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# Art and the clinical social worker

Lucy Goldstein

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Lucy Goldstein  
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## ABSTRACT

The current social work literature implores clinicians to create self-care practices to help reduce their levels of occupational stress. Literature from a variety of fields points to the healing capabilities of the art making process, yet there is a dearth of empirical evidence linking the two. This study examines whether self-directed art making can reduce stress for the clinical social worker.

Ten clinical social workers who make art either as a hobby or as a dual career were interviewed to determine how their art making practice impacts their clinical work and whether or not art making reduces their occupational stress level. Research findings revealed that a minority of respondents pointed to a direct correlation between their art making and their occupational stress level but the majority pointed to an indirect relationship between the two. They reported that art making improves their feelings of general wellbeing and helps to balance out their clinical work, which indirectly improves their occupational stress levels.

# ART AND THE CLINICAL SOCIAL WORKER

A project based upon independent investigation,  
Submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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## CHAPTER 1

### INTRODUCTION

*“I found I could say things with color and shapes that I  
couldn't say any other way--things I had no words for.”*

--Georgia O'Keefe

Evidence ranging from anecdotal to neurobiological suggests that the art making process is often healing and stress-alleviating. Meanwhile clinical social work research points to high rates of stress in clinician's lives and implores clinicians to tend to their stress through self-care practices. This paper will examine whether self-directed art making can reduce stress for the clinical social worker.

For the purpose of this paper, the term art making refers to visual art pursuits such as drawing, painting, collage, sculpture, ceramics and photography. The term self-directed is included to distinguish between art therapy. The focus of this paper will be on artwork that is done as a self-directed hobby or para-professionally, not art created in conjunction with an art therapist. For the purpose of this paper, the word stress indicates the way in which the forces of the outside world interact with an individual. This paper will focus on occupational stress; the emotional strains on a clinician that negatively affects their professional and personal capabilities. The term self-care will describe efforts to bolster the interaction of self-awareness, self-regulation and balance in a person's life (Baker, 2003).

Due to the nature of their work, clinical social workers are often exposed to the darker sides of human nature, which can take an emotional toll. Recent surveys found

that well over half of the clinicians surveyed reported feeling symptoms of depression (Gilroy, Murra, & Carroll, 2002), as well as high levels of emotional stress (Reid, et al., 1999). Clinicians with compromised mental health are a risk to the field because their lack of emotional wellbeing affects not only themselves but the clients who rely on them for care. Therefore, the act of reducing stress for clinical social workers is vital to the field to ensure effective care for clients (Deutsch, 1985).

This paper will examine art as one modality to alleviate stress in clinicians' lives. Literature from fields such as anthropology, psychology, and neurobiology all point to the art making process as one that is basic, instinctual and necessary for optimal mental health and wellbeing. It is this researcher's hypothesis that the art making process is a cathartic experience that allows access to subconscious emotions and imagery (Riley, 1997), and therefore that self-directed art making may be used as a tool to reduce stress for the clinical social worker. Art making may not work for every clinician and art making alone is not enough to relieve the large amount of stress that accompanies clinical work; therefore, art making will be examined as one out of many methods of self-care and stress release for clinicians.

Within current research literature, there is heavy support for both the healing capabilities of art making and the need to alleviate clinician stress; however, there is a dearth of empirical evidence linking the two. The following study will attempt to address this gap in the social work discourse first through reviewing the existing literature, and then through collecting original data to examine the effectiveness of art making as a stress-reliever. To collect the qualitative data for the study, this researcher will interview clinical social workers who make art as either a dual career or hobby to determine

whether or not they consider art making to be an effective stress reducer, as well as to determine the effect that self directed art making has on their clinical work.

This research is useful at this time because it contributes to a gap in the social work literature and may encourage future exploration into the link between art making and stress reduction and/or other methods to reduce clinician stress. Reducing stress in the lives of clinicians is especially important at this time, as clinical social workers adjust to a shift towards managed care systems, and at a time when they report high levels of occupational stress. “The therapists’ mental and emotional wellbeing is a foundation of his or her craft” (Deutsch, 1985), and in order to provide effective care for clients and improve as a professional field, clinicians must learn to care for themselves. Participation in the art making process may be one method for clinicians to ease the burden of the occupational stress they encounter as helping professionals.

## CHAPTER II

### LITERATURE REVIEW

The following review will draw on literature that points to scientific and anthropological research explaining the human impulse to create art and research that examines the healing and stress-reducing components of the art making process. The review will investigate the causes and consequences of stress and emotional strain in general, in the work place, and then specifically the ways that occupational stress impacts the clinical social worker. The review will share literature that emphasizes the importance of coping with stress for the clinical social worker and will then seek to demonstrate that art making is a tool that has the capacity to aid the clinical social worker in stress reduction.

Within this literature review and the subsequent study proposal, it is important to indicate that when discussing art making, the focus will be on the process of making art, rather than the resulting product. In this paper, art is not conceived as esoteric as it became in the twentieth century, but rather as an activity accessible to everyone; as it was for most of human existence. It is also important to mention that although this study pertains to self-directed art making as opposed to art therapy, literature from the art therapy field will be used in the review to explore the healing powers of art.



## *Art Making*

The Encyclopedia Britannica defines art as: “a visual object or experience consciously created through an expression of skill or imagination” (2006). Early cave paintings and artifacts dating back to the very beginnings of human-kind indicate that art is a truly basic impulse. In Art, Science and Art Therapy, Frances F. Kaplan summarizes the research findings of anthropologist Alexander Alland (*The Artistic Animal*), anthropologist John E. Pfeiffer and art historian Ellen Dissanayake:

Participating in art and art-related activities satisfies something deep within us. This satisfaction can be attributed to the likelihood that the universal impulse to make art is either a direct or indirect result of our evolutionary history and thus is embedded in our genes. (Kaplan, 2000)

The feeling of satisfaction and pleasure that comes from art making may be evidence in and of itself that art results from biological evolution, because “sensual pleasure [is] one of nature’s ways of reinforcing biologically significant behavior” (Kaplan, 2000).

Art making is not only pleasurable, but contemporary neuroscientific findings indicate that art directly contributes to wellbeing. Contemporary findings indicate: (1) That visual art expression can facilitate language development, (2) Art can promote creativity and problem solving, (3) Art can stimulate feelings of pleasure and increased self-esteem that arise from our biological natures, and (4) Art can “represent an island of successful functioning in a sea of mental deficits” (Kaplan, 2000). These findings have implications on education, recreation, and mental health. For the mental health field, neuroscience helps prove what psychologists have observed for years; that creativity and art making are necessary activities for optimal human growth

Sigmund Freud, the famous psychoanalyst and psychological theorist, wrote about a link between creativity and human development.

Freud believed that creativity was fueled by the instincts, which have an aim (usually sexual or libidinal, and/or aggressive) and an object (the person or thing at which the aim is directed). In the course of development, children begin to *redirect* their instincts from original (infantile) aims to other aims, which are culturally valued. Freud called this process sublimation. (Schneider Adams, 1996)

In other words, creative acts and pursuits are what allow people to express their basic urges in a culturally accepted manner. Freud also implies that without using creative acts to sublimate primal urges, the human child is unable to begin healthy psychological development (Schneider Adams, 1996). In accordance with anthropologists and art historians, he describes the creative impulse as truly basic, instinctual and necessary.

D.W. Winnicott, a psychoanalyst, pediatrician and object relations theorist also wrote about creativity and the relationship between creative acts and healthy psychological development. Like Freud before him, Winnicott believed that human development happens in a continuum and that the successful completions of tasks and stages in childhood are the foundations of the adult character (Schneider Adams, 1996). According to Winnicott, one of the human infant's most basic tasks is using transitional objects and transitional phenomena to act as a stand in for the mother; to help the child individuate. In doing so, the human infant turns one thing into another, creating a metaphor; the foundation of creative thinking and of art making. "The significance of transitional objects and transitional phenomena for Winnicott is their role as a cultural basis for later creative pursuits" (Schneider Adams, 1996).

Winnicott is also credited for introducing the squiggle game in his therapeutic interactions with children. He encouraged children to draw simple squiggles on paper

which he used as a form of therapeutic “communication with children” (Winnicott, 1971). He noticed that simple, undirected art making can express people’s inner worlds; oftentimes parts that they are unable to express verbally. “Winnicott suggested that the drawings could be used to communicate something of the child to others...he found that the drawings expressed the troubles of the child” (Thurrow). Thus Winnicott, like Freud, viewed creative processes as basic and necessary for healthy psychological development, and he additionally viewed art making as a form of communication and a mode of accessing subconscious emotions.

In her article on art psychotherapy as stress reduction, Shirley Riley explains how the art making process allows entry to the subconscious. “Nonverbal memory is already well established at birth. It functions parallel to verbal memory but its retention is effortless, image based and timeless” (Riley, 1997). Citing the works of cognitive scientists and neurologists, Kaplan adds that, “the brain systems responsible for vision occupy nearly half of the cerebral cortex....[and] that more brain neurons are devoted to vision than to any other of our senses” (2000). Therefore, at any given time human beings have huge volumes of visual memories stored at a subconscious level.

It appears that we know our world through several channels, verbal and nonverbal, but the visual knowing remains silent until the cognitive, verbal capacities of our thinking processes bring the impressionistic meanings to our awareness through language....In other words, we make a choice when we bring words to image.(Author, 1997)

It is Riley’s understanding that art making is one method to access the nonverbal images and make sense of them. In other words, the process of creating art is cathartic and therapeutic because it allows access to our emotions and inner most experiences. Both Riley and Winnicott suggest that this process need not occur through skillful works of art;

for them, the creative process is valued over the product and simple scribbles and primitive drawings are effective: “the simplicity of art [has] no bearing on the meaning embedded in the product or the power to externalize feelings” (Riley, 1997).

Mihaly Csikszentmihalyi, a psychologist and creativity researcher, points to art in his research on optimal human experience or “flow.” Csikszentmihalyi describes flow as “that which gives life joy and meaning” and views flow as an important component in human development throughout all life stages. Flow has nine characteristics.

