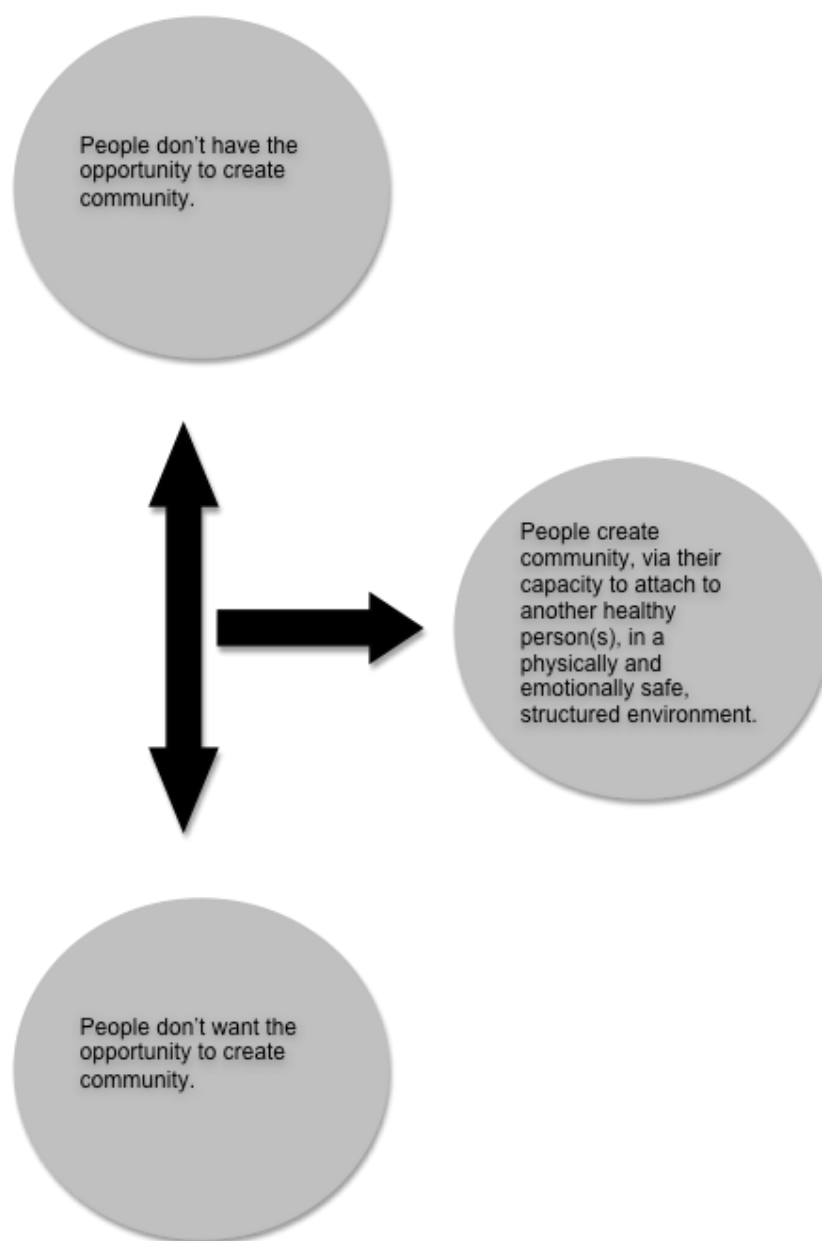


Figure 17. Dialectic 3: Opportunity to Create Community

Table 2

Data Sources and Results

Data Sources	Emergent Themes	Contexts
Site A	Refuge and Self-Soothing	From the harsh conditions of the street, weather, and drugs
	Safety	Physical/Emotional
	Structure	Within the artwork, but also the structure that art therapy provided for the clients
	Expression	As a luxury, and only after most clients attended art therapy for a period of time
	Healthy connection	To an individual or an attachment process
Site B	Expression	As a part of their artist identity
	Safety	Emotional
	Freedom	To create what they wished, share or not share
	Healthy connection	To others in the group
	Community/Family	They felt like they were a community

Initially, I had deduced the themes from the artwork, written responses, observations and field notes prior to the interviews that I conducted. However, I wanted to see if the interviews with the participants confirmed what I was seeing in the written reflections and art. After I cross-examined the interviews with the emergent themes, the intern and I discussed the all of the results with all participants. Two members of the art therapy open studio at Site A who were interviewed as well as the core- participants of the open studio at Site B checked the themes for validity. For the most part the participants agreed with the findings. One participant from Site B admitted that she did not have a familial feeling toward the other participants, but did feel a sense of connection to others in the group and a part of a community.

Site A Themes

Refuge and Self-Soothing. Although the open studio group at Site B had a commonality in that all identified as being artists, Site A did not have this identity in common. The commonality at Site A, by contrast, was that all of the participants who came to art therapy were either homeless or had been homeless at some point. Most came to art therapy to escape the conditions of the street, the inclement weather or the desire for using drugs. They used the art materials, the back and forth motion of coloring, and the safety of the space to self-soothe; they found comfort in the art materials and used them art therapy. The open studio at Site A was a “refuge within a refuge.” The participants were able to enter into the art therapy space and become identified as artists, not simply marginalized people in their society who were struggling with issues related to homelessness. The participants who came to art therapy could

escape. They escaped the uncertainty of the living room where chaos sometimes followed the participants from their outside lives (e.g. not knowing where they would sleep, what they would eat that day) and they escaped into use the art materials, where they had the freedom to choose what they created, and talk to another person more intimately. The “refuge within a refuge” was clearly a liminal space, it offered a threshold within the site where participants entered and became artists.

Structure and Safety. Participants would come into Site A and sit in the shelter’s living room, sometimes all day long without really moving, seeking respite, possibly taking a shower, or eating a meal. The desire for structure within the art therapy program at Site A was evident from the start. Rachel felt that she needed to provide a clear structure in order for art therapy to function properly within the shelter, which often seemed chaotic and unstructured. People were coming in and going out of the shelter, bringing the complex issues that correlated with homelessness with them, such as aggression, addiction, and anxiety, which resulted from constantly attending to their own survival. Rachel set up art therapy in what the organization called the intake room. She brought materials and put a sign on the door, “Art Therapy in Session.” She would personally invite the participants who were sitting in the living room to attend art therapy. She extended her invitation consistently 2 days a week, and was there consistently for 4 hours at a time.

The shelter agency also was kind of a liminal space or a bridge where shelter participants were able to transform themselves using the shelter’s resources from being homeless to working and living off of the street. During the time art therapy started the agency was thrown into chaos. In particular, the executive director for the last 25 years

had been let go, but had difficulty leaving the place she had helped to create. When the new executive director went into work, the former executive director had changed the locks and placed her own people on the board of directors. Ultimately, the struggle for executive control over Site A was left to the local governmental court to decide.

Although the court's decision supported the new executive director for the first half of the research, the system at Site A was in more chaos than normal. The participants spoke about the uncertainty of the site's new administration, with some taking sides with either the new director or the former director, and there were arguments over who was best fit to lead. The security guards threatened to walk out because they weren't paid; the accounts had been frozen. The daily contact person who was placed at the site by a volunteer organization was unsure if that organization would pull him at any time because the space was potentially unsafe without a clear director. Rachel and I spoke about making sure she always took safety precautions, and if the security guards left because they weren't going to be paid that day, Rachel was to leave as well.

Many of Rachel's process pieces, as well as mine contemplated the theme of structure versus chaos (Figures 18 & 19). We also created many images where we tried to provide structure for the chaos (Figures 20 & 21). We created these images as our own responses to what we experienced at the site in the midst of uncertainty, and our clinical instinct told us that we needed to provide structure to effectively hold art therapy there. Within the art therapy sessions most clients preferred to work with straight edges, rulers, and stencils. They also preferred to have a clear direction to their work. For example, Mark used the book to answer questions from, and then the art materials to express his



Figure 18. Chaos and Structure A-Emily



Figure 19. Chaos and Structure A-Rachel



Figure 20. Chaos and Structure B-Emily

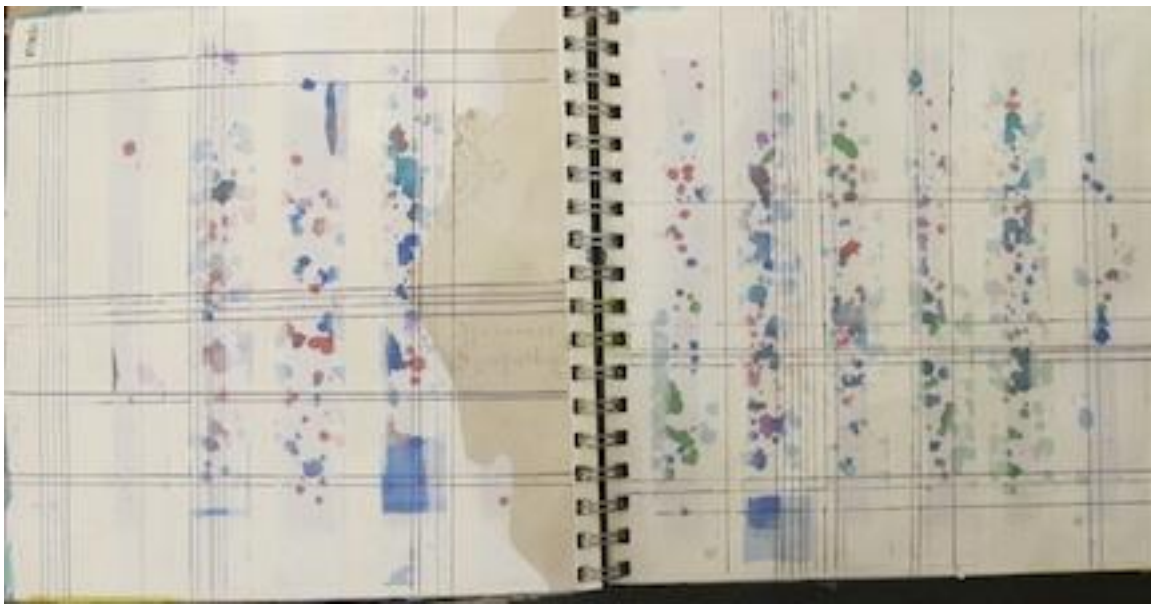


Figure 21. Chaos and Structure B-Rachel

concerns. Art therapy structure was one more way the clients could create structure within their lives, using the art materials to create that structure.