1. Clear goals
2. Feedback regarding progress
3. Exercise of skill
4. Intense concentration
5. Diminished awareness of mundane concerns
6. A sense of control
7. Loss of self consciousness
8. An altered sense of time
9. Enjoyment of experience for its own sake

These characteristics are consistent with artists’ reports of their experience during the art making process. Flow may also occur in other activities, such as athletics (“the zone”) and meditation. In whichever form flow takes, it is characterized by a challenge that a person approaches with a certain level of skill. By successfully meeting the challenge, there is a sense of mastery and psychological growth (Kaplan, 2000).

Helen Q. Kivnick and Joan M. Erickson are researchers who believe in the healing nature of creative pursuits and of art making in particular. During the 1980’s, they conducted a qualitative research study to determine the specific reasons that art making is beneficial for people’s mental health. As reported in *The American Journal of Orthopsychiatry* (1983), Kivnick and Erickson gathered empirical research from patients

participating in art programs at two different in-patient psychiatric facilities to determine the ways art making contributed to patients' recovery from mental illness. In their study, they highlight seven ways in which art making is healing, and they comment on the implications for other clinical programs and for people outside the mental health field. The participants in the study were aged 17-35, the facilitators of the program were artists who, "functioned as art teachers, not as therapists or psychological experts." The study occurred in art studios housed within the in-patient psychiatric facilities which were both filled with an abundance of diverse art materials. Within the studio "only those rules existed which were necessary to maintain safety and to protect the integrity of equipment and of work in progress" (Kivnick and Erickson, 1983).

Through extensive observation, the researchers identified seven properties of art making that they felt contribute to positive mental health and are healing. For the purpose of their study, they define healing as, "means of which it contributes to a patient's recovery from mental illness and to the development of increased vitality." The researchers conceived of the seven properties as seven, "encounter[s] between two opposing attitudes" (Kivnick and Erickson, 1983). The first property is: *Activity vs. Inactivity*. Through the process of making art, the participant exerts themselves physically and they engage in the world. While other activities fulfill this role, art making is unique because, unlike most sports or games, it does not require ongoing participation with other people, nor does it require ongoing supervision. "It is empirically, inherently interesting and non-threatening enough that many young people participate of their own volition" (Kivnick and Erickson, 1983).

The second property is: *Lawfulness vs. Unpredictability*. The lawfulness of artistic materials and media provides the structure for all artistic expression and while the laws to various media may be complex, they are inherently precise and predictable and can be learned. Once learned, “the relationship between individual and medium can... become secure, reliable, and extremely satisfying. This consistent lawfulness of materials provides the artist a safe arena in which to test personal strengths, and also become aware of personal destructiveness.” The third property is: *Imagination vs. Overconcreteness*. Imagination is important for both positive health (“playfulness and imagination contribute to the feelings of delight and joy which are essential to psychological health”), and as a crucial skill in successful functioning; imagination is what helps people find solutions to life’s challenges. Art making is an activity that exercises one’s imaginative abilities and it is a pursuit which is culturally sanctioned throughout the lifespan. “Art activities provide one of the few arenas in which playfulness and imagination are viewed as appropriate for persons who are no longer children.” The fourth property is: *Sensory Expressiveness vs. Strictly Verbal Communication*. It is common knowledge that communication is expressed both verbally and nonverbally, yet art making is “one of the few forms of socially acceptable behavior in which the individual actively uses nonverbal thought and expression” (Kivnick and Erickson, 1983). For those in the mental health field, where verbal communication is emphasized, this may be an especially important balance.

The fifth property is: *Concentration vs. Distraction*. Art making is practice in concentrating on the task at hand, resisting distractions, and planning for the future. Art making is especially helpful because it requires concentration at all levels. “It requires

attention to the internal feelings being expressed, to the process of craftsmanship, and to the response of the materials.” The sixth property is: *Catharsis vs. Inhibition*. As Shirley Riley (1997) suggested, art helps people express internal perceptions or feelings rather than inhibit and distort them. Kivnick and Erickson report that, “working with materials on any but the most superficial level taps the artist’s emotions in a number of different ways. The external, impersonal, nonverbal nature of materials permits patients to express what it otherwise inaccessible.” Lastly, the researchers observed that art making is an effort in *Mastery vs. Hopelessness*. In any life, there are forces against which any individual is existentially helpless. “Thus, the individual’s experience must be resilient in the context of realistic dimensions of helplessness.” Kivnick and Erickson see a completed art project as a “concrete illustration of the artist’s or craftsperson’s ability to be effective in the external environment.” Thus art making becomes a metaphor for life’s tasks: “working with materials necessitates acceptance of the uncontrollable and its incorporation into a re-conceptualized whole” (Kivnick and Erickson, 1983). Art making forces individuals to make the most of what they have available, as does life.

Kivnick and Erickson conclude by sharing their hope that their research “represents the beginning of a concrete way to conceptualize relationships between the arts and mental health.” The last line of their study is, “we believe that in a setting in which people are encouraged to engage in art activities, almost anyone, if not absolutely everyone, can experience the unique sense of healing along with the satisfactions embodied in working creatively with materials” (Kivnick and Erickson, 1983).

The process of making art is a basic impulse that fulfills important neurological, cognitive, and psychological functions. As Edith Kramer, one of the founding mothers of

art therapy says, “Since human society has existed the arts have helped man to reconcile the eternal conflict between the individual’s instinctual urges and the demands of society. Thus, all art is therapeutic in the broadest sense of the word” (Rubin, 1999). Art making is a basic, fundamental need, yet so few people living in twenty-first century America participate in regular art making. In summing up the opinion of art historian Ellen Dissanayake, Frances F. Kaplan writes:

As society became more complex, art became increasingly distant from the mainstream culture. Our natures have not changed, however, and on a deep level we feel diminished by the removal of [art] from our daily lives. (2000)

Kaplan concludes by saying, “it follows then that, for the sake of our mental health, we must find ways to reintroduce art making into our everyday worlds” (2000).

### *Stress*

In the Encyclopedia Britannica, stress is described from a psychological and biological framework as “any strain or interference that disturbs the functioning of an organism.” The body responds to that strain by using a variety of defenses, both psychical and physiological. “If the stress is too powerful, or the defenses inadequate, a psychosomatic or other mental disorder may result” (2006).

The biological origin of the stress reaction is linked to human’s fight or flight response to a perceived threat. As described in *The Effects of Stress*, “the heart rate, blood pressure and muscle tension all rise sharply; the stomach and intestines become disrupted; and blood sugar rises for quick energy” (Body Bulletin, 2003). For early humans this physiological response was a reactive defense against potential predators. In today’s complex, technological society a person is more likely to experience small doses of a stress over a prolonged period of time rather than in sudden bursts the way early



humans did; in modern times stress is often on-going and persistent. Potential consequences of this form of stress include:

Chronic, prolonged stress may lead to health consequences and disease. It can depress immunity, making you susceptible to frequent colds or more serious conditions...Studies suggest that stress-related complaints account for 75%-90% of visits to health care providers. (Body Bulletin, 2003)

Robin Miller, a social worker adds that, "other possible outgrowths can include poor decision making, increased fighting with those closest to you, and even drug or alcohol abuse" (Rowh, 2005). Stress is hard to avoid in this day and age yet, "there is little doubt that an individual's success or failure in controlling potentially stressful situations can have a profound effect on his ability to function" (Encyclopedia Britannica, 2006).

### *Occupational Stress*

One potential stressor in a person's life is their professional responsibilities, which is referred to as occupational stress. Anthony Urbaniak from *Supervision*, a journal targeting management level business professionals, describes the effects of stress in the workplace as, "increased absenteeism, job turnover, mistakes on the job, lower productivity, and low levels of motivation." He points to research that estimates that excessive stress, "costs the United States industry billions of dollars annually" and that over one-third of all employees experience reduced work effectiveness due to stress. Urbaniak explains that stress is often the result of an imbalance between perceived demands and one's capacity to meet those demands. He concludes the article by suggesting four methods for reducing stress in the workplace, the third of which is, "learn to relax away from the job. Develop non-work-related hobbies, and build time into your schedule for engaging in these hobbies on a regular basis" (2006).

### *Clinical Social Work Stress*

For clinical social workers, occupational stress can be especially acute. Like the target audience of Urbaniak's article, social workers have responsibilities, deadlines, paper work, and pressure with which to contend (especially as the field moves toward managed-care models) however, in addition clinical social workers have the challenge of hearing and often holding their clients' stress and trauma. Many clinicians enter the mental health field to do work that feels rewarding and meaningful, however the costs of holding others' emotions can at times feel overwhelming: "even the most experienced clinicians become emotionally fatigued processing the life-traumas of their clients, a process that is an inescapable part of the therapeutic procedure" (Riley, 1997). The costs and consequences of emotional fatigue and occupational stress can be potentially detrimental to both the wellbeing of the clinician and to their clients.

In the introduction to their study on clinician stress, Samantha and Keith Marriage cull out themes from recent research on the emotional stress levels of clinicians. One of those themes is clinician burnout. Christina Maslach, a researcher of burnout, describes it as, "A syndrome of emotional exhaustion, depersonalization and feelings of reduced personal accomplishment that occurs in response to the chronic emotional strain of dealing extensively with human beings, particularly where they are troubled and having problems" (Marriage and Marriage, 2005). Clinical burnout may affect the clinician's job performance, their outlook on life and their health (Maslach, Schaufeli & Leiter, 2001). While burnout can happen in fields other than mental health, "results from several recent surveys of mental health professionals have suggested that their 'burnout' and poor

mental wellbeing are at high levels compared with other occupational populations” (Reid et al., 1999).

Secondary trauma, also known as secondary posttraumatic stress, or compassion fatigue is another theme that the Marriages identified. Secondary trauma is, “the emotional duress experienced by persons having close contact with a trauma survivor- a natural response to the survivor’s traumatic material with which helpers may identify and empathize” (Figley, 1983) (Marriage and Marriage, 2005). As Shirley Riley explains,

Therapists enter their clients’ imagery through empathy and confirmation of the recalled memory. However, in the process of this experience, they often find that the empathic encounter leaves an emotional and visual residue that impinges on their lives. An uninvited shadow of their clients’ ordeals remains with them and interferes with their own reality. (1997)

Because the human brain is image-oriented, with many neurons dedicated to visual knowing (Kaplan, 2000), the process of hearing clients’ stories can leave a deeply-rooted and lasting impact on the clinician. “There is no way that practitioners can avoid taking in these client-generated descriptions and translating them into their own image bank” (Riley, 1997). Clinicians not only react to clients’ emotional response as they hear their life stories, but additionally the clients’ imagery often becomes embedded in the clinician’s own mind and as such, it can feel as if they too experienced a level of trauma. Riley goes on to say that, “attending to this condition [secondary trauma] is of primary importance if therapists are to continue to provide optimum care for their clients” (1997). Clinicians that do not attend to their secondary trauma and burnout risk a decreased ability to help their clients and an increased likelihood of feeling overwhelmed and potentially of leaving the field.

Contemporary clinicians must also adjust to the increased presence of managed care providers in the mental health field. While the introduction of managed care in the health care field has certain benefits for clients and clinicians, it also creates new stressors and challenges for clinicians who are given larger caseloads, fewer sessions with clients, and increased paperwork. “As resources for human services shrink, practitioners are being asked to do more” (Reid, 1997).

In addition, clinicians increasingly face the threat of malpractice suits, which can have huge professional and emotional implications. “Experiencing a complaint can threaten psychologist’s professional self-confidence and exacerbate their sense of emotional vulnerability” (Thomas, 2005), Yalom (2002) adds, “Therapists feel betrayed by the experience of litigation. After dedicating themselves to a life of service and always striving to enhance the growth of their patients, many therapists are profoundly shaken and sometimes permanently changed by the experience.” Even clinicians that are not personally charged may find the threat of litigation to be a stressor as the fear of betrayal hovers over their clinical work.

Clinical work in the mental health field can be rewarding and valuable, and it can be taxing. Clinicians not only manage a level of occupational stress that comes with any job, but they also risk feelings of burnout and secondary trauma through holding their clients’ stories and, due to recent shifts in the field, they have the additional burden of adjusting to managed care policies and living with the threat of malpractice suits. Gilroy, Murra, and Carroll (2002) discovered how taxing these stressors are when they surveyed 425 clinicians to assess their level of emotional distress. Their findings indicate that 62% of the participants reported suffering from depression. In a similar survey of 476

clinicians conducted several years earlier by Pope and Tabachnick (1994), researchers found that 61% of clinicians reported being depressed, 29% reported having suicidal thoughts, and 4% reported having made a suicide attempt. In other words, assuming the researchers' sample is representative, well over half of the clinicians in the mental health field are practicing while in a state of emotional distress.

This number is troubling because, due to the nature of the field, a clinician's distress not only affects the clinician, but also the clients who look to them for support. Clinicians who practice while distressed are less likely to effectively empathize and care for clients, and they are at greater risk of potentially harming their clients through boundary violations and over-identification. Clinicians may reverse the roles in the clinical dyad and unintentionally seek help from the client (Cooper and Lesser, 2002) and/or they may become less aware of clinical boundaries and more vulnerable to hazards such as dual relationships, boundary violations and sexual indiscretion with clients (Previlon, 2006). For these reasons, it is clinicians' professional and ethical responsibility to minimize their emotional distress for the sake of themselves and the clients they serve.

### *Self-Care*

The nearly universal advice to clinicians is to develop coping behavior or 'self-care' practices in order to prevent feeling overwhelmed by the work they do. In an article in the *Journal of Psychology* coping is defined as: "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person" (Thornton, 1992). In *Caring for Ourselves: A Therapist's Guide to Personal and Professional Wellbeing* (Baker, 2003), the author defines self-care as the interaction of three components: self-awareness, self-

regulation and balance. He describes self awareness as: “benign self observation of our own physical and psychological experience to the degree possible without distortion or avoidance.” He views self regulation as, “regulatory processes, such as relaxation, exercise and diversion,” that “help us maintain and restore our physiological and psychological equilibrium.” And, he describes balance as finding equilibrium between the personal and professional self (Baker, 2003) (Previlon, 2006).

In the Marriages’ 2005 qualitative study on clinician stress and coping, they interviewed experienced mental health workers to find the types of coping methods clinicians develop to remain professionally engaged and emotionally available even after years of listening to people’s ‘sad stories.’

These experienced therapists managed stress by self-monitoring their emotional responses, continuing professional education, the employment of collegial support networks, formal and informal, interests outside the work environment, and the support of significant others. (Marriage and Marriage, 2005)

Self-care is necessary for all human beings, but is especially important for clinicians given the nature of their work and their ethical obligation to clients. According to Baker (2003), “if we are not adequately self-aware, we risk acting out repressed emotions and needs in ways that are indirect, irresponsible, and potentially harmful and costly to our self, personally and professionally, and to our patients, family and others.”

In their chapter, *Creating Strategies for Self-Care*, Kenneth S. Pope and Melba J.T. Vasquez, “strongly recommend creating strategies for self-care before opening a practice, using them as a basis for professional planning, and making them a fundamental part of the professional life” (2005). Coping methods differ in effectiveness from one person to another; what works for one clinician may not work for another, however the

research indicates that the important thing is that clinicians make a commitment to some form of effective self-care because “the therapists’ mental and emotional wellbeing is a foundation of his or her craft” (Deutsch, 1985).

### *Stress and Art*

The literature demonstrates that stress can negatively affect a person’s physical and mental health and that occupational stress is acute for the clinical social worker because they are exposed to their clients’ emotions and trauma. Clinicians who are overwhelmed by their professional stress are less engaged with clients and may even put their clients at risk. Over and over again, the literature advises clinicians to engage in some type of self-care/coping activity or activities to help them reduce their stress level and outlet the, “emotional and visual residue” (Riley, 1997) that client encounters can leave.

Meanwhile, research about the art making process demonstrates that there are evolutionary, cognitive and psychological reasons for making art and that engaging in the art making process is likely to improve a person’s wellbeing and serve as a cathartic outlet. As such, it is logical to assume that if clinicians need coping activities to reduce stress, and art making is an activity that reduces stress, then art making will work as a stress reducer for some clinicians. However, there is a dearth of research to substantiate this correlation. One study, conducted by a Smith College School for Social Work graduate student revealed compelling findings supporting the correlation, but the study is unpublished and there does not appear to be published results to verify the researcher’s findings (Stewart, 1990).

In the study, the researcher quantitatively examined art making as one of three possible coping mechanisms for the clinical social worker. The researcher created three scales to measure clinical burnout and coping mechanisms: the personal accomplishment scale, the emotional exhaustion scale, and the depersonalization scale. She was not able to quantitatively point to a relationship between art making and coping using the first two scales; however, she did find a relationship on the third. By cross-referencing clinical social workers' survey responses about their professional attitudes and their outside hobbies, she found that clinicians who participate in fine arts pursuits report feelings of greater competence and success with clients and lower degrees of burnout than clinicians who don't participate in art making (Stewart, 1990). Unfortunately, there appears to be little published research to substantiate her findings.

Even anecdotally, little is written about social workers who use art making as a form of self-care. However in the related field of art therapy, therapists are encouraged to engage in their own art work. Paula Howie, an art therapist and artist has the following to say about her dual careers:

My life as an artist and art therapist are so fully interwoven that it is difficult to separate one from the other; indeed one nourishes, guides and informs the other. Art taught me, from the earliest explorations, to appreciate that which is non-verbal and grounded in affective experience. (1999)

Howie's statement is supported by the art therapy literature which describes a mutually beneficial duality in which both a clinician's therapeutic effectiveness and the quality and depth of their art making are enhanced through active participation in both activities. This researcher assumes that clinical social workers would benefit from this type of



relationship to art making and therefore sees this area of study as both important and troublingly absent from the existing literature.

In order to contribute to the current hole in the social work literature, this researcher created an original qualitative research study to survey clinical social workers who, despite the lack of encouragement in the field, participate in art making either as a hobby or as a dual career. In the research study, participants discuss their personal relationships between art making, clinical social work, and stress and they offer advice to other clinicians interested in incorporating art making into their self-care practices. According to D.W. Winnicott, “it is only in being creative that the individual discovers the self” (Rubin, 1999). This researcher hopes that the following study contributes to a dialogue examining art making as an aid to clinical social workers in their efforts to discover and nourish their selves, and to find improved career satisfaction and better care for clients.

## CHAPTER III

### METHODOLOGY

The literature supports both the need to alleviate clinician stress and the healing capabilities of the art making process; however, there is a dearth of empirical evidence linking the two. Can self-directed art making reduce stress for the clinical social worker? In order to examine the question, this researcher interviewed ten artists/clinicians to determine whether or not they believe that art making reduces their occupational stress level.

#### *Sample*

The ten clinicians/artists who participated in the study were selected because they identified as clinical social workers and participated in art making an average of at least two hours per week. Participants were initially recruited through a sign up sheet from a symposium about art and social work at an NASW conference and then through the snowball method. The ten participants were at various stages of their social work careers and worked in a variety of sectors within the field. Participants ranged from a clinician with 5 years of experience in the field, to one with 45 years. For the most part, interviewees were in the latter part of their careers (i.e. six participants had over 30 years of experience as social workers). All told, participants worked a combined total of 280 years in the field, which means on average, participants in this study had 28 years of social work experience. Because of the breadth of experience, participants report working in a wide variety of sectors within the social work field; those with more experience often

worked in several different clinical arenas throughout their social work careers. For instance, five participants currently work in private practice, but of the five, three worked in private practice only after many years working in other sectors of the field, for example hospital social work and administration. One participant did private practice earlier in her career, but now works in a supervisory and staff advisory position at a local college. The other four participants currently work: at a multi-cultural mental health clinic, as a supervisor in child welfare work, as a creativity coach, and one participant was newly retired after a career working with urban youth.

Participants report using a variety of mediums in their art making practices: painting, drawing, photography, collage, pottery, and welding, and many reported using a couple different forms of media for artistic expression. Eight of the respondents report that drawing and painting are their primary or secondary form of expression. Participants also reported a range of time spent making art each week; many said it varied from week to week and at various points in their lives. The range extends from one participant who is currently taking a break from art making while she attends to family commitments to a participant who has spent as many as 60 hours per week on art making and a participant who describes the art making process as “constant.” Many respondents were reluctant to give a precise number of hours per week spent making art, the five participants that did, averaged 8 hours per week dedicated to art making.

Questions about participants’ race, ethnicity, gender, able-ness, and sexual-orientation were not included in the screening or interview process and therefore subjects were not directly recruited for diversity. However, efforts were made to recruit participants from different sectors within the social work field and to have a mix of male

and female participants. All participants identified as clinical social workers and partook in art making on a regular basis over the last couple years, an average of at least two hours per week.