The participants also used art therapy to structure their day at the site. They used materials within art therapy to give structure to their creations as well. The structure was needed in order for the clients to feel safe—structure and consistency creates reliability

and furthers trust. Rachel provided structure within the chaos of the space and in turn the clients were able to feel a sense of safety in art therapy. The clients could settle within the studio and rely on art therapy because they needed the safety and the structure within their lives.

Shortly after Rachel implemented more structure, people began to open up and share. When anyone jeopardized the safety of the environment, Rachel made sure to act in a way that would preserve the participants' continued safety. For example one man, Robert (pseudonym), came into the studio and pointedly questioned the value of what the participants were doing. Robert was angry; Rachel knew the art therapy participants were scared of him. The other participants cowered from him in the room, and the energy became tense. Rachel kindly talked to him, careful not to shame him but to validate his concerns, and began to explain the value of self-expression. He wouldn't have it. She offered to see him for an individual session, and said that unless he was going to participate and not make the other people scared, he would have to leave the art therapy studio. She wanted him to know that he was valued and that he was welcome to participate, but he wouldn't be allowed to make the others feel unsafe through his yelling and aggression. I agreed with Rachel's evaluation and therapeutic decision to keep the group safe in that instance by inviting his presence and offering him personal time with art therapy. Eventually, Rachel did have individual sessions with Robert where he revealed that he had experienced severe abuse in his lifetime. He was mostly focused on what he needed to do to survive; trusting others and creatively expressing himself were not part of what he thought he or others needed to do to survive.

Expression. Expression for the participants at Site A was different than the participants at Site B. While the artists at Site B had the commonality of using the art studio for expression and creativity, the artists at Site A held expression as less important than the other themes that emerged within the research. Expression for them was a luxury compared to self-soothing, refuge, structure, and safety—in short, survival. For some participants, using art for expression seemed out of their reach. Robert also made it clear that expression was a luxury. When the participants were able to feel safe, create structure, and connect to an individual (which was in this case with Rachel), expression became more salient. Only then could they use art to express themselves and feel empowered. Both Robert and Mark were able to express their anger after all of these needs had been met. Art therapists who work in both the clinical and community setting, therefore, must make sure the basic needs of safety, structure, and a trusting relationship are met, because only then will the group will be able to see expression not as a luxury but a basic human right and need. In the eyes of the participants, healthy expression through art became an attainable luxury. Within the liminal space that was created in the shelter, the participants were able to grow their potential to see that some comforts and even transformation were within their grasp.

Healthy Connection to Individual or Attachment Process. I had hoped that art therapy could further create a sense of solidarity and feeling of community within the participants at Site A. Although the participants were in a physical proximity to each other, they did not seem to see this as an asset, or actually attempt to connect to one another. Robert, who had questioned Rachel angrily during the art therapy session, inquired about the legitimacy of her presence at the site. He challenged the relevance of

art making as something that could help the people at the site in the ways they truly needed, which was to help them practically survive. Rachel asked Robert what “community” was and he answered, “Community sticks together... [this site isn’t community]...this is a refuge...[people here are] trying to get [from here] into the community.” He further informed her that the members had little interest in making connections to the other homeless people—they wanted to make connections to the community outside of the site. Other participants also saw little comfort in creating a community with people who were marginalized. Robert confirmed our thoughts that the site itself was a liminal space; it was a doorway where people could enter and become transformed into members who were no longer marginalized by their homeless status.

When the research project began, one of the objectives was to promote the participants’ feelings of self-agency. We assessed their self-empowerment in terms of their capacity and willingness to make art. The participants could only feel empowered by their art when they felt safety and structure. However, Mark was able to empower himself and express his anger appropriately when he felt safe, and could work within structure. Self-agency came through safety, structure, and connection to another healthy individual. Working within the liminal space of the art therapy room, which was bounded by structure and safety, and held the opportunity for healthy connection to an individual, the participants were able to develop their potential for self-empowerment using art expression. When participants felt personally supported by a healthy individual, they were able to promote and accept their own sense of self-importance and personal power, but a connection to individual had to come first.

Site B

Expression. All of the members of the open studio at Site B had at least one common goal: to make art in a group of people. Each person noted that they wanted to set aside time each week to develop and foster their creativity and artistic skills. Each week, the group made artwork together, but on separate pieces— at least until the shared art experience. Each person was interested in expressing their selves, of sharing their art making with others. They felt that if they came to the studio to make art each week, setting aside the time, this would keep them accountable to their creative process. Each person within the group identified as artists and the group members felt a collective need to express themselves through art making.

In contrast to the collective artist identity within the art studio at Site B, at Site A the participants did not identify as artists. The open studio at Site B developed out of very different needs, which already privileged using art as an attainable form of expression. The needs of this group, as determined through preliminary discussions with the clients before the research project began, was that they valued art therapy and felt a need to be with others who felt the same. This group, of which many did have a mental health diagnosis, wanted to come to the studio to strengthen their identity as artists and use their art as a way to grow and heal with others, despite having mental health concerns. Liminal space within the open art studio at Site B created an opportunity for them to grow as artists in connection to others because all of them entered the studio as artists and not mental health patients.