### *Data Collection*

Every effort was made to ensure that the data collection process of this study explicitly adhered to the Human Subjects Review Board guidelines. Participants were informed of the study's purpose and intention and each read and signed an Informed Consent Form [Appendix E] which explained that participation in the study was completely voluntary and that participants' responses were kept confidential and anonymous. The form also explained that participants could refuse to answer certain questions and were free to withdraw from the study until the end of the research period on May 1, 2007. If participants elected to withdraw, all materials pertaining to them would be destroyed.

For this study, a flexible, qualitative design was chosen because the area of study has not been extensively researched, and a flexible method was more likely to allow themes to emerge as the research progressed. Furthermore, the flexible, qualitative method was an appropriate match to the art making process, which is often amorphous and non-quantitative in nature; using a method that was more descriptive than fixed allowed participants to share richer, more expressive responses about their experiences.

Participants for this study were initially recruited through a sign up sheet from a symposium about art and social work at an NASW conference and then through the snowball method. Permission to contact the symposium's attendees was granted by the event's organizer and the Boston chapter of NASW. The recruitment process began by

contacting potential participants either by phone or email to determine whether they fit the sample requirements and whether they were willing to be interviewed and have their responses recorded for the study. When possible potential subjects were contacted first through email [Appendix B]. Potential participants that expressed interest in the study over email or participants for whom only a telephone number was available were then asked screening questions over the phone [Appendix C].

The researcher interviewed participants that met the criteria for a half-hour to one hour and tape recorded their responses. The interviews included a mix of semi-structured and open-ended questions with room at the end for narrative and anecdotal feedback [Appendix D]. The location of the interview was decided on an individual basis based upon the convenience of the interviewees; most interviews occurred in participants' homes or offices.

### *Data Analysis*

After the data from clinician interviews was collected and transcribed by this researcher, the participants' responses were analyzed for common themes. The units of measure were words and phrase used as anecdotal feedback to support or deny the hypothesis.

## CHAPTER IV

### FINDINGS

The clinicians interviewed for this study expressed a variety of different viewpoints about their art making and its effect on their clinical work, clinical stress level, and overall functioning. They reported an assortment of reasons for taking the time to make art and an array of challenges in doing so. Despite the different viewpoints, several distinct themes emerged throughout the interviews. Within these findings the themes are distinguished as follows: *Artist Identity, Art as Stress Relief, Reasons for Making Art, Connections between Art making and Clinical Practices, Challenges of Maintaining Both Practice, and Advice.*

#### *Participant Demographics*

The ten clinicians/artists surveyed for this study come from a variety of sectors within the social work field and are at various stages of their careers; some just a few years in and some near the end, winding down after decades in the field. Participants' clinical work runs the gamut from private practice, work at a multi-cultural clinic, child welfare, and clinical supervision. All told, over the course of their careers, participants reported working with individuals, couples, families, groups, children, adolescents and adults. Participants reported a range of time spent doing clinical work, all the way from newly retired to 60 hours/week.

In general participants in private practice, participants at the latter end of their social work careers, and participants who work less than 20 clinical hours/week reported

low levels of occupational stress, clinical burnout, and secondary trauma. Those who work in clinical agencies and longer hours reported higher levels of stress, but all participants reported feeling that their stress levels were manageable. No one reported feeling high levels of professional burnout currently, though a couple mentioned feeling burnt-out at earlier stages in their careers.

Participants use a variety of mediums in their art making practices: painting, drawing, photography, collage, pottery, and welding, and each has different levels of art education and years practicing art. Participants reported a range of time spent making art each week; some reported participating in art constantly throughout the day, some reported guarding a few hours each week, and one respondent said at the moment she's taking a break from art making while she attends to family commitments. Participants were not asked how they identify in terms of race, gender, ethnicity, able-ness, or sexual orientation, however efforts were made to recruit participants from different sectors within the social work field and to have a mix of male and female participants. Although this study includes both male and female participants, all respondents will be referred to using female gender pronouns in order to further protect confidentiality.

#### *Artist Identity*

Amongst the subjects, there was a variance in their levels of identity as artists. For some their artist identity is fundamental to everything they do and the way they process the world. According to one social worker, "I have to [make art] I have no choice....that's who I am." And to another, "I just draw...it wasn't conscious, it was more automatic. It was just my way." Others stressed that for them, art is a hobby, not an

identity: “They are very separate from one another. My artwork has nothing to do with me being a social worker.” Along the same lines, one participant reports:

I’ve never convinced myself that I’m an artist, I’m someone who likes working with their hands, but I’m not sure that I have the use of art as the total expression of myself the way some people do.....I like to do it, but I don’t have to do it....to me it’s two different worlds rather than an integrated world.

Others report being somewhere in between these poles. One participant explains that she holds onto both the clinical social worker and the artist professional identities, but views them as separate from one another, “[art making] feels quite separate from my clinical practice. It’s something that I’ve always loved....I feel like I kind of can’t not do it, but I don’t feel like I come at it as a clinical social worker.” One participant reports feeling uncertain how to identify herself:

Well I don’t see myself as..... I identify myself as a therapist, as a clinical social worker professional, that’s how I see myself. The art I see as more something separate from that, I see it as a hobby. But as I get more active in the art association here in town, as I exhibit my work, sell my work ... that’s an interesting thing because that pushes on the image of myself as an artist.

#### *Art as Stress Relief*

The subjects’ variance in artist identity was an unexpected result of this study and turned out to have bearing on how each individual viewed art making in relationship to stress relief and their clinical work. While nearly all the subjects were able to point to art making as a way to relieve stress, those who viewed their artistic and clinical identities as integrated were more likely to directly credit art making as a form of stress relief while those that viewed their artistic identities as separate from their clinical identities were more likely to view the stress relief as an indirect result of their art making. Participants who directly credit art making as a form of stress relief report:



I think my art definitely has been a tool that I use for self-therapy. I'm pretty low-key anyway so I don't get way stressed, but every once in a while ...certain times in my life you know those life struggles happen...the art really has been the thing to help me over the hump, it really helps me sort out things. I do a lot of drawing and some painting and when I hit those valleys when I can't make a straight line.... they don't last long, but it's always been those times when I've been doing work that's particularly stressful, I really went into my art at those times.

Meanwhile, when asked the same question, participants that view art as an indirect form of stress relief report: "I always feel better, feel more grounded...happier when I've had time to paint so I'm sure that it does benefit my clinical work, but I don't tend to paint more if I'm stressed." Another subject, when asked whether she views art making as a coping method for occupational stress reports:

I don't view it in that way. I view it as something that I love to do and I want to do. But I can tell you when I'm doing it, or when I've had a chance to do it, or when it's been successful for me, I feel really just....good, you know it's being 'in self' ...and I know it's nourishing to me.

However, she goes on to say that she feels good and nourished when she participates in anything she has a passion for, "I can feel that way if I go out and clean the garden as well;" for her, the satisfied feeling that she describes is not unique to art making.

Only one subject, when asked whether art helps to offset her occupational stress, described art as a cause of stress more than a relief:

I don't think it ever has. I think it's its own stress. I think when I started doing it in the beginning it felt soothing because I could, unlike working with patients ... I could mess up a pot and throw it back in [the pot of clay], but as I got more into it I developed my own stress which was, I started thinking 'well am I being true to the clay itself? Am I making it art or is it just a craft?' and then it became its own stress level.

Another participant who answered affirmatively that art relieves her stress, later addressed the critical piece that the above respondent describes, but explains that for her,

being able to address her inner-critic is one of the positive aspects of the art making process.

The second part is when you're really trying to get the effect that you want and that's when some of the critical voices come in, some of the hard part comes in... 'you're an idiot,' 'you didn't get it,' 'you need to go back and take another drawing course,' we have those with us no matter who we are...but somehow with art and I can pull myself out of it pretty quickly and I can laugh about it...and in that way I can actually step outside and be my own therapist and say that was kind of an interesting process there, how did that creep in?

Even those who categorize art as a stress reliever, acknowledge that art can also create stress. "You can get angst about it, you can get frustrated, 'this isn't moving' and 'why isn't this looking right?'" says another respondent "...but then you can just walk away from it and it just stays there, nothing happens until you get back to it, which is a nice thing about art. It doesn't mess up if you back off from it for a while." Assumedly all participants experience some amount of stress from their artwork, but the vast majority surveyed report that the stress relief outweighs the added stress, whether that relief is found directly or indirectly.

### *Reasons for Making Art*

In response to the participant who reported that art making was an added stress, this researcher asked: "If it's stressful then why do you do it?" to which the participant responded, "I don't know. I like color. I like trying to make something beautiful or trying to push myself to understand a different way of thinking about visual areas." Whether they viewed it as stress making or stress relieving, whether they viewed themselves as artists or hobbyists, the respondents reported many reasons for taking the time to make art. Participants pointed to finding beauty and joy as one reason to create, others reported finding satisfaction in being part of the art community, and others reported using art as a

form of sublimation, as a therapeutic outlet and/or as a means to raise social consciousness about an issue. However, when viewed together, the resounding theme of participants' responses was that art helped them to feel more balanced; especially in relation to their clinical work and identities.

Many pointed to art as an escape and alluded to the sense of "flow" that Mihaly Csikszentmihalyi described in his writings on creativity.

Obviously the part that's amazing about creating something is that when you're in that part of your brain and things become timeless and it's a totally different place...in the process of actually doing you lose all connection to time and urgency. So in that way it feels like a very different head place.

I think it's a little bit like meditating or exercising or any of those things that takes you into a different frame of mind. I feel like I can just completely lose myself in it. The hours go by and I don't feel like I'm thinking about anything, so in that way it's a kind of escape from the rest of my life or a way into another part of myself.

Several participants reported that art making boosts their self-esteem. "It allows you your own space. It reinforces your own importance." One participant reports that art making gives her confidence in an area outside the clinical work.

It's something that I feel...to varying degrees, depending on how I'm doing... accomplished in, I feel good at and I like what I do, so I think it just makes me feel confident in an area that has nothing to do with clinical work. And in that way I sort of feel like I have more pillars to sustain me rather than relying just on my clinical work to feel confidence or to feel a sense of accomplishment.

Likewise, many noted that art serves as a balance to the tasks of a social worker; whether it is a chance to center oneself after a day of sitting with a series of clients, or a way to explore lightness and positive images after hearing people's difficult stories.

I try and be very emotionally available when I'm sitting and talking with somebody, so it's a wonderful, fulfilling and draining way of being for 50 minutes and then you close the door, take some notes and meet the next person. And

they'll be entirely different.... so all day long you're switching from one way of being to another. Pottery is a time to center myself.

Oh I just think it's about balance...between giving with other people all the time and listening to really hard stories, and art making is just a way to experience joy and lightness, the positive, light side of life; Anti-angst.

One respondent agreed that art making just made her feel good and pointed out that unlike many other pleasure sources, art doesn't have negative aftereffects. "It must affect my serotonin levels because I feel good when I do it.... I feel high from it [yet] it's not fattening and it doesn't give me a hangover."

A few subjects pointed to art as a balance between the ways clinicians connect to the world: verbally, through people, and the way that art allows for other methods of connection. "There's something about being connected to the world not through people...in art you're connected to the world in a definite way, but not through people."

Making my art is something other than...it's different from my work where we're always talking about things and trying to put things into words, so often when people ask me about my artwork I feel like I don't have a lot to say I just want them to sort look at the artwork...I think I like the artwork because it isn't verbal.... It's just a different realm.

Lastly, a subject who identified as a photographer described the balance between the ambiguity of her clinical work and the concreteness art making brings her through the ability to create a tangible product.

When I do social work there's no end goal, successes are very hard to measure. When you succeed, what does that look like? You're not entirely sure. So that's why I love photography- it's very concrete, there's something you can touch; you know you're done when you get that one image so...the social work world is very chaotic, very trauma-filled...I need things that give me something concrete...and photography's something that...there's no ambiguity to it- you got the image, you're done.

### *Connections between Art making and Clinical Practices*

While all participants gave compelling reasons for making art, there were different levels of responses when asked to point out direct carry-over between their art making and clinical practices. Again, participants' responses related to how they identified as artists. Those that identified fundamentally as artists said that the two practices were inextricable from one another and one inevitably informed and drew upon the other. Those that identified their art making purely as a hobby were less likely to point to any relationship between the two practices, and those that fell somewhere in between saw the two practices as basically separate, but reported some carry-over between the two fields. In the sum total of responses, a few themes emerged.

One aspect that many respondents pointed to was that their art making practice helped them to work with clients who are artists. "For clients in the arts, it's helped my understanding of them and what they have to struggle with." Another subject reports: "at times when people are artists they have brought in sketchbooks or albums of pictures or something like that and I think that my comfort with the medium helps me talk to them about what they really want to talk about." One participant decided to focus her practice around working with artists and formulated a model of creativity coaching in which she uses her social work and artistic skills to help clients in the arts enhance their artistic expression.

Making art with clients was another theme that emerged. Although none of the participants are trained art therapists, several acknowledged using art with clients to varying degrees. "I've done art with kids who are my patients, used that as a way to accept disappointment, deal with frustration and feel good about themselves and what

they can produce.” Another subject reported that she did “a lot of drawings with those who were willing; mostly young folks” and went on to discuss the positive aspects of making art with clients:

I think that it’s definitely something that, if you’re open to it and if you have a client that’s at all inclined that way, it really is a means to start a clinical relationship, and it allows for...just like play therapy...anything else when there’s something in the middle that you can both focus on that’s not threatening...it’s good that way.

Another subject described the power of doing art with clients, but also her reasons for eventually separating the two practices:

One thing I thought that I wanted to do when I started is I thought that I might want to be an art therapist, and when I was a therapist in day treatment I ran an art therapy group and I really...I did love it...I thought it was a really good way to get people to talk about things that maybe wouldn’t come up in other forms of expression, but ultimately that’s when I realized that it was really a separate thing for me, that I really like making art myself and it’s really more of a private experience for me and I didn’t feel like I wanted to marry it with this other thing that I was ...I didn’t feel like there was a real benefit in that for me...I wanted to keep them separate.

The above respondent found greater comfort in separating the two pursuits, but many participants report successes combining their two interests; using art making to enhance their clinical work.

For a couple participants it worked the other way as well, and they used their clinical experiences to inform their art making. One participant who identified as a photographer describes an incident in which a client asked to be photographed to document her pregnancy.

One of my co-workers had a client who was 18 and she was pregnant and she wanted pictures to document her pregnancy, and my co-worker came and asked me if I’d be willing to take pictures of her being pregnant. So I did and we took this girl out to the park and got pictures of her with her belly, and the nice thing

was that she was over 18 and could sign a consent for me to exhibit some of this, so that turned out really great.

Another participant reported that she drew portraits of her clients to help her process information, “a lot of times I’d draw my clients, not when they were there, but afterwards. I’d draw them out and somehow it would help me *see* things.” The participant reported that afterwards she threw the pictures out or kept them in the client’s chart; she did not display them out of respect for confidentiality. This alludes to an ethical issue about allowing the clinical work into the art making. Where is the line between artistic expression and a breach of client confidentiality?

A couple participants mentioned using their art making for social commentary, to address some of the macro issues of the social work field. One respondent described making art to process an especially intense issue of oppression. She explained that at first she did not show her pieces because they were too personal, but then changed her mind when she realized their potential to impact others, “so this was a turning point in that I started using art to inform people about a social problem.” Art making on a macro social work level can be used as both a form of catharsis for the artist and a means of communication to express the difficult issues that social workers face. It has the potential to aid social change.

On both a macro and clinical level, participants mentioned that art making pushes them to think creatively, more outside-the-box, and to be more attuned to visual cues, “In one sense painting, drawing trains one to be very attuned to the visual sense, so I look at things more carefully, more intensely...I think that has affected the way I see certain

things.” In the clinical arena, one participant remarked that being an artist pushes her to view clients’ stories and challenges creatively and spontaneously.

It’s the kind of person you are...it’s the kind of mind you have...it’s a whole issue of who you are...so if you have the kind of mindset that allows you to be spontaneous, free and creative, that will affect your association with patients. It will allow you to say, ‘the theory says this but it doesn’t really fit and maybe we have to look at different theory or a different sequence of questions...and I think that’s how it affects you.

Along the same lines, several participants pointed to a parallel process between their art making and clinical practices. “I always tend to think of doing therapy as a creative process and there are certain things, skill-sets and knowledge to help people, using creativity. How can I approach this client? This couple? How can I approach them to help them get unstuck? There’s a link because there’s a parallel process to the creativity it takes for both.” Agreeing with the above respondent, another clinician added:

Finding the solutions [in art] is so amazingly freeing, it’s like in the office...your wheels are spinning and it feels really hard and then all of sudden you make an intervention. You step back and be meta to the situation and all of a sudden there’s a silence and you’ve reached the person...you give them the tools, the pathway through insight to find maybe there’s a way for them to look at the situation in a different way, and then a whole slew of solutions come up...And that’s what happens in art.

The two subjects who identified as potters made beautiful analogies between their relational work with clients and their work with clay. As one put it:

When I sit down with a piece of clay I will say to myself, ‘I’d like to make a large bowl’ or ‘I’d like to make a vase that’s round,’ but then I really feel that the clay directs what I’m going to do and it might turn out to be a bowl that has wide sides or a bowl that has tall sides, it just depends on how it works. I think it’s a real collaboration between the piece of clay and me, and I think that that’s what doing therapy is like too...whatever it is, something about the way I put my fingers makes the clay do something and then I have to do something in response to what it has done. I think that is what therapy is about too.



To sum up the connection between the two fields, and the creativity needed in both, a participant eloquently stated, “The soul of a good therapist is an artist.”

### *Challenges of Maintaining Both Practices*

When asked about the challenges of maintaining both art making and clinical practices, the majority of respondents named time as one of the biggest challenges; it was difficult for people to find enough time and energy to do both. “Time, that’s the main challenge; having time to do the artwork.” One subject notes that, for her the challenge of maintaining both practices is the lack of downtime.

One of the things that I’ve thought over the years is that, it isn’t that there isn’t enough time to do 2 or 3 or 4 or 5 different things, but that the creative piece comes in the free-think time, sort what are you thinking about when you’re taking a shower or driving a car; downtime. And there isn’t very much of that downtime. Either I’m thinking about a painting or I’m thinking about a clinical situation, but it’s hard to do both.

Several participants mentioned financial concerns. “Social workers don’t make that much money to begin with, so it’s hard to subsidize your hobby or your art.” Two interviewees suggested that the combination of the financial and time challenges brought up ethical dilemmas for them in deciding how to structure their time and their careers.

One respondent with a private practice stated:

I guess the main thing is if you really want to have time to do art then it does put some pressure on you to have a different kind of practice. I don’t think that’s entirely true, but I have sort of been slowly coming to the sense that I’d like to make more money so that I can work less so that I can paint more...which starts to impact how you think about what clients you take and what insurance you take...I could see overtime having a practice where more people can pay so that I can have time to paint. And I feel conflicted about that. I have a lot of Medicare patients now and I like that, so I want to keep a balance but it does put some pressure on me to try to make more money.

Both participants mentioned that one way they could make more money is to put greater effort into selling their art, but each expressed similar concerns about placing added financial pressure on their art making.

I don't want to take something that I love and turn it into something that I have to live off of, 'cause when you have to survive on your art I think it changes the dynamic. Because I do social work I have the luxury of charging not as much for my work and be willing to not do it. I have a choice to do art.

Along the same lines: "I've thought about pursuing a gallery or something, but it feels like it could take the fun out of it for me." Thus by pursuing both practices, clinicians must make sacrifices of their free time, and often make tough decisions on how to live off the combined earnings of two notoriously low-earning professions. According to one participant, when asked about both practices: "I think both are passions...if they're not, you don't need to be in it, because you're not getting paid."

Another challenge that came up was the intersection between the private and public image. As one participant put it, "the office is where I disclose only what I choose to about myself and with the art I feel a little more open and exposed." Another respondent agreed with the sentiment, "yeah it feels like a conflict for me too. I prefer that my patients don't know about me personally...for that reason, I don't hang my own artwork in my office, for me that would feel like bringing something personal into a professional space." One participant noted that this felt especially poignant in the Google age, if she were to create a website for her artwork, then whenever someone searched her name her art website would appear along with her clinical site. "I would just as soon keep it separate. I would almost like a second name."