Safety. As the predictability of who would be a stable presence in the studio each week was established, the group began to open up and share more about themselves. The inherent structure of the stable space of Site B and what the group established as

norms were solid enough to provide the safety the group needed to develop the bonds of the relationships within the studio. For example, one participant stated, “If I hadn’t been a patient here before, and knew this was a stable business that was going to be a secure, safe place, I wouldn’t have been able to participate.” This statement suggests that the participants needed to feel psychologically and physically safe within the space and the people present in order to connect to the group; and over time within this safety, the group members coalesced into one cohesive unit.

Freedom. The group members recognized the freedom they had to create what they wished, to share or not share, to attend or not attend. They were able to explore different materials, intentions for their work, and avenues of conversation within the studio with whom they chose. This freedom offered them more control and allowed them the choice to make the connections to the group in ways they felt most comfortable.

In contrast to Site A, people within the art studio at Site B had an internalized structure that they could call upon and were therefore able to use the materials more freely. At Site A, the members of the art therapy group needed clear structure in the work they created; they used rulers and traced images to create that structure for themselves. The members of the studio group at Site B did not have to worry about where they would sleep that night, what they would eat that day, or if they had enough clothes on to keep them warm outside. The members of the open studio at Site B were able to bring and utilize their own structure because their lives were so different, and then were free to use the studio and art materials as they wished.

Connection. After the initial focus group session, the members of the studio began to form personal connections with others in the group. In the third session where

Caitlyn (the new art therapist) and Cathy, a participant, were the only people present, each divulged afterward that they felt a greater sense of connection to each other. Cathy had experienced anxiety at work while being with her co-workers. Cathy often spoke of the isolation she felt even when she was with others, of not being “good enough” for others. When Cathy worked within a therapeutic space where she felt safe, secure, and valued as an artist, she removed her insecurity of not being good enough, tolerated her feelings of anxiety, and was able to connect to Caitlyn.

Roxy and Jon remarked that the studio gave them a chance to connect in a different way to each other than they would have been able to do outside of the studio. Roxy and Jon usually did not leave their apartments to be with others except for work, going to therapy, and the studio. Both Roxy and Jon had struggled with issues related to addiction. At times it was difficult for them to abstain from using drugs together, and to seek out others to provide them with drugs. Although they made art at home, at the open studio they were not only able to connect to each other through their creativity, but also could witness each other interact as artists with other artists. The open studio provided a space where Roxy and Jon developed their relationship through the experience of making art with others and interacting with others in a healthy way. Each person in the group was able to form a connection to other individuals, but also to the group as a whole. Open studio within liminal space allowed individuals the ability to form a connection to others because the participants were not tethered to their identities as people with mental health concerns. The participants within this liminal space thus were able to step out of their felt isolation in order to forge connections through their common artist identities instead.

Community/Family. A few weeks after the onset of the shared art experience the participants began to ask, “Have we become a family?” Two participants drew images in response to studio that day that included references that the group felt like a family. Rachel, the art therapy intern, drew an image that had five distinct circles and included references to family in her written response (Figure 22). Rachel drew the five circles to depict the five core members of the studio, who were connecting not only through art but also through shared life experiences. The members spoke about their families in the studio that day, referencing them in different contexts. Roxy drew five pumpkins in her response art and wrote above them, “My siblings and me” (Figure 23). One participant did not feel this was a pseudo-family, however, she felt her family ties were very strong and healthy, but did feel she belonged in the studio community. After the participants made personal connections to each other, they were able to connect to the group and create a cohesive community. They wrote in their responses that they felt accepted for who they were no matter what, which happens in healthy relationships, families, and groups. I further assert that the shared art experience brought this sense of community to a solid state as each person was beckoned away from only his or her personal art making, and to a shared experience with others. The people within this group valued each person present and invited them to express that value and their individual artistic skills together. The shared art experience engaged the group as a whole and allowed them to see the power of creative transformation they held together. Within liminal space created in the open studio each member of the group came in as an individual but each left transformed into a member of an accepting and expressive community.



Figure 22. Circles



Figure 23. Pumpkin Family

Attachment

The most significant finding during the research is in regards to attachment. As I reflected on my artwork, the intern's artwork, and the artwork made at both sites, I created an image that synthesized the research findings (Figure 24). I created an image of a child holding a doll and learning the process of attachment through play. I reflected on the parallel process that I observed happening at each of the research sites. At each site, people within the groups seemed to be contemplating the process of attachment through art therapy. I began to see that attachment processes were a common thread in all of the participants' potential to create community.