Lastly, a couple participants wondered whether their commitment to both practices caused them to be viewed by others as less serious in each field and/or whether pursuing both undermined their level of mastery in either field. “Originally...I don’t know if it’s still true, but originally, if social workers knew I was an artist they wouldn’t take me seriously and if artists knew I was a social worker they wouldn’t take me seriously.” She then went on to say:

I always thought that I would’ve gotten many more private patients if I weren’t doing two things...it’s a mixed message...I always think about Robert Frost’s poem about taking the road less taken and just because you take that road doesn’t mean you don’t still see the other path.

Another subject, when considering her participation in both endeavors commented: “now sometimes I do question how carrying on both at the same time limited my mastery of either side.” And then went on to explain:

Most of the impact was on the art side. Rather than do formal kinds of self ed. or continuing education that I would have done had I been focusing on art, I didn’t do as much of that. So I think it affected the art side more and I’m feeling it now because I’m trying to get stuff in galleries...the business side of art I’m not that good at...the marketing...someone says I’ll give you \$75 for that and I’ll say ‘Ok’...and artist colleagues will say ‘what are you doing?! You’re giving this stuff away!’

In response to her statement, this researcher asked if, at the same time, she felt that the two fields enhanced one another, to which she replied, “yes both ways. I don’t see them as disconnected.” As with any pursuit, there are downsides, and upsides. It’s a testament to the art making practice that the clinicians interviewed continue to do it despite the challenges and sacrifices inherent in the dual pursuit.

### *Advice*

When asked what advice they would give to someone considering maintaining both an art making and clinical practice, the resounding advice from the participants was: “Do it.” For several it was that straightforward, others emphasized the importance of participating in *some* form of self-care activity or hobby, art or otherwise, and others made suggestions on how to guard time and create structure around the art making practice.

Speaking about self-care, one participant said, “it’s just a matter of sort of growing up, maturing, and figuring out tools for living...what’s going to bring you peace *everyday*? What’s going to bring you joy *everyday*?” Another said, “as a therapist in general what we need is balance; it’s important for therapists to know who they are, what they need, and how they can take care of themselves better.” Self-care in general is important and advisable for clinicians, and those who are open to art making may find it to be an especially helpful method to balance out, and to enhance the creative work of a clinical practice. As one participant put it, “I think anybody who feels they have something artistic that they want to do, I hope that they find time for it, and I guess that having any kind of hobby is important in this kind of work, and this is a wonderful one because it’s creative...”

About her art making, one participant advised:

That’s the issue about doing art while you have other things going in your life—that it can’t be agonizing...or you don’t have time for more agony, be it another relationship or your work or kids, whatever it is...it has to have a different set of demands and frustrations than the ones that you have in your work and for me it always did.

Another describes some of the challenges in maintaining both practices and, as a result, gives advice on guarding time.

Just being a clinician associated with a teaching hospital, it wasn't just being a clinician, it was feeling like you had to write papers, and then you had to be a supervisor, and then you had to run a program and then you had to teach and so you had to have unique perspectives that you could articulate as a clinician and you had to keep up with the newer things that were happening so it became very time consuming. And it's the same way I feel with art: how do I keep it growing? How do I get a skill base that I need?

As a result, the advice she gives is: "think about how you work and protect some space for both, go where your heart brings you. Sometimes it brings you one place sometimes it brings you another. I suspect there's years you do it one way and years that you do it another."

Many participants echoed this sentiment, and advised people to guard time for the artwork and/or suggested leaving aside scheduled times to do art. One participant made specific suggestions about maximizing time and energy, "work no more than 40 hours a week, work less if you can. I also find for myself, I'm very focused in my interests. I don't do much outside of what gives me a lot of juice." She goes on to add:

I'm very careful about how I spend my time, I don't waste my time; I don't spend time with people I don't like, I don't do things I don't want to do. I try to keep my obligatory things minimal ...I sound so selfish...but that's what organizes work for me, selfish or no, I just do what gives me more energy.

She concludes by giving the following advice to others: "'follow your bliss,' we only have one life that we know about, don't waste it; don't waste your precious time."

The overall message from participants was that clinicians should do whatever they can to cope with their stress and to care for themselves. For the vast majority of those interviewed, art making is one method that helps give balance to their lives and in

some way either directly or indirectly, helps them to counteract some of the occupational stress intrinsic to clinical work and/or to feel good in general. One participant put it well when she said, “I’ve found it very helpful in my career and, if that’s at all your bent: art, music, poetry, any of it...let it flow right with you, ‘cause it will help you.”

### *Conclusion*

The research generally supports the hypothesis that art making helps clinical social workers cope with their occupational stress, but the results were more reluctant and indirect than expected. Three of the participants directly corroborated the hypothesis, but many subjects were reluctant to make a direct connection between their art making practice and their clinical work/stress level. Some were hesitant to make the connection at first, but as the interview progressed started noticing a relationship between the two to varying degrees, and one or two maintained that they were unrelated throughout, including the one participant who denied the hypothesis.

One of the most interesting and unexpected findings of this study was how participants’ support of the hypothesis depended on their sense of identity as an artist, and how frequently the issue of artistic identity came up despite the fact that it was not directly covered in the interview questions. The balance between social worker and artist seemed easy for a small few who simply saw themselves as both, but for most appeared to be an ongoing evolution: is art a hobby or a dual career? How important is art making in structuring one’s career and free time? Perhaps the most compelling finding is that no matter how people identify or what connections they make between art making and occupational stress, each participant in the study described major sacrifices of time, and energy to maintain an art making practice. It nourishes them all in some way.

## CHAPTER V

### DISCUSSION

The participants' responses to interview questions were expected in some ways and surprising in others. The following chapter will examine the responses, comment on the findings that were expected and unexpected, and will point out several areas that may be points of interest for future research and investigation.

#### *Participant Demographics*

Based on the research suggesting that more than half the clinicians in the mental health field are practicing in states of emotional stress (Gilroy, Murra, & Carroll, 2002), it was a surprise that no participants in this study reported currently feeling high levels of occupational stress. It is possible that the sample is skewed because so many of the participants are in the latter parts of their careers (there may be a natural selection component; clinicians in emotional distress are not the ones who work for several decades in the field) or it is possible that this research pool is less likely to report high levels of stress because, as clinicians who take time to make art, they are a group that values self-care. Lastly, it may be that this group reports lower levels of stress because art making is an effective method of reducing stress for the clinical social worker. The sample size is too small to draw major conclusions, only further study will indicate whether or not there is a definite correlation between art making and clinician stress level.

### *Artist Identity*

The theme of artist identity was an unintended finding in this study. This researcher did not expect the amount of reluctance and uncertainty from participants in referring to themselves as artists. The working assumption was that someone who dedicates time to making art is an artist, in the same way that someone who plays tennis regularly is a tennis player. Within the sample however it was not that clear cut. Many participants went out of their way to point out that, for them art is a hobby rather than an identity. Perhaps it is the same with any pursuit; perhaps someone who plays tennis would also be reticent to call them self a tennis player, but perhaps it is unique to art making. It may be that the artist identity feels loaded for people; perhaps calling oneself an artist suggests some sort of mastery over the pursuit, or some level of profitability.

Participants' responses may also reflect a topic alluded to earlier in this paper, which is that art making in modern times, in this country, is a much more esoteric pursuit than it has been for most of human existence. For adults in twenty-first century America, art making is generally not considered a basic, fundamental activity, and it is commonly limited to those who display their work in galleries and get paid for it. Art making as a pursuit for art's sake is something that is undervalued and this may be reflected in participants' responses. Future study could seek to find: what does the artist identity represent for people? What gets in the way of people viewing themselves as artists? What role do socio-cultural values play on a person's willingness to identify as an artist?

Such inquiry would be helpful because within this study, participants' level of identity as artists had ramifications on their responses to interview questions. Those who identified as artists without hesitation were those who most whole-heartedly endorsed the



hypothesis and pointed to art making as an activity that directly and positively impacts their stress level and clinical work in general. Those who rejected the artist identity or maintained the identity as something separate from and unrelated to their clinical identity, were less likely to point to a direct correlation between their art making and clinical stress level.

### *Art as Stress Relief*

As expected, the vast majority (nine out of ten participants) related their art making in some way to a decrease in their overall stress level. The unexpected response was that only three out of ten participants pointed to a direct correlation between art making and stress reduction, while the other six identified an indirect connection between the two and could not point to a direct correlation.

One participant who sees a direct connection between art and stress describes art making as a form of ‘self therapy,’ “certain times in my life you know those life struggles happen...the art really has been the thing to help me over the hump, it really helps me sort out things.” In other words, she substantiates the literature that describes art making as a method of catharsis. As Kivnick and Erickson (1983) suggest, art is a way to feel catharsis over inhibition: “working with materials on any but the most superficial level taps the artist’s emotions in a number of different ways. The external, impersonal, nonverbal nature of materials permits patients to express what it otherwise inaccessible.”

The expectation going into the study was that most respondents would describe art making as a form of catharsis and sublimation and as such an obvious stress reliever, thus it was a surprise that only thirty percent of participants pointed to those factors (the same thirty percent that unhesitatingly identified themselves as artists). Meanwhile, the

other sixty percent of respondents pointed to the more anthropological and evolutionary reasons for making art; they reported that art making just makes them feel good. They did not see a direct relationship to their clinical work or stress level, but they noticed that making art helps them feel better in general, thereby indirectly benefiting their stress level and clinical work. Participants substantiated the literature that points to art making as something basic; that humans make art to satisfy “something deep within us. This satisfaction can be attributed to the likelihood that the universal impulse to make art is either a direct or indirect result of our evolutionary history and is embedded in our genes” (Kaplan, 2000).

One out of the ten respondents reported that for her art is a greater stressor than stress reliever. This is not surprising given that art making is a difficult undertaking. As several participants pointed out, the art making process can be frustrating and it exposes the artist to criticism, both internal and external. However even the participant that describes art making as a stressor continues to participate in the process. She regularly takes time out of her days to create art, thus there must be some kind of positive gain for her that mitigates the added stress in her life.

#### *Reasons for Making Art*

More than anything else, participants’ responses regarding their reasons for making art reflected the work of Mihaly Csikszentmihalyi, the psychologist and creativity researcher, who researches optimal human experience or “flow.”