Capacity for attachment is developed in infancy and can be furthered by the therapeutic process and a person's willingness and ability to engage in a healthy relationship (Schoore, 2008.) According to attachment theory, "any relationship partner can serve as an attachment figure if he or she becomes a reliable source of protection and support" (Mikulciner, et al, 2012, p. 607). The child who successfully individuates from the mother, by moving through transitional space, is able to develop a secure and stable sense of self in relation to others (Winnicott, 1970). It is from the transitional or liminal space that the child leaves the dyad and moves into greater world of family and community. People have to have movement toward a secure attachment or a secure attachment in place before they can actively seek out community. Ergo, in community art therapy and community treatment art therapists cannot assume that people can always form or connect to community. Art therapists can, however, provide safety, structure, and the opportunity for expression that helps to establish community.



Figure 24. Attachment

In art therapy, art relaxes defenses at the primary level, which is also the level that attachments are formed within between the therapist and participants (Schorer, 2000, 2008). At this primary level relationships are formed and

can be conceptualized as involving an attachment bond; the therapist can become a safe haven and secure base for the client, thereby heightening the client's sense of attachment security, which in turn can facilitate healthy emotion regulation and exploration of new possibilities. (Mikulciner, et al, 2012)

The art therapist and art therapy can promote the affect-regulatory properties necessary during healthy attachment relationships. The new possibilities can include the ability to connect to community.

Proponents of contemporary attachment theory assert that the theory can now be described as a regulation theory (Schorer & Schorer, 2008). As such the client and therapist interact, explicitly talking, making art, and so on, but also implicitly through neurobiological communication. "Regulation theory thus describes how implicit systems

of the therapist interact with implicit systems of the patient” (Schore & Schore, 2008, p. 14). The client develops the ability to regulate his or her emotions based on this implicit communication, as long as the therapist is willing and able to provide a safe, secure, reliable relationship and has a personal sense of healthy attachment security (Mikulincer, et al, 2012.) This implicit interaction takes place in what Winnicott (1970) described as “transitional space.” The client and therapist interact within the inter-subjectivity of the transitional space, and in that space the connection is made and developed between them. Then the client is able to emerge from that space to create healthy connection to others and to form community.

I identified in this dissertation two clients who were representative of each environment, who showed a positive change in their abilities to strengthen their attachment security. At Site A Mark was able to connect to Rachel and through that connection moved towards joining the larger community, which was exhibited in his participation of the open studio at Site B. At Site A, Rachel met Mark in the liminal space, and the relationship, structure, safety, and trust that developed allowed Mark to feel empowered and further secure his capacity to attach and form healthy relationships to others. Mark also showed this in his motivation to work with Rachel to create the gallery event at Site A, which showcased the work of the group. Clearly, he valued the work done by the other artists and held them as important enough to share all of their work with others. Mark organized the show and helped Rachel display the work. Mark began to create a cohesive community at Site A. However, during the course of his work with Rachel, he repaired his relationship with the mother of his daughter, expressed his love to her, and asked her to marry him.

At Site B Jon was able to move toward his own creation of community when he used the group and studio as the stable, secure target of attachment. Jon openly admitted to his avoidance of community, but the safety and acceptance that he felt within the space helped him to continue to return each week. The liminal space at Site B empowered Jon to develop his ability to form community by providing a space from which he could create a healthy attachment.

Conclusion

In this chapter, I illuminated the results of the PAR through two case studies from each of the research sites. Within those case studies I identified ways in which the participants worked within liminal space to use art to express themselves through art making and to create connections to others. I also discussed the themes that emerged within the research and placed them into greater context. I explored the most significant finding of attachment that bridged the two sites where the art therapy research project took place, and how the process of attachment occurs within liminal space. In the following chapter I will offer a grounded theory of liminal space and discuss this research and its implications for further research.

CHAPTER 5: DISCUSSION AND CONCLUSION

Introduction

In the previous chapters, I discussed the relevant literature that grounds this research project. I discussed two major paradigms within art therapy: the clinical and the community. I offered the definition of emancipatory practice and ways to practice from that standpoint to create what I also defined as liminal spaces within art therapy. I asserted that liminal spaces within art therapy can open up new narratives for practice and shift the already established paradigms to include new possibilities. In this chapter I will discuss the beginnings of a grounded theory of liminal space as applied to the practice paradigms. I will also discuss the implications this research has on art therapy and future art therapy research.

Liminal space

When liminal space is set up through ritual and implemented with boundaries, safety, and structure, art therapists can steward clients toward transformation. Art therapists who create liminal spaces to practice art therapy provide the opportunity for people to grow and to create new potential, thereby becoming more free (Figure 25). By free I mean that clients are able to develop their abilities and their capacities in myriad or alternative ways and identities, as opposed to relying upon fixed patterns of behavior. In this research project, the intention was to aid in the participants' ability to create community through collective artmaking. A significant finding of this study was that the participants' potential to connect to community was significantly influenced by their attachment capacity and histories.