Csikszentmihalyi’s Flow has nine characteristics.

1. Clear goals
2. Feedback regarding progress
3. Exercise of skill

4. Intense concentration
  5. Diminished awareness of mundane concerns
  6. A sense of control
  7. Loss of self consciousness
  8. An altered sense of time
  9. Enjoyment of experience for its own sake
- (Kaplan, 2000).

Participants made several references to the characteristic that Csikszentmihalyi describes: the altered sense of time, the diminished awareness of mundane concerns, the joy they get from art making, and the exercise of skill in creating art.

I think it's a little bit like meditating or exercising or any of those things that takes you into a different frame of mind. I feel like I can just completely lose myself in it. The hours go by and I don't feel like I'm thinking about anything, so in that way it's a kind of escape from the rest of my life or a way into another part of my self.

If art making is an evolutionary necessity the way some scientists claim, this feeling of 'flow' may be the human body's signal of the activity's importance, "sensual pleasure [is] one of nature's ways of reinforcing biologically significant behavior" (Kaplan, 2000). As one participant said about art making, "It must affect my serotonin levels because I feel good when I do it...I feel high from it [yet] it's not fattening and it doesn't give me a hangover." The joy, pleasure, and overall feeling of wellbeing that participants describe supports the claim that art making is a basic and healthy pursuit.

In describing their reasons for making art, participants also addressed a hole in the current social work literature. Through sharing anecdotal feedback about why they make art, participants gave voice to the unique ways that art making is helpful for the clinical social worker. Some described art as a cathartic and informative tool for social workers to communicate about issues of oppression and to raise social consciousness towards the issues that social workers see in their work. On a clinical level, several participants

pointed to art making as a means of boosting self-esteem in a venue outside the clinical work. For some, art making served as a positive and joyful experience which helped to balance out some of the difficult and overwhelming conversations intrinsic to clinical work and art making was described by one participant as a way to center one self after a day of sitting with different clients throughout the day.

A few participants pointed to art as a balance between the ways that clinicians connect to the world: verbally, through people, and the way that art allows for other methods of connection. “There’s something about being connected to the world not through people...in art you’re connected to the world in a definite way, but not through people.” “I think I like the artwork because it isn’t verbal.... It’s just a different realm.” And art making was described by a photographer as something concrete compared to the ambiguity of her clinical practice; for her, art making serves as a chance to create a tangible product- a particular sense of accomplishment generally not found through clinical work.

All told, participants’ responses about their reasons for making art were highly supportive of art making as a positive activity from an anthropological and evolutionary perspective; participants make art because it makes them feel good and, as clinicians, it helps to balance out the harder parts of their work. Participants said less than expected about art as a healing pursuit. Only a couple participants pointed to art making as a tool to access images and emotions that lie below surface level. This could be because this researcher did not ask a direct question about participants’ reasons for making art and instead recovered respondents’ reasons for making art through their answers to other interview questions or to follow-up questions. Or it is possible that high numbers of

participants did not point to the cathartic nature of art because it is a process that is not entirely conscious. Perhaps one of the aspects of art making that makes people feel good is a catharsis that happens below the conscious level. It is difficult to say. Future research could further examine clinical social workers' unique reasons for making art and, in order to bolster the work of this study, future research could ask participants questions about their motivations in a direct and pointed manner.

### *Connections between Art making and Clinical Practices*

In discussing whether or not they identified a carry-over between the two pursuits, participants continued to contribute to a dialogue, currently absent from clinical social work literature, as to whether or not there is a positive relationship between art making and clinical social work. Again, an unexpected finding was that participants' responses related to how they identify as artists.

Most respondents were able to point to some carry-over, indeed half commented in some way about the parallel process between the two pursuits. In this area, participant responses were especially eloquent and thoughtful; some made direct analogies between their art making and clinical work practice, and some connected the creative thought process used in both activities, "the soul of a good therapist is an artist." In certain ways, when describing their reasons for making art, participants pointed to the process as a counterbalance to the clinical work, however when asked about carry-over between the two practices, participants often described the processes as similar and related; they felt that the art making helped them to practice the creative thinking needed in clinical work.

Participants were more apt to point to the ways that art making impacts their clinical work than the opposite. Only the three participants who unhesitatingly identified

themselves as both artists and social workers mentioned a mutual relationship between the two (their art making practice affects their clinical work while their encounters and identity as social workers informs their artwork). This was a surprise. This researcher assumed that more respondents would describe their clinical work as a source of inspiration and images from which to draw upon for their artistic pursuits. However more often than not, participants described the content of their artwork as unrelated to the clinical work they do. Again, most described art making as a process that makes them feel good rather than a form of sublimation.

Of course, as noted in the Findings section, obtaining inspiration in the clinical work can be risky. The link between art making and clinical social work is not a topic discussed in the social work literature, so there are no clear ethical boundaries to protect client confidentiality. Obviously creating a realistic portrait of a client and selling it as art, would be a breach of client confidentiality, however other scenarios are less clear cut. What about creating an abstract portrait or sculpture of a client and selling it as art? What about illustrating an image discussed in therapy? What about the scenarios described by participants: what if a client requests to be portrayed by a clinician? What if a clinician draws a client, but does not display the work? Again, where is the line between artistic expression and a breach of client confidentiality? Perhaps this moral ambiguity is an impediment for some participants to use their clinical work as artistic inspiration. Further research and discourse could seek to define clearer boundaries to protect client confidentiality and/or could question clinicians' perceptions of using inspiration from the clinical work to inform artistic expression.

When asked about a carry-over between art and social work, six out of ten participants mentioned using art with clients at some point in their careers. Participants reported primarily using art with children and adolescents or with groups and mentioned that it helped in the engagement process, it helped clients to express themselves nonverbally and it gave clients a sense of mastery. “I’ve done art with kids who are my patients, used that as a way to accept disappointment, deal with frustration and feel good about themselves and what they can produce.” These are similar attributes to the ones described by Helen Q. Kivnick and Joan M. Erickson in their research on art making and mental health. Kivnick and Erickson conclude their study by saying, “we believe that in a setting in which people are encouraged to engage in art activities, almost anyone, if not absolutely everyone, can experience the unique sense of healing along with the satisfactions embodied in working creatively with materials” (Kivnick and Erickson, 1983). Within the social work field there is little crossover between the related field of art therapy. Future research may examine how art therapy techniques and practices might aid the clinical social worker, and vice versa. It seems highly plausible that art therapy techniques, used in conjunction with other clinical techniques, could aid clinical social workers’ healing work with clients.

#### *Challenges of Maintaining Both Practices*

It was not surprising that participants pointed to time and money as the main challenges in maintaining both practices. Art and Social Work are two notoriously low wage fields and it is easy to imagine the challenge in trying to earn a livable wage through the combined earnings of the two fields and/or finding the extra money needed to buy art supplies and studio space. Likewise, it was assumed that carving out time to do

both activities would be a challenge for clients. The ethical dilemma that one participant describes about yearning to make more money in order to devote more time to art making, and therefore worrying about undermining her commitment towards helping poor clients, is a good example of the intersection between time and money challenges. “I could see over time having a practice where more people can pay so that I can have time to paint. And I feel conflicted about that.” Another example is the dilemma that two participants acknowledged about art making for profit: they could try to make more money from their art making practice, thereby lessening their financial stresses, but would then risk losing some of the pleasure that they currently get through the art making process. “I don’t want to take something that I love and turn it into something that I have to live off of.”

Participants in this study were not asked about their personal life choices, and therefore it is not known whether or not participants have families and whether or not they have additional income sources outside their art and clinical social work. A future study examining the details of participants’ lives may give a better sense of how clinicians find the time and money to participate in both art making and clinical work, and the sacrifices they make to do so.

Participants also pointed to other challenges including: concern that dividing time between the two pursuits limits mastery or outside acceptance from both fields, and the intersection between the private nature of clinical work and the public nature of art. Because there is a dearth of research and investigation into the intersection between art making and social work, there is little precedent or advice for clinicians trying to navigate the challenges of the dual pursuit. Hopefully future research and documentation will



advise clinicians on how to feel successful in both fields and how to accentuate the ways the duality enhances rather than detracts from their abilities in either field. Likewise there must be techniques to maintaining a sense of privacy within the public world of art. One participant makes the good suggestion, borrowed from the writing world, of using a pseudonym in her art making practice to protect her sense of privacy. An ongoing dialogue and further research would help future clinicians to consider how to optimize their art making capabilities without compromising their therapeutic work with clients.

#### *Advice*

Participants' advice to others considering participation in both the art and clinical social work fields is consistent and supportive of the advice found in the social work literature; social workers should participate in some form of self-care activity. Kenneth S. Pope and Melba J.T. Vasquez, "strongly recommend creating strategies for self-care before opening a practice, using them as a basis for professional planning, and making them a fundamental part of the professional life" (2005), a sentiment echoed by participants who made comments such as: "as a therapist in general what we need is balance; it's important for therapists to know who they are, what they need, and how they can take care of themselves better."

For most participants in this study, art making is one form of effective self-care. Participants gave some specific advice to others on guarding time to do art, but for the most part participants' advice was more general than specific; they encouraged anyone with an interest in the arts to "do it." "I think anybody who feels they have something artistic that they want to do, I hope that they find time for it, and I guess that having any kind of hobby is important in this kind of work, and this is a wonderful one because it's

creative,” and “I’ve found it very helpful in my career and, if that’s at all your bent: art, music, poetry, any of it...let it flow right with you, ‘cause it will help you.”

### *Conclusion*

In many ways this study generated more questions than answers. Can self-directed art making reduce stress for the clinical social worker? Three out of ten respondents answered a definitive ‘yes’ while the other participants gave responses that were less clear and lead to questions about the impact of artist identity on participants’ answers and the differences between direct and indirect stress relief. What can be drawn from participants’ responses is that art seems to positively affect clinicians’ wellbeing.

Frances F. Kaplan writes, “for the sake of our mental health, we must find ways to reintroduce art making into our everyday worlds” (2000). The ten clinicians in this study maintain art making in their everyday world despite sacrifices of time, energy and money. Their reasons for doing so are compelling and basic: it makes them feel good and gives them a sense of balance. Only further, larger-scaled research will reveal whether clinicians who participate in art making report lower levels of stress than those that do not and therefore whether self-directed art making reduces stress for the clinical social worker. In the meantime, as clinicians are universally encouraged to participate in self-care activities, participants’ responses relating art making to a sense of wellbeing suggests that the intersection of art making and clinical social work is a topic worth examining further in the future.