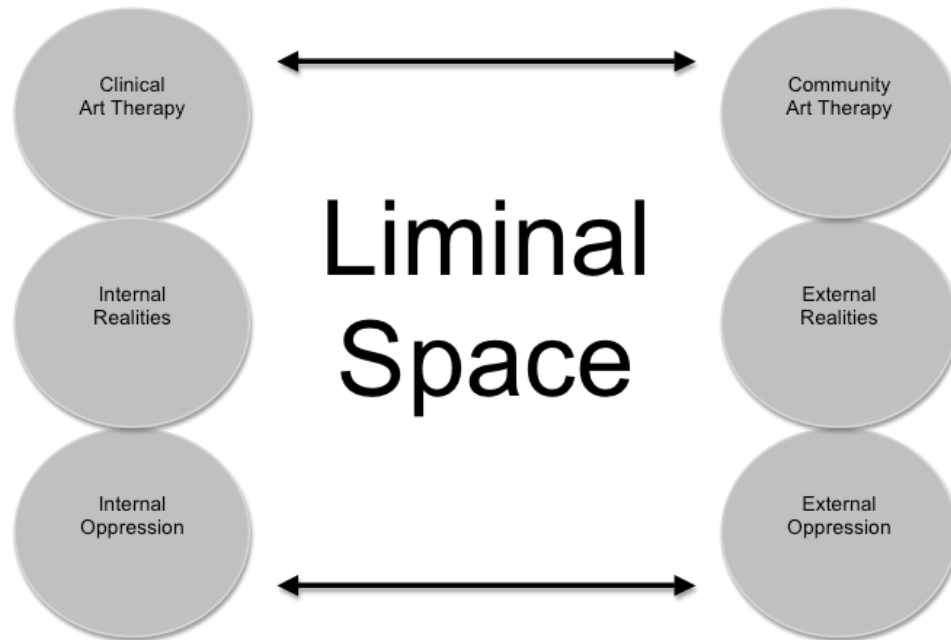


Figure 25. Developing Freedom

Therefore, therapeutic potential as well as challenges to creating community were exhibited by participants' past histories, which in turn influences the here and now. Through an emancipatory practice lens I looked at attachment processes and relationships rather than pathology-based hierarchies as labeled by diagnoses. This lens is clinical in the therapists' knowledge of attachment theory but emancipatory in its application. Specifically, the complexity of the individual is not reduced to these earlier attachment narratives, nor their expression of these patterns in the present.

Within liminal space, art therapy practice transcended itself as either a fixed clinical or fixed community model of practice. For participants, the art they created not only served the purpose of using art-as-therapy and art to elicit insight and meaning, but

also aided in their growth and transformation. Once again, this transformation relates to expanding the complexity of the clients' attachment patterns, among other variables.

Within liminal space art therapy can transcend the social structures and hierarchies to which it is commonly confined. However, it is essential that this transcendence does not come from therapists rejecting their clinical knowledge, but rather by incorporating into treatment an understanding of all pertinent contexts of the participants who engage in art therapy.

Suggestions for Art Therapy Practices

During the research for this dissertation, whereas one's attachment potential emerged as the most significant component of the ability to create or connect to community, the integration and use of post-modern theories, such as emancipatory practice, was solidified in my mind as effective for art therapy. Art therapists who participated in this research project attended to client needs and used an aesthetic-relational approach that relied on a bio-psycho-social-historical-cultural model of practice. Although Site B continues to offer private individual and family art therapy sessions, I recognize that most private therapy operates within a system, which includes responsibilities to managed care and enables people to come to therapy with a problem or from a place that underscores the reality that there is something wrong with them. However, the community treatment model accepts all people, as both feeling broken but innately whole at the same time. We must practice from a place in both settings that privilege the clients as experts in their own lives though bounded by systemic expectations. Because we are art therapists, this does not allow us to be the experts on others; our education and what we know can contribute to our participant's wellbeing

through sharing the information we have learned. We are educated to be attuned, to assess and to implement art therapy directives. We are the experts in these practices, and because we are so skilled, it does not mean that we need to deny this knowledge; in fact, it is our ethical responsibility to use our knowledge in the most critically reflective way for the benefit of the participants who seek to engage in art therapy.

The Boundaries of Liminal Space

At several points prior to and throughout the research, I was aware of possible boundary crossings and the implications they could impose on the participants' and therapists' experiences. Prior to the research project I was concerned about my participation in the weekly studios at Site B. I reflected on my ability to authentically participate in the open studio and the possible negative implications for my individual therapy clients who also used the studio. I determined that I would not be the primary manager of space; I would invite the clients and the other art therapists, who do not see individual clients at Site B, to manage the open studio. This diffused the hierarchical power that was present within the space. When I participated in the open studio, it was as an artist. I was not in charge.

When I brought in my children to participate in the studio as members of the public, I was aware of my interactions with my children and the possibility that our interactions could impact the participants negatively. However, this did not happen. The children were welcomed and their energy contributed to the atmosphere within the studio.

Rachel and I discussed boundaries during many of our supervision sessions. For Rachel, keeping appropriate boundaries was a matter of safety but also encouraged people to disclose and to feel safe. We made sure that Rachel did not walk the halls of

the desolate floors of Site A alone with participants, unless she had a relationship with them and there was a direct need. Twice times during the research Rachel and I discussed boundaries and were aware of possible boundary crossings. Rachel took the bus with two women to the art museum and also took the bus with two men to the open studio. Prior to the bus rides, we discussed the most appropriate way for her to transport the clients to the museum. We determined that the bus was a public mode of transportation and would pose the safest choice and make the most sense ethically, rather than have Rachel drive the participants alone in her car, for example. Rachel did not take participants with to the museum or to the studio that she did not already have a relationship.

Rachel kept in touch with me via text during both of the entire travel adventures. She updated me as to where they were and how they were doing. During one of the bus rides, a woman disclosed to Rachel and the other participant that she had been raped at an overnight shelter. Rachel listened and did not switch into authoritative therapist mode; she was aware that doing so could hurt the woman and their therapeutic relationship. She instead exhibited empathy and brought the incident to supervision to process further. The woman was not asking for her help, she was asking to be heard. While traditional therapy does take place within an office, our therapeutic relationships do not need to stay bounded within that space. Case managers transport clients to community appointments frequently. Our liability insurance covers us when we leave with clients to participate in community behavior modification interventions, and it will cover us when we take community participants to the museum or art studio.

Limitations

The outcomes of the research implemented within this study are valid in that the findings included the review and participation of the co-researchers in extracting and validating emergent themes, member checking, as well as the participation of research advisor's role in triangulating the findings. I do wonder the extent to which the findings are based on my own personal lens. While I know that my own personal experiences of attachment and ability to create and connect to community inform this research, I believe such knowledge doesn't take away from the findings but rather contextualizes them.

Implications for Future Research and Practice

If the primary finding of this study is that in order to connect to and create community one must already have or have the capacity to move toward a secure attachment, then the next steps are to educate and supervise art therapists in both community and private treatment settings to develop and maintain their clinical skills and knowledge in regards to attachment processes and the creation of healthy therapeutic relationships. From my standpoint, this does not mean that art therapists leave their art studio practice and join the dominant narrative of the psychological profession that may be oppressing clients. Rather, it means that we continue to keep the studio model of art therapy present in both contexts and utilize best practices, which includes the integration post-modern theoretical approaches and practices. The open studio model as developed by Allen is a large contribution to our field. However, I believe that this model as it is currently practiced at Open Studio Project, primarily benefits people who already have secure attachments. Further research is needed to extend the myriad ways that art therapy can be practiced within liminal spaces and continue to ground the theory.

Part of what I wanted to know through the research is whether these programs are sustainable. At this point they are, however, sustainability is only possible with a student intern. Site B donates the art supplies to Site A, I donate my time to supervise the intern; Site B barely recovers the costs of the supplies for the open studio through the suggested weekly donations. If we want to expand our program offerings to more agencies, we need more human resources. For many reasons I question the ethics of using interns to fully staff programs. But another option may be to create a hybrid for-profit/non-profit organization where donations can cover program development, implementation, and staffing costs, while private individual and family sessions cover rent, utilities, and supplies for those sessions. Site B as an organization also is also considering partnering with non-profit agencies that have the capability to apply for additional grant money, which can be used to fund community art therapy and social action projects. It will take more time and further research to consider all of the possibilities to make these programs fully sustainable.

As I reflect back on this research, what has emerged is that multiple access points to art therapy were also created within liminal space. More people with or without insurance were able to participate in art therapy. While this was not intended in the study objectives, the finding is important in that it de-privileges art therapy and allows for more people to utilize to art therapy services. Further research is necessary to explore this finding further.

CONCLUSION

In this dissertation, I described the beginnings of a grounded theory of liminal space in the art therapy setting and how it impacts clients, art therapists, and links the

paradigms of clinical and community art therapy practices. I explored the use of emancipatory practice as effective practices used by art therapists, which employs critical reflective methods to limit further oppression and promote freedom for our clients. I discussed my research project and the implications the results have on art therapy and future research, stating that more research is needed on possible ways to create liminal space in art therapy and to open up more practice sites that create more access to art therapy services.

In conclusion, within this dissertation I explored the relevant literature to the history of the community and clinical art therapy paradigms, critical theory, and liminal space. My study took place as a Participatory Action Research within liminal space for 12 weeks. Within this study, I found that it is possible to conduct art therapy in a liminal space, and that in order for people to connect with and create community they must have or have the ability to move toward secure attachments. Furthermore, art therapists and community art therapy programs must provide safe, secure, and consistent relationships and environments in order for positive change to occur. As art therapists we can continue to hone our therapeutic skills in order to facilitate prompt connections and secure relationships with our clients and within groups, which will in turn aid in their abilities to connect to others. Connection to others and sense of belonging helps people find meaning. Meaning gives people purpose, the purpose to lead authentic lives, and contribute positively to our communities.

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MA LPC, ATR-BC is an adjunct faculty member at Mount Mary and an art psychotherapist at Bloom: Center for Art and Integrated Therapies, LLC, a private practice, studio and gallery space in the Milwaukee area. She is also a member of the inaugural cohort in the art therapy doctoral program at Mount Mary University.

Education

- | | |
|-----------|--|
| 2011- | Doctorate in Art Therapy,
Mount Mary University, Milwaukee, WI
Graduation expected 2014 |
| 2003-2005 | Master's of Arts in Counseling Psychology: Art Therapy
Adler School of Professional Psychology, Chicago, IL |
| 1996-1999 | Bachelors of Fine Arts in Art Education, University of Illinois,
Urbana -Champaign |
| 1994-1995 | Barat College, Lake Forest, IL |

Licenses

- | | |
|--------|---|
| 2/2011 | Art Therapist Registered – Board Certified #08-207 |
| 2/2008 | Licensed Professional Counselor, Wisconsin, #4057-125 |
| 2005 | Licensed Professional Counselor, Illinois #178004089 |
| 1999 | Art Teacher Certification K-12, Illinois |

Therapeutic Work Experience

- | | |
|---------|---|
| 4/2012- | Bloom: Center for Art and Integrated Therapies. LLC
Executive Director/Co-owner
Clinical services, Adults, Children, Couples, Families
Professional Supervision for Art therapy registration and
Professional Counseling Licensure
Community Open Studio
Art Therapy Programming at Repairers of the Breach, Milwaukee,
WI |
|---------|---|

Participant and curator of Bloom's artwork display during Gallery Night in Bayview, Milwaukee, WI, Quarterly

- 9/2007-6/2012 Art Psychotherapist in Private Practice, Cornerstone Counseling Services,
Brookfield, WI
Individuals, Couples, Families
Professional Supervision for Art therapy registration and Professional Counseling Licensure
- 5/2007-10/2007 Art Therapist, Experiential Therapy Department,
Rogers Memorial Hospital, Milwaukee, WI
●Providing group art therapy to partial and inpatient groups and individual assessments
- 7/2005-11/2006 In-Home Clinical Psychotherapist- NCO Youth and Family Services, Naperville, IL
●In-home therapist, On-site therapist for the Westmont Public Schools, Junior High, and High School, co-creator of the program for *at risk students* implemented in the schools, as well as Individual, Group, Couples and Family Art Psychotherapy and Psychotherapy at the agency in Naperville, Leader- Life Workshops, psycho-educational group for teen girls funded by a grant from United Way
- 2004-2006 Crisis Intervention, 1000 Hours NCO Youth and Family Services, Naperville, IL
- 2004-2005 Practicum, 350 Hours- NCO Youth and Family Services, Naperville, IL ●Individual, Couples and Family Art Psychotherapy and Psychotherapy, Parenting Group
- 2004 Practicum, 350 Hours- Linden Oaks Hospital at Edward, Naperville, IL
●Adult Dual Diagnosis Group Therapy, and Art Therapy Groups in Chemical Dependency, S.A.F.E Alternatives, S.A.F.E. Expressions, Dual Diagnosis, Adolescent, Alternative School, Eating Disorders

Teaching Experience

- 2008- Adjunct Faculty Mount Mary University, Art Therapy Department
●Techniques of Therapy in the Helping Profession, Supervision, Ethics and Professionalism in Art Therapy, Theories of Counseling and the Arts in Psychotherapy, Materials and Processes, Supervision

Collaboration with the STAR center, Medical College of Wisconsin, Milwaukee, WI

- 2002-2003 Art/Technology Teacher, West Aurora High School, Aurora, IL
- 2000-2002 Art Teacher, East Aurora High School, Aurora, IL
- 1999-2000 Art Teacher, St. Scholastica Academy, Chicago, IL

Presentations

- 2014 Presentation, HAN University, Nijmegen, Netherlands, "Integrating Clinical and Community Art Therapy Practices."
- 2013 Presentation, American Art Therapy Association, Seattle, WA, "Starting a Private Practice."
- 2013 Presentation, Mount Mary College, Milwaukee, WI, "From Planting to Bloom."
- 2013 Workshop, HAN University, Nijmegen, Netherlands, "From Planting to Bloom."
- 2012 Digital Poster Presentation, American Art Therapy Association, Savannah, GA, "Child as Image, Family as Canvas: Art Therapy, Parenting and the 4 Goals of Misbehavior."
- 2012 Workshop, Mount Mary Symposium, "The Next Step: Panel Discussion with the Inaugural DrAT Cohort."
- 2012 Workshop, Mount Mary Symposium, "Unfolding: The Use of Bookmaking in Art Therapy" with Lori Mackey
- 2011 Presentation, Mount Mary College, Milwaukee, WI, "Art Therapy, Parenting and the 4 Goals of Misbehavior."
- 2009 Presentation, Mount Mary College, Milwaukee, WI, "Relieving Minor Situational Distress Using Art Therapy"

Published Writing

- 2013 View point article, "Common Ground of Two Paradigms: Incorporating Critical Theory into Current Art Therapy Practices." *Art Therapy: Journal of the American Art Therapy Association*, 30 (4) 177-180.

- 2013 Book Review, "What we see and what we say: Using images in research, therapy, empowerment and social change." Author, Ephrat Huss. *Art Therapy: Journal of the American Art Therapy Association*, In press.

Professional Memberships

American Art Therapy Association
 Wisconsin Art Therapy Association
 •Nominating committee

Awards and Service

- 2009- School and classroom volunteer, Washington Elementary School
- 2004-2005 Co-President Adler School of Professional Psychology Art
 Therapy Student Association
- 2000-2002 Co-founder/facilitator of the Mural Club, East Aurora High School
- 1997-1998 Dean's List, University of Illinois, Urbana-Champaign
- 1992-2000 Christian Brother's, La Salle Manor Retreat Center, Plano, IL,
 Volunteer

References

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