## REFERENCES

- Baker, E. (2003). *Caring for ourselves: A therapist's guide to personal and professional wellbeing*. Washington DC: American Psychological Association.
- Cameron, J. (2005). *Letters to a young artist*. New York, NY: Penguin Group.
- Case, C., & Dalley T. (1992). *The handbook of art therapy*. New York, NY: Tavistock/Routledge.
- Cooper, M., & Lesser J. (2002). *Clinical social work practice: An integrated approach*. Needham Heights: Allyn & Bacon.
- Deutsch, C.J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice*, 16(2), 305-315.
- Dewey, J. (1934). *Art as experience*. New York: NY: Pedigree Books.
- Figley, C.R. (n.d.). Compassion fatigue: An introduction. Retrieved October 12, 2006 from <http://www.greencross.org/Research/CompassionFatigue.asp>.
- Gilroy, P., Murra J., & Carroll, L. (2002). A preliminary survey of counseling psychologists' personal experiences with depression treatment. *Professional Psychology: Research and Practice*, 33(4), 402-407.
- Heenan, D. (2006). Art as therapy: An effective way of promoting positive mental health? March 2006. *Disability & Society*. 21(2), 179-191.
- Howie, P. (1999). Feature: Art therapists who are artists. *American Journal of Art Therapy*. 38, 15-18.
- Kaplan, F.F. (2000). *Art, science, and art therapy: Repainting the picture*. Philadelphia, PA: Jessica Kingsley Publishers.
- Kivnick, H.Q., & Erikson, J.M. (1983). The arts as healing. *American Journal of Orthopsychiatry*. 53(4), 602-618.
- Marriage, K., & Marriage, S. (2005). Too many sad stories: clinician stress and coping. November 2005. *Canadian Child and Adolescent Psychiatry Review*. 14(4), 114-117.

- Maslach, C., Schaufeli, W.B., & Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology*. 52, 397-422.
- Moon, C. H. (2001). *Art therapy: Cultivating the artist identity in the art therapist*. London, GBR: Jessican Kingsley Publishers.
- Odell-Miller, H., Hughes, P., & Westacott, M. (2006). An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. January 2006. *Psychotherapy Research*. 16(1), 122-139.
- Pope, K.S., & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice*, 25(3), 247-258.
- Pope, K. S., & Vasquez, M.J.T. (2005). *How to survive and thrive as a therapist*. Washington D.C.: American Psychological Association.
- Previlon, G. (2006). An exploration of therapists' views on self-care and their personal practices. Master's Thesis.
- Reid, W.J. (1997). Long-term trends in clinical social work. *Social Science Review*, 71(2).
- Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., & Bebbington, P., Thornicroft, G., Prosser, D. (1999). Improving support for mental health staff: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology*. 34, 309-315.
- Riley, S. (1997). An art psychotherapy stress reduction group: for therapists dealing with a severely abused client population. *The Arts in Psychotherapy*. 23, 417-415.
- Rowh, M. (2005). Stress busters. *Current Health 2*, Retrieved October 15, 2006, from <http://libproxy.smith.edu:2124/magazine/article?id=14&query=stress>.
- Rubin, J.A., (1999). *Art therapy: An introduction*. Philadelphia, PA: Brunner/Mazel.
- Schneider Adams, L. (1996). *The methodologies of art*. New York, NY: HarperCollins.
- Silver, R. (2001). *Art as language: Access to thoughts and feelings through stimulus drawings*. Philadelphia, PA: Psychology Press.
- Solso, R.L. (2003). *The psychology of art and the evolution of the conscious brain*. Cambridge, MA: The MIT Press.
- Stewart, M.F. (1990) Clinical social workers experience of burnout and their coping methods: A project based upon independent investigation. Master's Thesis.

- Stress. (2007). In Encyclopedia Britannica. Retrieved May 22, 2007, from Encyclopedia Britannica Online: <http://search.eb.com/eb/article-9069962>.
- Thomas, J. (2005). Licensing Board Complaints: Minimizing the Impact on the Psychologist's Defense and Clinical Practice. *Professional Psychology: Research and Practice*, 36(4), 426-433.
- Thurrow, J.A. Interactional squiggle drawings with children: An illustration of the therapeutic change process. Retrieved December 12, 2006, from The Focusing Institute Web site: <http://www.focusing.org/chfc/articles/en/thurrow-interaction-squiggle-total.htm>.
- Unknown (2003). The effects of stress. *Body Bulletin*, Retrieved October 15, 2006, from <http://libproxy.smith.edu:2124/magazine/article?id=22&query=stress>.
- Urbaniak, A. (2006). Managing stress. *Supervision*, Retrieved October 15, 2006, from <http://libproxy.smith.edu:2124/magazine/article?id=1&query=stress>.
- Williams, K. (2002). Commencement address at Vermont College of Norwich University, September, 2001. *American Journal of Art Therapy*. 40, 193-202.
- Winnicott, D.W. (1971). *Playing and Reality*. New York, NY: Basic Books.
- Yalom, I.D. (2002). *The gift of therapy. An open letter to a new generation of therapists and their patients*. New York: HarperCollins Publishers.

## APPENDIX A

February 8, 2007

Lucy Goldstein  
65 Boston Street, Apt. 1  
Somerville, MA 02143

Dear Lucy,

You have done a fine job with your revisions and all is now in order. We are, therefore, happy to give final approval to your study.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain signed consent documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Alexandra Graham, Research Advisor

## APPENDIX B

### Email Inquiry

Subject: Art and Clinical Social Work

Dear \_\_\_\_\_,

My name is Lucy Goldstein, I'm a second-year student at Smith College School for Social Work, currently living in the Boston area. For my Master's Thesis I'm researching clinical social workers who make art either as a hobby or dual career to see how the art making process affects their clinical work, especially their occupational stress level.

I received your name from the sign-up sheet of an NASW symposium about art and social work and am writing to ask you to participate in my study. Your participation would include 1 telephone call or email correspondence to ensure that you fit the study qualifications and 1 interview no longer than one hour, at a time and place that is convenient for you.

Please let me know if this is something you're interested in, or if you have any questions. Also, if you know any other clinical social workers/artists that may be willing to participate in the study, I would greatly appreciate suggestions.

Thank you very much,  
Lucy

.....  
Lucy Goldstein  
Smith College School for Social Work  
Phone: 978-621-3378

## APPENDIX C

### Phone Screen Questions

1. Do you identify yourself as a clinical social worker?
2. Do you engage in some form of visual arts (such as drawing, painting, collage, sculpture, ceramics and photography)?
3. Do you engage in art making at least two hours each week, on average?
4. Are you willing to set up a time to meet for no more than one hour to discuss how your art making practice affects your clinical work- specifically whether or not it helps you to reduce your occupational stress level?
5. Are you willing to have these meetings audio-recorded and transcribed by myself for use in my master's thesis for Smith College School for Social Work?
6. Do you have any questions for me about the project and its intended use?



## APPENDIX D

### Interview Questions

1. How many years have you worked as a clinical social worker?
2. Brief description of past and current clinical experiences
3. How many hours/week do you spend doing clinical social work?
4. How many hours/week do you participate in the art making process?
5. How many years have you participated in art making?
6. What type of art do you make?
7. As a clinical social worker, what are your reasons for maintaining an art making practice?
8. How would you describe your current clinical social work stress level [especially as it relates to characteristics of burnout (emotional exhaustion, depersonalization and feelings of reduced personal accomplishment) and of secondary trauma]?
9. Do you view art making as a coping method (form of self-care) to counteract your occupational stress levels?
10. How does art making affect your level of occupational stress?
11. Can you point to any specific incidents in which art making had a direct impact on your clinical social work practice (either in terms of your stress level or the course of a case)?
12. What are the challenges of maintaining both a clinical social work and art making practice?
13. Do you have any advice for other clinical social workers interested in maintaining both practices?
14. Is there anything else that you'd like to share?

## APPENDIX E

### Informed Consent Form

Dear Participant,

I am a graduate student at the Smith College School for Social Work. I am conducting a research study to examine whether art making as a hobby or dual profession helps the clinical social worker reduce their occupational stress level. I will collect data for this study by interviewing clinical social workers who engage in art making. This study is being conducted for a thesis presentation and publication for the Master of Social Work degree at Smith College.

You are being asked to participate in this study as a person who has met the following criteria: 1) you identify yourself as a clinical social worker 2) you engage in some form of visual arts (drawing, painting, collage, sculpture, ceramics and photography) as a hobby or para-professionally for an average of at least 2 hours per week 3) you agree to participate in one interview session in which I will inquire about how your experiences making art affects your clinical abilities and stress level. This interview will last no longer than one hour. The interview will be audio-recorded and transcribed by myself.

This study is considered low-risk because it involves the discussion of a hobby/avocation and minimal discussion of stress and burnout. However it is important to emphasize that your participation is entirely voluntary; you may refuse to answer certain questions and, should you choose, you are free to withdraw from the study at any time before May 1, 2007. Should you withdraw, all materials pertaining to you will be destroyed. There are no financial benefits for your participation. From participating in this study, however, you may benefit from considering the ways that art making affects your clinical capabilities, client care and overall functioning and you will have the opportunity to share the lessons that you have learned with other clinicians. Furthermore, you will contribute to a field of social work research that has not yet been extensively studied.

Throughout this study, your confidentiality will be protected. After the interview, your name will be removed from the transcripts and tapes and replaced with a numeric code to ensure that no one other than myself can link your name to your responses. The only other person with access to your responses will be my research advisor who will have access to the data only after identifying information has been removed. Information will be reported in scientific papers and publications in the aggregate only, with some illustrations and brief quotations that cannot be linked to identifying demographic data

about you or any participants. In accordance with federal regulations, all data and tapes will be kept in a secure place for three years. After that time data and tapes will either be destroyed or kept in a secured place until it is no longer needed, at which point it will be destroyed.

If you have any questions please feel free to ask them. I can be reached at 978-621-3378 or lgoldst2@smith.edu.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATION IN THE STUDY.

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
SIGNATURE OF RESEARCHER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

***PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS***