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ABSTRACT

This research study explored how clinical social workers perceive their practice with clients who self-identify as artists. The study was based on qualitative interviews with 13 participants who described their clinical experiences with people who self-identify as artists and discussed whether they believe that this type of client is clinically distinct. Using grounded theory (Engel & Schutt, 2013), the study analyzed responses, clinical examples, nature of interventions, and personal reflections that each participant shared about her or his practice. Case vignettes provided real-world examples of the great satisfaction participants feel about their work with so-called artist-clients as well as concrete and conceptual challenges they face in practice with this population.

While the study investigated the practice implications of working with the artist-client and explored how the self-identity of this so-called type seems to have unique clinical attributes, participants did have some difficulty categorizing all self-identified artists as a special population. Still, almost all stated that they feel that some specific practice implications do exist for working with this type of client. Despite the fact that this was a small exploratory study, the research offers the field a nuanced description of the characteristics of this type of client (the artist-client) and offers clinical examples to illustrate the nature of interventions clinical social workers use in practice.

**THE USE OF SPECIALIZATION:
ARE ARTISTS A CLINICALLY DISTINCT POPULATION?**

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

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2016

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I want to thank the generous participants who kindly shared their fascinating experiences and observations of working with the self-identified artist. I hope to continue the conversations we began.

To friends and family who encourage my endeavors I also offer my heartfelt thanks: Sonya, who while writing her own thesis joined me for little treats and aimless walks; May, who patiently reminds me that I am whole; Alex, who has been my teacher and comrade in the mental health field and reminds me to “love the work!”

To my love, James, thank you for pushing me to think more deeply—while providing comfort when it is most needed.

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CHAPTER I

Introduction

In the artist of all kinds I think one can detect an inherent dilemma, which belongs to the co-existence of two trends, the urgent need to communicate and the still more urgent need not to be found. This might account for the fact that we cannot conceive of an artist's coming to the end of the task that occupies his whole nature.

Donald Woods Winnicott

The field of social work includes a wide variety of professional positions (e.g., caseworker, psychotherapist, administrator, organizer), each of which role must, professionally speaking, consider three areas of practice: micro, mezzo and macro. While such terms may sound vague or perhaps alluring, they are traditional social work perspectives, with “micro” referring to individual work, “mezzo” referring to practice that concentrates on the impact of organizational structures and institutional influence on communities, and “macro” referring to a practice focus on systemic change, such as lobbying for social policies and addressing complex social issues.

Previous Research

In an effort to professionalize social work, there have been a series of educational models and pedagogies to train students on its fundamental skills and philosophies. Whether a social work curriculum adequately prepares students to become competent social workers remains in question, however, and is a central concern of this study. In the United States, for example, the Council for Social Work Education (CSWE) has been the arbiter of accreditation since 1951 (Robbins, 2014). Most recently, CSWE made Competency Based Education (CBE) the standard used by social work schools nationwide and with its implementation came a series of “core competencies” designed to train and measure the skills with which students are equipped (or not)

to utilize in real-world practice. In 2008, CSWE identified “critical thinking” as one of the core competencies that a social work student must learn in order to be able to “augment creativity and curiosity about their field” (Guidelines, 2008, p. 4). Since its latest revision in 2015, however, “critical thinking” no longer exists as a fundamental skill; instead, it is bulleted in several areas of CSWE’s Educational Policy Accreditation Standards (EPAS) document, which Gambrill, Green, and Baskind (2001) argue is an integral part of a social worker’s capacity to “critically appraise” the findings of social work research (p. 232).

While knowing that a social work education undergirds the basic training of all clinical social workers, this study reflected on how specialized skills factor into real-world practice with distinct populations. Since social work strives to understand the multiple dimensions of a person’s suffering, the impetus for this study was to discover if there are shared traits among clients who self-identify as artists—that is, to further understand if clinical social workers conceive of them as distinct and require a special set of skills.

The Study

To contextualize the use of specialization in social work practice, the literature review in the next chapter presents an overview of professional accreditation as it relates to licensing and postgraduate training with particular emphasis on whether self-identified artists might constitute a so-called special population in terms of practice (approach, skill set, etc.).

The study reported in this thesis document consisted of interviews with 13 clinical social workers who work with people who self-identify as artists. The participants (13 workers) were asked a series of semi-structured questions (Appendix F) intended to explore their clinical experiences, including conceptualizations of this client type and their use (if any) of special skills. The two eligibility criteria for participating in the sample were: (1) credentials as a

practicing social work clinician and (2) current or previous practice with one or more persons who identified themselves as an artist. Interviews were conducted both in person and over the telephone, depending on geographic proximity to me. Participants were found through snowball techniques and targeted recruitment using letters and emails describing the study within the agency where I was placed (Appendix C), listserv postings (Appendix D), and direct emails (Appendix E).

Contribution to Social Work

The relevance of this study comes from the fact that specialization does indeed occur in social work practice. In fact, there are countless so-called special populations but little to no research on what actually constitutes a population as distinct, and different in terms of practice from other populations. This is also true as it relates to people who come to social work as self-identified artists; and the paucity of literature reveals a need to better understand clinical practice with this population, since there are indeed social work practitioners who do appear to either specialize in working with self-identified artists or whose caseload includes such types.

Through qualitative interviews with practitioners who offered an abundance of details about their work including clinical examples, interventions, and personal reflection, it would seem that the “artist-client” is, in fact, a distinct type in terms of practice and therefore, probably does constitute a special population. Hopefully, these findings will help clinical social workers to better understand the special needs and clinical implications of practice with self-identified artists. Finally, it was an aim of this study in and of itself to use critical thinking by *augmenting creativity and curiosity about (the) field* (CSWE, 2008, p. 4), which might encourage CSWE to elevate and once again emphasize this core competency as a valuable social work skill rather than subsume it (critical thinking) in bullet form under important skills!

The next chapter offers, as noted above, a review of the pertinent and related literature on the concept of special populations in social work practice. A chapter follows that on the methods used to implement the study. The next chapter presents the findings of the study, including the characteristics of the sample. The final chapter offers a discussion of the findings as well as suggestions for future research.

CHAPTER II

Literature Review

As a clinical social work student, I am often asked an ostensibly simple question: *What population do you want to work with?* Beyond answering, *People*, the question itself has often made me wonder: *What constitutes a population—and what might make it special?* To better understand this phenomenon, I began to research the use of specialization within the field of social work. I discovered a complex history of social work education, accreditation, and licensing that obfuscates the actual skills that clinical social workers incorporate into daily practice. Specialization as a concept—meaning a professional practice focus—compelled me to develop a study that would ask practicing social work clinicians about how they conceptualize and work with people they (we) call “clients.”

As a context to understand the phenomena of specialized work, this research review considers the person (i.e. client of the social work practitioner) who identifies *primarily as an artists*. In short, do artists require a certain mind-set or specialized skill set in and/or from a clinician in order for treatment to be effective? How do we know what specialized skills clinicians do in fact utilize in real-world practice? What do those skills actually look like and/or feel like in practice? In sum, the study described in this thesis asked the following question:

Are there practice implications for clinical social work with people who identify themselves primarily as artists?

My review will begin with an outline of the basic tenets of a social work education and its accrediting body. I make mention of how this relates to acquiring a clinical license and specialty skills for social work practice. Next, I provide examples of well-known clinical populations to reference the ways in which a specialty focus is incorporated into social work curricula and

practice. Finally, I surmise about clinical characteristics of artistic people.

A Short History of Accreditation

In the United States, after the establishment of the Council for Social Work Education (CSWE) in 1951, there began a series of standards and guidelines to accredit schools across the country to prepare future social work clinicians (Robbins, 2014). Since then, CSWE has continually revised its guidelines for both Bachelors of Social Work (BSW) and Masters of Social Work (MSW) programs to reflect changes in the field of mental health. In 2008, a philosophical shift moved curricula toward a competency-based education (CBE). Implemented by CSWE as Educational Policy Accreditation Standards (EPAS) to reflect core competencies, CBE became the gold standard of social work education. As a requirement for accreditation, a CBE curriculum enacted a new paradigm of learning and with it a number of challenges, including how to both measure practice skills and test for competency. From an international perspective, Malan (2000) summarizes the historical use of an Outcomes-Bases Education (OBE), which touts a similar pedagogical approach to CBE. I imagine CBE as a nugget nestled within OBE, similar in shape and construct. Malan (2000) explains that CBE gained prominence in America in the late 1960s based on concerns that students were not adequately prepared with “skills they require in life after school” and that therefore, more flexible ways to pace themselves were needed until they could test for competency (p. 23). To remedy this situation, Laitinen (2012) recently suggested that time-based units translated to credit hours to measure for educational achievement despite little evidence of a relationship between time and learning. In fact, Laitinen (2012) argues, “If credit hours truly reflected a standardized unit of learning, they would be fully transferable across institutions” (p. 7). Thus, with an ambiguous definition of what CBE actually means in relation to myriad other educational-based acronyms, it is hard to

gauge how useful it is to accredit students as social workers with this model of learning. In response to this, Frank, Mungroo, Ahmad, Wang, De Rossi, and Horsley (2010), who conducted a systematic review of the various definitions used for CBE, finally created their own version, which “de-emphasizes time-based training and promises greater accountability, flexibility and learner-centeredness” (p. 636). Nonetheless, both proponents and critics of a CBE model agree that as a standardized set of competencies it “satisfies a legitimate public demand for accountability” and gives “greater credibility to professional education” (Kovacs, Hutchison, Collins & Linde, 2013, p. 231).

Social work as a profession has mostly adopted a CBE model internationally, although Australia and the United Kingdom have long used this approach. Even so, there is still little consensus of its outcome. Lymbery (2003), who wrote about competence-based social work education in the United Kingdom, argues that it oversimplified and obscured the complexities that lie inherent in the work. Rather, he asserts, social workers are required “to synthesize information from various sources” and believes that “good assessments require the exercise of a social worker’s creativity” (p. 113). Furthermore, CBE is defined differently in other fields of practice, such as medicine and psychology, and its implementation in professional educational settings is not fixed but fluid. After exposing debate around the utility of CBE and its influence on accreditation (mostly for reasons of its rigidity in design), I now discuss its amorphous use in real-world practice.

Competency Based Education (CBE) as Bulwark

More recent calls for a change to CBE structure cite critical thinking as a compromised competency skill. Back in 2008, when CBE was first implemented by CSWE, “critical thinking” was part of an “explicit curriculum” (see: “*Educational Policy 2.1.3 - Apply critical thinking to*

inform and communicate professional judgments”). However, in CSWE’s latest revision, finalized in June of 2015, the competency skill for “critical thinking” changed from a skill for social workers to master and utilize in their daily practice to a term peppered throughout the guideline document under various other competencies. The rather vague direction to “apply critical thinking,” makes it difficult to understand how social work students are taught to think critically about their work in the field. The previous definition was operationalized to emphasize a crucial need for social workers to use critical thinking to *augment creativity and curiosity about their field* (CSWE, 2008, p. 4). In contrast, the recent version de-emphasizes critical thinking, and as Gambrill, Green, and Baskind (2001) aptly address in an editorial that summarizes revisions made to CSWE, “if social workers are to draw on research findings as required in the NASW Code of Ethics, they must have the skills to critically appraise these findings” (p. 232).

Does the social work license exam ensure competency? One study published in 1999 analyzed how the American Association of State Social Work Boards’ (AASSWB) licensure exams compared to CSWE’s Master of Social Work (MSW) curriculum requirements. What resulted was a large disparity between the ideas of educators and practitioners. For example, Black and Whelley (1999) argue that despite a shared commitment to prepare competent social workers, the licensing exam does not reflect “prominent educational commitments such as cultural and social diversity, ethics and values, social welfare policy, and research” (p. 74). Attending social work school and taking the license exam ensures that students have obtained enough competencies to protect the safety and welfare of their clients. Despite this, Shimberg (1981) points out a need for licensure exams to reflect job activities that have “criterion-related validity” based on the actual skills employees must perform and by which they must abide (p.

1143). Thus, in the same way that students are taught to develop a therapeutic alliance with their clients, it would behoove educators and practitioners to collaborate more on the exam requirements so that both academic and real-world goals are met rather than what may be considered a “parallel process” (Black & Whelley, 1999, p. 75).

Protecting the public: a continuing education. There is much written about requiring licensed social workers to enroll in continuing education to develop specialized skills. To encompass the wide-ranging issues that this entails would detract from the central subject of my study. Suffice it to say, therefore, that there is great pressure put on social workers to engage in clinical courses that keep them current in evolving (and revolving) evidence-based practices and that the related issue of how to make continuing education “accessible, affordable and tailored to the context of social work practice” is a growing problem in the field (Martin, 2014, p. 227). In England, for example, Moriarty and Manthorpe (2014) recently researched the efficacy of a requirement for continuing professional development (CPD) as part of an initiative to regulate professions in a cost-effective way, such as enrollment in courses offered by membership organizations. However, when the researchers surveyed social workers to assess if post-qualifying programs were helpful, little evidence showed that CPD was actually effective (Moriarty & Manthorpe, 2014).

Working in the field. Once a clinical social worker is in practice, the role of a supervisor is to help the clinician to process and work through aspects of the therapeutic work as well as to ensure that ethical and practical boundaries are maintained. In a climate of managed care programs, in which “issues of accountability and performance management rather than supportive and developmental functions” are the focus, social work clinicians often seek *external* supervision for help with their clinical skills, which reveals how burdened supervisors are with

managerial duties (Martin, 2014, p. 230).

With this brief overview of social work accreditation and how it relates to clinical licensing and practice, I next describe populations in the field of social work with a specialty focus.

Specialized Populations

Around the turn of this century, Rosen, Slotnik, and Singer (2003) conducted a comprehensive study to assess whether social workers were adequately prepared to serve the needs of an aging population. Their goal, using data collected by the Strengthening Aging and Gerontology for Social Work (SAGE-SW) project, was to “gerontologize” social work education to include competencies and specialized skills (Rosen et al., 2003, p. 26). The study cites several hindrances to incorporating gerontological practice, such as “inadequate resources” of trained faculty in this concentration as well as funding for related studies, a “limited opportunity to specialize” for MSW students who may have an interest in working with older clients but cannot enroll in elective courses that relate to such specialization unless they have a concentration in this area, or for BSW students whose education is generalist in nature. Notably, all survey respondents indicated *continuing education* as the “primary source of gerontological education and not the social work academic curriculum” (Rosen et al., 2003, p. 28-29). Their study further reflects on specialization in social work as “resource intensive” and describes a semantic confusion between “specialization” and “concentration,” with the former considered “a subset of concentration” (Rosen et al., 2003, p. 31). The question, then, is how a specialty practice becomes part of a social work curriculum. Rosen and her colleagues (2003) identify two ways of including specialized content: *infusion* which may be thought of as a “pouring” of content into all areas of the curriculum and *integration* to coordinate “uniting of content with the rest of

curriculum” with no designated model but rather a *commitment to integrate* (Rosen et al., 2003, p. 31). That said, it is important to note that social work educators have long contested the integration vs. infusion model and that the hurdles to change content in social work curricula are many.

Subsets of Older Adults

Related to the aforementioned example of how social work curricula respond to specialty work, it is generally understood in the field that older adults comprise a clinical population. In fact, in terms of social work practice, several subsets of older adults exist that further address a need for specialty care. For example, clinical skills for social work with older Asian Americans, researcher Hong (2014) suggests, are largely due to a patriarchal social structure in Asian families that tend to value interdependency among family members. This notion of filial piety is considered distinct from a Western notion of a welfare system, which exists alongside a cultural stigma of mental illness that prevents many Asian Americans from accessing mental health services (Hong, 2014). In addition, Mokuau, Garlock-Tuiali'i, and Lee (2008) identify “worldviews and values emphasizing a collectivist orientation” as key issues for Asian and Pacific Islander clients, who they cite “have lower utilization rates of formal services when compared with other ethnic groups” (p. 118).

Practice with older gay and lesbian adults is considered another area of specialization. As Langley (2011) states, “although the presenting problems may be the same for ‘straight’ clients, solutions need to be seen in the context of the particular needs, vulnerabilities and strengths of older lesbian women and gay men” (p. 917). Her study finds oppression and heterosexism are salient issues for older lesbian and gay clients, especially in the experience of “referral, assessment and review” documents that implicitly ask a client to “come out” due to a

heteronormative framing of questions (Langley, 2011, p. 928). The results of her study reveal a need to develop an “anti oppressive and empowering practice” to educate clinicians about the lived experiences of minority clients (Langley, 2011, p. 926). An example of how this relates to clinical practice is refraining from asking a client to declare his or her sexuality during an intake interview.

Queering the clinical practice lens. This is easier said than done, Willis (2007) notes, regardless of age. In their review of how a queer perspective can be incorporated into social work practice, Willis emphasizes the use of narrative therapy techniques from an “interpersonal level” as “most compatible with the critical stance of queer theorists,” further outlining several aspects of this approach, such as: “avoiding assumptions, encouraging individuals to author their own sexual experiences, questioning sexual and gender binaries, and challenging heteronormative values” (Willis, 2007, p. 192).

Cultural Competency Takes Practice

In addition to working with older adults and LGBTQ populations, much research has been written on developing practice models that are culturally competent, and part of this movement recognizes that clinicians are not neutral. As recent as this year, authors Sue, Rasheed, and Rasheed (2016) have outlined a culturally competent approach to social work practice that asserts the following: “Given the multiple dimensions of identity and the complexities of culture that present tensions in social work practice, it is essential that social workers develop an in-depth understanding of what cultural competence is and how it can be implemented” (p. 22). Minority clients often require specialized skills for this reason. Another recent study by Jones and Guy-Sheftall (2015) evaluates the use of a feminist theoretical orientation with black female clients. What these researchers discovered was that feminist therapy as a clinical approach falls

short when it comes to the specific struggles that black women face, such as “marginalization and discrimination” beyond gender issues (Jones & Guy-Sheftall, 2015, p. 344). In light of this, their study reviews several black feminist therapists who advocate for therapeutic methods that “incorporate a fundamental understanding of black women’s historical, sociocultural, familial, and developmental heterogeneity” (Jones & Guy-Sheftall, 2015, p. 344). On a broader level, Organista (2009) addresses the specific needs of a Latino population by developing a practice model that consists of a “matrix of four major dimensions of culturally competent practice” to target both generalist and specialized practice levels (p. 297). These four dimensions include: (1) an increase in service and access as well as (2) noting the barriers that prevent Latino clients from obtaining social services, (3) culturally and socially acceptable interventions, and (3) increased accountability (Organista, 2009).

“As social workers we need to understand the worldviews of the clients we hope to serve” (Sue et al., 2016, p. 8). With an understanding that “isms” lie inherent in the work, social workers must recognize their social location within a constellation of lived experiences that include racism, sexism, classism, ableism, and heterosexism as real *and* socially constructed realities. It seems fair to ask, therefore, if we can consider the client who self-identifies as an artist to have a worldview that requires specialty skills. To speculate on how a worldview might shape the artist-client seeking social services, I now surmise about some clinical characteristics of this so-called type of client.

Some Thoughts on the Artist-Client

Before I begin, it is important to define the language used for this study. In order to provide parameters for my research, I operationalized the term “artist.” This helped participating clinicians to discern the type of person (client) in whom this study was particularly interested.

Clinician participants were asked to define the client in question as a person who identifies *primarily* as an artist as opposed to being interested in the arts or very creative. My study's central focus was on the "self-identified artist" within a therapeutic dyad. This "self-identified artist" may also be referred to as "artist-client" throughout the study. What follows are other relevant terms used with participants in the study and in this document: "client" is used interchangeably with "patient" depending on the writing; "treatment" or "services" refer to psychotherapy as a modality used by clinician participants (all social workers by education and training toward intra-sample consistency) for clients seeking help, although it was possible that their theoretical orientations varied within the broad professional construct of social work. The goal was for the study to discover whether or not there are in fact shared qualities among clients who self-identify as artists. To further examine this question, I will discuss ideas other writers and researchers have put forth concerning possible characteristics of the artist-client.

Clinical Implications. What makes the artist special in a clinical sense? According to McWilliams (2006), who wrote about schizoid dynamics as it relates to creativity, there is a familiarity with primary process thinking, which she found essential to developing insight:

I have been impressed repeatedly with the phenomenon of the highly creative, personally satisfied, and socially valuable schizoid individual who seems, despite an intimate acquaintance with what Freud called the primary process, never to have been at serious risk for a psychotic break. The arts, the theoretical sciences, and the philosophical and spiritual disciplines seem to contain a high proportion of such people (p. 4).

Her thoughts on schizoid dynamics in the therapeutic dyad derive from the subjectivities of people who do not fit the diagnostic category of "Schizoid Personality Disorder" as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR, 2000). McWilliams

prefers a less pathologizing version of schizoid psychology inferred from a psychoanalytic understanding of their special proximity to the unconscious. She notes, “Schizoid people are not surprised or put off by evidence of the unconscious” and believes that schizoid people’s intimacy with primary process thinking makes them especially suitable for psychoanalysis since they more readily access ideas that lie out of awareness for others (McWilliams, 2006, p. 5). McWilliams further asserts that schizoid individuals are stigmatized because “the rest of us unthinkingly reinforce in one another the assumption that our more mainstream psychology is normative” (2006, p. 6). Another aspect of her definition concerning “schizoid” is the recognition that such persons have a deep need for solitude and yet desperately crave connection with other people. Books based on the subject of the “highly sensitive person” (see popular titles, such as Elaine Aron’s research on the “HSP” published in 1996), describe similar characteristics of being deeply empathic yet overwhelmed by interactions with people. She states that she has never seen a schizoid patient “whose reclusiveness was not originally conflictual” (McWilliams, 2006, p. 7). Perhaps there is a relationship between the so-called schizoid (or highly sensitive) person and the client who identifies as an artist.

As McWilliams (2006) suggests, artists may engage more easily with psychological processes and are less defensive of what they observe from within. Carl Rogers (1954) suggests creativity is “dangerous” in a conformist society, and notably, his working definition of an artist necessitates that a product should come out of a creative process, i.e., a work of art (p. 249). This work of art is produced by a creative individual, and yet the “product is not the individual, nor his materials, but partakes of the relationship between the two” (Rogers, 1954, p. 250). Similar to McWilliams (2006), he imagines that these individuals are more “open to their experience” and further suggests that the artistic product is something novel and unique to creativity (Rogers,

1954, p. 253). Therefore, artists may view their unconscious as less foreign, or less ego dystonic, than others and may choose to live in ways that resist society's implicit rules. In turn, by their resisting conformity they are able to create something new, out of their imagination.

A relative sense of time. Elliott (2011) advocates the use of art-making and narrative techniques to apply therapeutic interventions and describes a liminal experience in which the artist inhabits. She defines this imagined space as “between remembrance and anticipation” or simply “a realm of possibility” (2011, p. 96). Similarly, Graves (2009) considers another liminal experience in which the artist is easily “lost in time” while making art (p. 75). For example, if an artist is engrossed in a creative act she might forget what time of day it is or when she last ate. The result of this lost time may be understood as an expansion of time itself in which a work of art is the product. This involves risk, Graves states, as “an engagement with the unknown” (2009, p. 76). Thus, are artists more familiar with this kind of risk-taking, and if so, what might be the implications for clinical practice? Her central argument centers on “interest” as a “capacity to be engaged, to succumb to curiosity, to be distracted” (Graves, 2009, p. 75). There is also the ability, she argues, for the artist to “make time” through the act of doing work, all the while knowing that it can never “finish” (Graves, 2009, p. 75). Thus again, a relative sense of time may be applicable to the artist-client.

The unconscious as artistic material. Pazagli and Rossi Monti (2010) discuss works of art operating within the language of images, which they believe possess a power to open up “psychic passageways” (p. 733). They cite film as an artistic medium to explain this process. While watching film, the subjectivity of the viewer mingles with the film's narrative to create a representation unique to the person recalling/and or retelling its plot. In their view, works of art share “points of entry” into unconscious material and suggest that the artist is especially adept at

accessing them (Pazaggli & Monti, 2010, p. 734). Therefore, using a language of images might rouse the unconscious to enter the preconscious. Pazzagli and Monti (2010) understand this as a form of psychic play that an artist may engage in more naturally than other clients.

As the examples above describe, it seems that artists possess a learned receptivity to signs from the unconscious that serves to fuel their creativity. Another clinical example by Phillips (1998) uses literary artists Henry James and John Keats to demonstrate how the role of inspiration derives from a “kind of actively alert, passively available act of transformation, not unlike Freud’s dreamwork” (p. 84). He describes a trained artistic ability of the artist to pick up on “hints” in what people say through “unconscious radar for affinities” (Phillips, 1998, p. 84). This comes in the form of something inspiring yet unintentional in its packaging. A useful interpretation in analysis, he points out, cannot predict how people will react; but a client’s free association might produce a revelation. This subtle hint, as Phillips (1998) illustrates, “speaks to one by calling up one’s own voice” (p. 84). In this sense, a person who said or did something remarkable may be unaware of what so-called hint she revealed to the artist by doing so. Thus, if it is the unconscious language of another person that serves to spark creativity in the artist, is there a way that clinicians incorporate this capacity when offering interpretations to artist-clients?

There are endless possibilities for how to conceptualize clients who identify primarily as artists. This review of the related literature serves as a mere starting point. It describes the artist-client as possibly more apt to use primary process thinking, possibly having schizoid tendencies that may positively affect therapeutic interventions and ways of conceptualizing salient issues that particularly advance the work, possibly able to suspend time and inhabit a liminal space through which they are more receptive to inner thoughts, and perhaps especially adept at

developing and using insight because of their astute ability to create works of art from “hints” they receive from observing and listening to other people.

Conclusion

After surmising about the ways in which a so-called “artist-client” might be clinically distinct, it feels necessary to refer back to a central tenant of social work as a discipline and a profession that aims to serve and understand people within a complex system that contextualizes individual biology, psychology, and environment. As a professional practitioner one must examine the micro, mezzo, and macro aspects of an individual’s life to identify symptoms (seen as the ways in which the client suffers) and also keep in mind the contributing factors of presenting issues. This reflects back to social work accreditation. With recent calls for more research on accreditation and its utility, as well as the identification of critical thinking as an important skill for CBE by the American Psychological Association Task Force (2006) that is no longer required but only suggested (Robbins, 2014), one wonders if there is space for clinical social workers to be curious—and think creatively—about the clients they serve. This question is what initially drew me to consider the use of specialization as a topic of study.

How do we decide populations are worthy of being conceptualized as special, and thus, worthy of particular study (knowledge, skill set, etc.)? Does thinking critically factor into the decision to designate a special population? In the next chapter, I present the methods I used to carry out the research that aimed to answer the very question with which I began this review: *Are there practice implications for clinical social work with people who identify themselves primarily as artists?*

CHAPTER III

Methodology

To pursue my thesis question about whether people who identify primarily as artists might be a special population, I chose to use an exploratory, qualitative design as my research method. Within the realm of qualitative research there are varying approaches, as well as philosophical underpinnings, to collect and interpret data. I chose to use grounded theory, which Engel and Schutt (2013) define as a way to “build up inductively a systematic theory that is grounded in, or based on, the observations” (p. 600). To the best of my knowledge, no prior research exists on my specific topic and therefore a careful analysis of what clinical social workers reported in interviews was the “evidence” I sought, “which refers to the narrator’s own words...central to content analysis” (Steinberg, 2004, p. 120). The findings of my research are not meant to be generalizable but instead serve as way to think critically about how special populations come to be. The research was conducted using in-person interviews, and telephone interviews if the participant lived outside of New York City or preferred to be interviewed this way. Interviews were semi-structured and used open-ended questions to gather narrative data about the subject of my study (see the Interview Guide, Appendix F).

Sample

The eligibility criteria for my study were as follows: (1) participants had to be practicing clinical social workers with licensed credentials at the time of study (theoretical orientation was not specified); (2) they must either advertise their work with artists as a focus in practice (via professional website, brochure, business card, etc.) or believe that they work with people who identify as such; (3) the client(s) they chose to represent in the interview must identify primarily as artist. The research excluded participants who are not licensed clinical social workers and do

not believe they currently work or have worked in the past with clients who identify primarily as artists. I relied on self-reporting of participants to determine eligibility. The final sample consisted of 13 clinician participants.

To identify and recruit appropriate participants I prepared various forms of documentation that included information about my research topic, eligibility criteria, and a summary about the nature of my study. This included a recruitment letter approved by the clinical director of Training Institute for Mental Health (Appendix B) that was printed and distributed (Appendix C) in the mailboxes of fellow staff at the clinic, where I was placed as an intern at the time of study; a posting on listservs (Appendix D) to which clinical social workers subscribe, direct emails (Appendix E) to clinicians in my professional network (to forward to potential participants) as well as direct emails to clinical social workers I had identified in professional listings, brochures or business cards. The Human Subjects Review Board (HSRB) at Smith College approved each document prior to my conducting any outreach efforts.

Recruitment

To find participants for this study, I used nonprobability methods that included a combination of convenience and snowball sampling. These sampling methods are suited to exploratory research, and as Engel and Schutt (2013) point out, convenience sampling, also known as “availability” is recommended when the researcher “is exploring a new setting and trying to get some sense of prevailing attitudes,” while the use of snowball sampling “is useful for hard-to-identify populations for which there is no sampling frame” (pp. 258-264). Since it was difficult to know if I would be able to find a large enough sample to interview about the specific subject of my study, these methods offered flexibility and way for participants to share my contact information to recruit others.

After initial contact with potential participants, I sent them a copy of the HSRB-approved informed consent (Appendix A) and made myself available to answer any questions about consent as well as the nature of my study prior to the interview. Upon agreement to meet for an interview, arrangements were made to either find a quiet public setting or a private office to conduct the interview. If the participant was interviewed over the telephone, a designated date and time was scheduled. Both scenarios required that a signed informed consent form be collected before the start of the interview, and this was obtained either through email sent by the participant as a PDF file or in person on the date of the interview. At the start of the interview, whether in person or over the telephone, I reviewed the informed consent form again in order to leave room for any questions or clarification the participant may have and also to ensure that they understood the requirements and limitations of their participation. The participant was then given a copy of the informed consent to keep and was advised that s/he could refuse to answer any questions and had the right to withdraw from the study within two weeks after the date of the interview.

Ethics and Safeguards

The Smith College School for Social Work's Human Subjects Review Board (SCSSW HSRB) approved my study before I began research with participants. This approval ensured ethical safeguards such as informed consent, voluntary participation, and a clear and understandable explanation of what the data were to be used for. All participants in the study were provided with informed consent forms (Appendix A) and time to ask questions about the study before the interviews took place. The informed consent forms were stored separately from notes and transcripts of interviews, and each participant was assigned a code number to de-identify his or her name from the data. Participants were instructed to keep the content of the

interview as well as the identities of the clients with whom they work confidential. In addition, any content from interviews that was identifiable, such as details or anecdotes involving clients or work settings, was de-identified so that no reader of my final thesis, or of any writing that may evolve from it, could guess the identities of participants or their clients.

There were minimal risks of participation. Each participant was asked to report his or her own impressions of clients who fit the criteria of the study, which included clinical experiences, personal reflections, and any theoretical ideas or readings they wanted to impart on the subject. There was a risk that participants could become uncomfortable speaking about their work with clients who identify primarily as artists, or about the nature of their practice and related clinical skills in relation to working with a perceived special population. There was also a possibility that participants may not be able to answer my questions, which could cause discomfort. However, participation in my study was voluntary, and I emphasized that my intent was not to judge their work but rather to learn from their experiences. I also made it clear to participants that they could decline to answer any question at any time or could end the interview. Interviews were held in private locations when possible, such as the participant's office or an office used in the clinic I worked in at the time of study, with permission from the clinical director (Appendix B). The participant also had the option of meeting in a quiet public setting or being interviewed over the telephone.

Due to limited monetary resources, I was not able to compensate participants for their time. However, I was able to accommodate any participant who chose to have a beverage or snack during the interview. Benefits to participants in my study included an opportunity to reflect on their work with clients who identify primarily as artists, opportunity to educate me on

their area of perceived specialization, and the knowledge that their observations contributed to research on this subject and that their reflections may constitute a basis for further study.

All research materials including recordings, transcriptions, analyses, and informed consent/assent documents have been stored in a secure location and will continue to be so stored for three years beyond this publication according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed and then destroyed. All electronically stored data has been password protected and will remain so during the entire storage period.

Data Collection

Qualitative data were collected first from the transcriptions and then from hand-written notes of individual interviews. Each interview was allotted 60-90 minutes and recorded with a digital audio recording device with the participant's permission. This amount of time provided space to describe my study, ascertain the participant's interest and eligibility, and time for any questions they had concerning consent forms or the nature of the study. I transcribed the data by listening to the recordings on my personal computer and then coded the material for analysis. Interview recordings were deleted thereafter. During analysis I made every effort to maintain a neutral stance, using the coding process to search for disconfirming data and incorporating an understanding of "tacit knowledge" as evidenced by nonverbal behaviors I observed during the interview between the participant and myself (Engel & Schutt, 2013, p. 590). As researchers Vaismoradi, Turunen and Bondas (2013) point out, "It is the responsibility of researchers to conduct data gathering in such a way that any complex data would be suitable to present interesting findings" (p. 402).

While in-depth interviews allowed for open-ended questions and probes to elicit detailed responses, the limited number of participants as well as a broad sample frame make the findings impossible to generalize. That said, this approach was “interpretivist” in nature, which derives meaning from the belief that “social reality is socially constructed and the goal of social scientists is to understand the meanings people give to reality” (Engel & Schutt, 2013, p. 120). Thus, it must be noted that my own preference for this type of research analysis, as well as my perspective on the topic, may have influenced interviews with participants in implicit ways. With that in mind, reliability was sought by using the same semi-structured interview guide for approximately the same length of time with each participant.

The development of the semi-structured interview guide (Appendix F) aims to address participants’ work setting, theoretical orientation, thoughts about clinical specialization and related skills, and experiences with the subject of study, i.e., people in clinical social work treatment who identify primarily as artists. For example, participants were asked if they believed that there are clinical implications for working with people whose primary self-image is that of an artist, and if so, to provide examples of those implications. Further, participants were asked if they believed that any theories or theoretical orientations apply to social work with this type of client, regardless of presenting problems. If so, how was this understanding incorporated into practice? If not, why not?

Data Analysis

In summary, this research used a qualitative method of analysis and grounded theory (Engel & Schutt, 2013) as its theoretical foundation, allowing flexibility as well as feasibility for the scope of the project. The data collected from interviews were summarized into conceptual categories (i.e. themes) that were coded, continually refined, and linked through the “frequency

and distribution of phenomena,” an “iterative and reflexive process” that began with the transcriptions and notes from interviews (Engel & Schutt, 2013, pp. 577-600). This process allowed for a nuanced understanding of how participants responded to interview questions, and with these data I could interpret themes that arose and through the “story” ultimately created for this particular sample, answer the overall research question. My findings are presented in the next chapter.

CHAPTER IV

Findings

As described in the literature review, the intent of this study was to explore the use of specialization in clinical practice as it relates to distinct populations. My research question focused on the person who seeks social work services and identifies primarily as an artist. The interviews conducted with 13 social work clinicians yielded findings, presented below, that address this question.

Qualitative interviews with participants describe nuanced clinical experiences related to work with self-identified artists. The interviews explored whether specialty practice and its related skills factor into social work training, and if so, how this might affect a conceptualization of the artist-client. Participants further reflected on the difficulty of categorizing the self-identified artist as clinically distinct. Through interviewing subjects about this topic, themes emerged about the ways in which art and art making are integral to a person's identity as social work client and his or her worldview, illustrated through clinical examples provided by participants as noted below.

The Sample and its Characteristics

For the purposes of this study and to ensure confidentiality of its participants, the demographic information collected was broad in scope. What is known about participants is presented in long form versus a chart to review the fundamental characteristics of the sample. Other than the clinician's practice setting and theoretical orientation, no other personal information is known or recorded. Therefore, an informed reader would have difficulty identifying a single participant based on the information presented.

Practice Setting and Population

In pursuit of practice implications for clinical social work with people who identify themselves primarily as artists, this research study examined the responses of 13 participants, nine of whom described working in private practice. At the time of study, one participant solely worked clinical hours while training at a psychoanalytic institute with an LMSW degree; two worked in a private practice fee-for-service system in addition to clinical hours while training in a psychoanalytic institute with LMSW degrees. One worked in a mental health clinic with a LMSW degree and is in training at a psychoanalytic institute. One worked in private practice based in a psychoanalytic institute with a LCSW-R degree. Two had home-based offices and are licensed with PhD and LCSW degrees. Two work in private practice as sole proprietors with LICSW degrees in a suite of offices. Finally, four participants worked in private practice as sole proprietors with LCSWs in a suite of offices.

Theoretical Orientation

Out of 13 participants 12 identified being either “psychoanalytically informed” or “psychodynamic” in their theoretical orientation. One identified an “attachment-based theory” orientation with “cognitive behavioral techniques as needed.” Five used the term “eclectic” to describe their approach, and all participants incorporate various theories and techniques in practice, such as: Eye Movement Desensitization Reprocessing (EMDR), cognitive behavioral technique (CBT), adaptive information and sensory motor processing, energy psychology, body-based somatic work; mindfulness and meditation; internal family systems, systemic and social constructivism, ego psychology and object relations, relational, Winnicottian, Jungian analysis, and life coaching.

Specialty Experience

At the time of interviews, nine participants were either candidates or completed psychodynamic and psychoanalytic training in an institute in the United States, four were certified in EMDR or completed a level of training for this. Various other courses and training programs included somatic experiencing, eating and the body, alcohol and drug counseling, employee assistance specialist, critical incidence and stress debriefing, couples therapy, emotional focused therapy, and positive psychology.

When asked to elaborate on specialty experience and its related skills, the following areas were noted: relationship problems “particularly separation, divorce, remarriage and step families post divorce parenting,” “mental health and the arts,” trauma, anxiety, eating disorders, gender concerns, women’s issues, family therapy, body-based therapy in group work, gay men, first breaks with psychosis, transition to adulthood, identity issues, complicated grief and bereavement. When asked to name specialty skills that referred to the aforementioned, participants had more difficulty. Participants cited being “generalist” in their approach. Working with “analogies,” having perspective and “pulling a lens back as wide as possible, learning where anxiety is coming from and is in reaction to,” “helping people to negotiate challenges and distress” were all named as skills related to specialty training they received. Clinical examples provided throughout this chapter describe skills in relation to specific interventions.

Specialty practice was not offered in any of the social work graduate programs that participants attended. As one participant stated, “I wish there was more specialization, but there’s so much material to go over, and it’s such a broad field, so it really depended on the professor you had and what their specialty was.” Elective courses and concentrations were offered and

included substance abuse and addictions, cognitive behavioral therapy, object relations, work with victims of trauma, art therapy, personality disorders, eating disorders, adolescents and gender theory, and family and child therapy.

Client Population

All participants identified working with individual adults at the time of study. Some referred specifically to work with artists and “creative people,” adolescents and young adults, “college and graduate students in the arts.” Different modes of art making were referenced in relation to clients who self-identify as artists. Two participants worked only with actors in this category, one with musicians, and the remaining 10 named visual artists, writers, videographers and filmmakers, sculptors, fashion designers, and dancers as other types of artists. The characteristics of the sample suggest, therefore, a wide spectrum of practice and identities for clients within the category of “artist.”

Are There Commonalities Shared Among Artists?

In order to establish a working definition of what an artist is for purposes of this study, participants were asked only to speak about clients who identify *primarily* as artists. This particular definition de-emphasizes the type of art clients engage in and whether they are able to make a living at it. Most important, the *self-identity* of an artist was central to answering the study’s question about possible clinical implications for practice. All but one participant experienced difficulty with deciding if such clients are clinically distinct and frequently returned to the question during the interview to refine their answer.

More willing to engage in feelings. Participants often referenced their “artist” clients as “more in touch with their emotions” and having “little resistance” to questions like “How do you feel?” Clients were described as: “very willing to understand themselves,” “creative and

passionate,” “courageous,” “brave,” “constantly trying to make meaning from their experiences,” “having an expanded awareness and perception,” “more open and curious,” and a “willingness to dive into whatever is going on.” One participant noted, “[Artists] are all deeply sensitive. But I think everyone is when they’re given the space to be. It’s more on the surface with them...so you can tap into their experiences a little more easily.” Similarly, another participant described working with actors:

There’s a willingness on the patient’s part to put something out there, to be open about it, and willing to explore it... to bring it up in different contexts [i.e.,] personal history, personal life and their professional lives. So you get to see the issue as it plays out professionally as well as personally. In contrast, if someone has a corporate job that’s going well, it just goes on in the background and you don’t hear much about it...it gets segregated from the person’s personal life. With actors, the issues tend to turn up across their lives, and they’re willing to look at them and to discuss them; things tend to be less segregated and compartmentalized.

Somatic experiencing of emotions. The idea that artists experience their emotions primarily in their body was frequently mentioned. Interventions using mindfulness techniques and meditation were reported to be helpful, as well as noticing how the client presents symptoms by “being very aware of what’s happening physically with the patient as well as myself” one participant said. Another stated:

For artists very often the emotional experience is somatic in nature—very physical; they feel it in their bones. I will ask them where they feel something and they talk about a physical experience, while others talk about feeling it in their mind or with some kind of imagery, and artists often express it physically.

To explain how emotions manifest through the body and how this is worked through in treatment, the same participant used this clinical example:

A writer came in suffering from writer's block, and the emotion [she felt] was fear and this was not connected to a thought process it was just visceral fear. [The client] was blocked around a certain part of her novel. So when I asked her about where she felt this fear, it was in her hands, which, of course, is the end point of the body where the words come into the hands and into the computer she was writing on. So it made perfect sense that that's where it would physically manifest. So we didn't engage in intellectual process but just noticed the fear...and low and behold it would travel through different parts of her body and eventually it left her body. Then she started to have spontaneous ideas about where she was going to take her novel. So it was an example of a somatic experiencing of the emotion versus the intellectual.

Artistic identity derived early in childhood. Despite the fact that most clients seem to feel that they were artists from early on in their lives, several participants described how a struggle with self-acceptance outside of an artistic community was commonly shared. In terms of being an actor, one participant relates that clients "often mock it. They'll say, 'I'm an actor...' and then make fun of it. In their community they feel much more safe." Another participant stressed the importance of validating the identity of an artist:

If someone is an artist you really want to spend time with the incredibly difficult and complicated choice. Some artists will say they never had a choice to pursue a line of work or to have an identity. That is always a struggle because of the economics and our government, and society doesn't support artists. I also feel like they probably feel different, and it's interesting to know in what way. Do they feel different in a good way?

Do they feel proud of that difference? Do they feel weird, like people don't understand them? Do they feel like only another artist can understand them? When they're going through divorces you hear, 'Well I should have been with an artist...no wonder my partner can't understand what my needs are...'

A historical sense of feeling different was explored in the therapeutic process: "I feel there's some sense of alienation. They felt different; they felt separate. So usually their [artistic] practice is an attempt to make sense of that experience, that alienation." As to whether the client chose to make art or being an artist seemed inevitable, one participant noted:

I think that's another chicken and egg thing... You have to be a reasonably confident passionate person to make it to adulthood and still feel okay about saying 'I'm an artist,' and I separate that from other people who say 'Well, I'm kind of an artist, but not really, but kind of...like I do this thing...' People who are just willing to broadcast that identity and feel worthy of it are a confident bunch of interesting people.

Some people face ambivalence about being an artist and wrestle with making a decision to continue working in the arts. If facing a career change, as one participant explained, "It's a tough place to be...like stripping away a sexual identity or something... and it betrays so many years of hard work—their parents, their mentors." The participant then remembered a client saying, "This is all I've known" in reference to being an artist. An overlap between work and life—and being unable to separate the two—was another observation:

What I find is that artists, understandably, spend a lot of time thinking about art, and I'm not sure everyone else I see who has a career, often an interesting one, spends that much time thinking about it when they're not doing it.

Clinical Implications of the Self-Identified Artist

Most participants struggled to answer whether there are clinical implications for the artist-client. Several sought clarification and asked for examples. One participant responded by saying, “Artists aren’t formed by clinical implications,” although this same participant went on to note that “ADHD and organizational problems” are common among clients who identify as artists and that it is “hard to say what’s this or complex PTSD. Disorganization can be a traumatized reaction.” Interventions that this participant found helpful include “creating structure” and “coaching” in tandem with working dynamically; “[Dynamic] therapy left that out.”

Other participants noted various clinical diagnoses among artists. “Depression runs throughout,” said one; “Of the 90% of artists I work with, more than half have borderline features,” said another. After a long pause one participant said, “Sometimes I wonder about stimulus barrier...that they take in more information than other people, maybe. So I wonder about that awareness being detrimental to mental health.” Working primarily with a student population one participant said:

There are different self-esteem and identity issues in terms of their ability to create; there’s also an emphasis on what people think of their work which often gets translated to what people think of them and then how they may be attached to depression or anxiety simultaneous with wanting to be less depressed and less anxious...So that can create a conflict to be analyzed and worked with.

One participant used a clinical example to describe how a life event can affect an artist’s ability to create and its challenges to doing clinical work:

When an artist can't do their art because of extenuating circumstances, they get very sad and depressed, and it's very hard to fix that. I have a dancer client who gave birth to a child who is severely disabled, and so she had to put everything in her life on hold to be involved with the care of this child so now she can't dance...that's very hard.

Another respondent discussed making meaning and art as integral to an artist-client's well-being, and said:

Authenticity is really important, because in a way I think art is about this—struggling to find a deeper meaning. I also think that for some people it's like a compulsion...with musicians for example, I've noticed they have to play music, or else they don't feel balanced.

A fear of feeling better. There appears to be proximity between a person's resistance to feeling better and an attachment to what they believe is fueling their art. One participant stated, "I think there's a glorification of the 'tortured artist,' and I think it's really difficult for artists to envision being a happy artist and an artist that's at peace, because then what kind of work would come out?" The same participant used a clinical example to demonstrate how the idea of an artist might prevent others from acknowledging psychological symptoms:

For example, I was doing a differential diagnosis between 'psychosis' and 'art student.' He [the client] was talking about how he creates this world where the trees talk...and the way he was talking I was having a hard time thinking, 'Is this world in your head, or is it something you're drawing?' And what can be challenging with an art student is figuring out what's them being creative and what might be stepping into the realm of psychosis. That for sure comes up more with this population, and especially college students, because they're at that age of emerging psychosis and first breaks.

Another participant might sense that a person's art relates to a psychological issue but chooses to wait until the piece of art is finished to say something:

I am careful about saying anything about their ongoing work, because I don't want to steal their motivation. At the end I can share but wouldn't want to in the middle of their process. With other clients I wouldn't worry about this...I want them to get there [resolving internal conflict] as quickly as they can.

In terms of psychological health being a deterrent to doing "good" work, the same participant slightly contrasted this by saying:

[There's a] fear that therapy can inhibit the work because it's being fueled by their demons. So helping them to deal with this not getting in the way...I tell artists that the more feelings they can feel and express and the more they know themselves the bigger palate they have to enhance their work. I tell them this. But they worry about it and it makes sense that they do.

On choosing whether to recommend medication. Deciding whether to refer a client to a psychiatrist for psychotropic medication was an issue some respondents raised. One participant stated that she believes that medication appears to affect the artist's quality of life:

Sometimes I think that would be improved [with medication] but sometimes not.

Sometimes if an artist is properly medicated they can become very depressed even if they're feeling better, because they're not able to access more intense feelings, I think, like depression or mania or sadness...they're not afraid to really go there. So you have to keep that in mind too.

Another reflected that people who struggle with depression feel conflicted about whether to treat their symptoms; "[They] don't want to be depressed but are afraid: 'I make the best work when

I'm depressed' [the client might say]... With artists there's a focus on 'Would I be able to think the same way or create the same way [if taking psychotropic medication]?' In light of its dulling effect on people, this respondent feels some personal conflict about whether or not to even recommend medication:

With art students, a lot of the time they may have some elements of psychosis, but they're able to function and create work, and they're happy. Some of them want to take medication, and some of them don't. The thing is with antipsychotic medication... that really can dull your creativity. It's a reality, and so the conversation becomes different with an artist as opposed to a regular human being. Sometimes they do have to choose: do I prefer to be a little creatively dulled but be able to function better in the rest of my life? So that can be an issue that comes up with them, and that can be a challenge.

Later in the interview, the respondent noted, "Some artists I see who go on medication can actually do better work, because they're not so inhibited by their symptoms."

Participants shifted their view depending on the client and were undecided about how to handle the issue of medicating symptoms in general. One summarized the issue by addressing the discomfort it creates for the clinician:

The issue of medication is an interest within this frame of mental health and the arts: I need to understand and be open to patients who struggle with Bipolar I or II or maybe depression with psychotic features of hallucinations...or manic without depression. These individuals may not want to take medication to be able to do their work and that needs to be treated differently, with more patience or with more of an open mind. You really have to be mindful of their autonomy and how that's different from someone not in the arts,

and that's hard, because I would feel so much more comfortable if they were medicated... but they wouldn't.

Creative blocks. Four respondents discussed how creative blocks among clients are approached in practice. Using EMDR techniques, one participant discussed how an inability to create relates to "blocking beliefs," and as an intervention explained that, "In artists, very often the artistic block is a blocking belief, and so focusing in on this and deconstructing it to access a line of feeling that is about emotional responses very often can clear the block." Another aspect of creative blocks, this same participant reflected, is a focus on the intellect:

The danger of over intellectualizing with artists is a major problem. Many of my colleagues are trained in analysis and the theoretical concept that the mind will overcome emotional stress...but if you try to work with an artist that way, very often the analysis enhances the creative block. If you have an artist who uses their raw visceral responses to the world and channels that into a creation and you try to modulate that, you are going to remove the fuel that they use to create art. So if an artist is depressed I will try to use that depression into something they can use as opposed to remove that depressive energy. I am trying to change it into something they can use again. So if the root of depression is anger towards the self, I want to make them more angry whereas in traditional therapy, you might try to remove it. [By getting angry] they start to direct it into their art, and it moves and changes...and low and behold they start to feel better.

Another participant found that creative blocks naturally dissipate through the act of processing a presenting issue, and said:

I think what's really satisfying for me is how we'll work on a psychological issue and once we've processed it enough, a lot of times they'll have a breakthrough in where they

were stuck with their art, whether it's working with writing or they're struggling to develop a new medium or a new style in their art.

Speaking of an overall concern that artists may associate creative blocks with personal failure and how this relates to pathology, one subject said:

Artists have different reasons they're attached to their pathology or self-defeating patterns related to creativity and art, and working with the issue of creative blocks is typically related to a fear of failure, anxiety, or depression. They feel unmotivated even if it's motivated by an underlying issue and therefore feel they're not as good as others, particularly with the art student population.

In a different way, a respondent tied creative blocks to childhood dynamics and a sense of safety, and noted:

[With artists] there is the performance anxiety or issues with creative blocks, and the reasons that people struggle with having access to their full creative potential and expressing themselves authentically vary from person to person, but it can be a very challenging and painful process to work through and as with anything it has to do with individual family dynamics and what wasn't safe.

Substance misuse and its connection to art. Two respondents spoke of substance misuse among clients who self-identify as artists. The first, who works primarily with young adults, emphasized:

There's a lot of substance abuse that on one hand people [i.e. clients] want to change but they're ambivalent because they think smoking pot all day frees them up to be more creative...but then they're aware of things that hold them back...but then it's so common

in college and an added layer as an art student there's a lot of ways to rationalize using substances.

She went on to use a clinical example to illustrate this issue:

I had a student who was addicted to heroin, and she really thought she could not create work if she wasn't doing heroin, so one of the interventions we used when she was in a phase of being clean was to start a new sketchbook...so we worked on comparing her "sober sketchbook" with her "drug sketchbook" and saw how in some ways the sober art was more interesting or better...so she had proof right there that she could remind herself that she could still be an artist without drugs, without being anxious or depressed, or [other] self-defeating behaviors.

The second respondent stated:

I have many patients who use drugs and if an artist wants to expand their mind through acid or something, sometimes that can be hard to deal with if they're doing it too often. They're not aware of the dangers if they say for example 'It's for my art,' or 'It's because I'm bipolar' [and] I'm thinking, 'No it's not; it's just an excuse.'

In contrast to both respondents, another who works with actors reflected, "There's a stereotype of substances with actors, but none of them have substance abuse problems...none of them are pathological."

Work/Life Balance and Making a Living

A major issue discussed in all but two interviews is the difficulty of making a living while being an artist. One participant noted that "feeling shame" is common among artists, because they are often in an "economically lower bracket." The same participant identified feeling this way personally as a musician and described making art as "rewarding...more

spiritual...maybe I'm idealizing, but [I think] there's an innate connection to greater good and a tuning into the soul...not just making a living." Another respondent spoke about ambition among actors and how rare it is to succeed in the arts:

It's so hard to make it, and everyone is ambitious. Another quality [of actors] is being resilient and busting your ass to succeed. Because if you don't, you're lost. This relates to [a] primary self-image because you have to have so much passion that you'd kill to succeed...what happens when you don't 'make it'...at what point do you give up? Even if you're selected...it's a crazy life... kind of masochistic. How long are those days, how little are you getting paid...?

Affording therapy. Ten of the 13 respondents discussed artists as not being able to afford therapy. As one of them reflected:

The majority of people I work with who identify as artists struggle with money: making enough money, having enough money, and figuring out how to have enough money to be artists. As a social worker I think it's my job to recognize that and work with it as opposed to saying 'Hey we don't need to talk about that...tell me about your mother.' I think it's a real thing that makes them stand out as a population. It's a constant struggle.

Another respondent simply stated, "Most of them have something on the side." One subject who hoped to start a practice to work only with artists admitted financial constraints are a hindrance:

What's challenging about the work is the financial aspect. A lot of artists have to freelance and that sucks. I have days when I wish I wasn't interested in artists because when I move to private practice I'm realizing there's a real problem here with scheduling and finances. I've had to terminate with multiple artists because they could not pay.

One participant reflected on the burden of needing to succeed in order to afford to live as an artist:

Rationally [it is important] to understand that the resources available are so so restricted and it's really, really hard and coming to terms with that reality and whether or not there's a way to continue without being a star and whether or not there's a way to continue and make a living or to continue and realize there's a lot of compromises...

A participant who has worked with an artist for many years put it this way:

I have a sliding scale, and some people pay \$0. I had a guy who lives in his studio and has for about 20 years. The landlord knows it's really not okay, but it's okay. He pays rent of \$300 a month and showers in his sink. He has wonderful woodworking skills, and so he's built all kinds of things in his studio to be able to live there...so there are artists I think who are very much married to their work and interested in changing the system, society...they have very different worldviews.

This participant further revealed that bartering for sessions became necessary, and in fact, a useful intervention:

For some this is very unorthodox, but it is okay within the code of ethics. I have bartered with some people. I've had to choose art and then talk about how much they believe it's worth and that kind of thing, so it does get into all kinds of stuff that's different.

Another subject reflected on work with younger artists and the pressure to decide on a career path early on, "[There are] family pressures and financial pressures as working artists or students who are going into a field that won't be practical...So there's a conflict between do I do something that's my passion, or something that I know will reliably pay the bills?"

Scheduling concerns and disruption of treatment. Several respondents noted how an artist's lifestyle creates an erratic schedule, which can often interrupt treatment. Notably, a sense of satisfaction in work with self-identified artists trumped any financial inconvenience felt among participants. One respondent reserved two hours a week as "free therapy" and usually filled this slot with a self-identified artist, and explained how this works in practice:

Artists are notoriously late and have abnormal schedules...and very often artists don't have access to healthcare, so getting paid is hard. You need that level of flexibility as well. I maintain two hours a week that I consider free care. Very often I'll have artists in those slots. It doesn't make the work any less rewarding if you give yourself over to the understanding that this is a donation...in my opinion art makes the world a better place.

Another respondent described what this looks like among different types of artists:

So with actors in particular, there's an intense period of work on a play or a TV thing and then it's gone, and you're starting all over again. For musicians and actors too, there can be a lot of dislocation [i.e.,] going out of town for work; and if you have a relationship it's a significant stressor if one or both are often away and how to handle that and the same is true for musicians who travel for work and the unpredictability, because you don't really have control of your life in a way. With actors it can be painful to feel like you're not in charge, so if you're on vacation and there's an important audition, you're probably going to come back for that audition. It's hard, because spouses get upset about not feeling like they can make plans and count on them, because if they get a job they'll be rehearsing for six weeks or something like that.

Despite scheduling and money being a struggle for many clients, one respondent stated that it does not interfere with treatment, "Money is a perennial issue for artists and musicians. Then

again, this is a guy [said in reference to a client] who has a sporadic income and goes on tour and yet he comes to therapy, so again, even with very limited resources he's valuing the therapeutic process."

Being Recognized...or "Seen"

Several participants spoke of creating a "nonjudgmental space" for clients who identify as artists, particularly because of how much judgment they face in society. One participant noted the importance of recognizing the artist in the client:

If someone really is an artist, and that is how they identify and you as the therapist don't really notice and honor that, you're not seeing the client, because probably, I'm going to assume, it's so important to them, it's so meaningful to them, and if you miss that then I feel like you're missing the whole presentation, and then they walk away with this weird hollowed feeling of having not been seen.

Another respondent explained that what is paramount in working with artists is a need to first "see" them for who they are *as artists*—before the work can begin:

People [who come] in need to feel that I'm going to understand what they're up to and what they're talking about, but once they gain that confidence the clinical issues are like what other people have. An actor wants to feel that I understand the physical and emotional things they do on stage and will understand what that's about and be sympathetic to it. It's like working with gay men: they want to feel a therapist will understand their 'special' and particular issues, but once you've proved that you understand those particular issues, gay men are like actors and 'normal people' so in a sense it's like providing window dressing.

Are Self-Identified Artists a Distinct Clinical Population?

Throughout each semi-structured interview there were slight redundancies in the questions posed to elicit as much information as possible about clinical work with self-identified artists. The last question in all 13 qualitative interviews asked if participants believed the self-identified artist is clinically distinct. Twelve of the 13 respondents ultimately answered “yes,” with some qualifications. The only respondent who did not answer in a definitive way, reflected:

I don't know; it's a really good question. I guess not. I feel like there's so many different types of people who make so many different types of art. Maybe it's because I define art as so broad, you know. Maybe if I only considered it for people who do painting and drawings, or particular genres...there might be some commonalities. I think that to be an artist takes a lot of courage because it causes a person to put on display something that they created from themselves. And I think different people are more cognizant of that than other people.

Yes, they are a distinct population, but... One respondent stated simply with “Yes, I think they're a distinct population.” The remaining 11 respondents answered yes but chose to elaborate on their answer. One respondent defined the self-identified artist as a “distinct soul type.” Overall, there was much hesitation to categorize all artists into a distinct population of people with shared traits. In part this relates to the many kinds of artists and artistic practices the participants referenced. Subjects identified differences among their clients, although the struggle to be an artist, to identify as one, and to survive making art was frequently mentioned. As one respondent stated:

Yes and no. There's all the same problems...relationship issues, family of origin, so I guess maybe I would sort of [agree]...how can I say this? It's kind of like a spectrum.

Imagine a color wheel. Everyone has a color wheel, and for some people there will be areas of that wheel that will be more intense than others. For people in the arts it would be realistic reality constraints and impacts of the ways in which our culture relates to the arts and the lack of support for the arts and at the same time an idealization of artists, which is kind of a confusing thing to deal with, and then some of these internal issues related to creative expression that may have drawn someone to the work and how that plays out. I think those issues are more highlighted with artists but isn't totally unique to people in the arts. It might manifest differently but you see that in other people as well.

In each interview, the challenge of finding a way to answer “yes” was ballasted with great enthusiasm for working with the self-identified artist. The sentiment of “They’re so interesting!” was heard time and again. One respondent admitted, “I’m curious about their perspective and *we have a lot of interesting conversations that I would pay them to have.*”

A mutual identification with the arts. Of the 13 participants, just over half expressed an interest in the arts while the remaining six identified as artists themselves, either in the past or at the time of the interview. When asked if there was a correlation between an interest in the arts and clinical social work with self-identified artists, all respondents emphasized their pleasure working with this type of client. Two respondents related feeling “envy;” the first felt “jealous of their creative talents,” while the second reflected on how a personal career change from the arts factored into the work, “Sometimes, there is some envy related to my own feelings of loss about changing careers, but I get so much satisfaction from my work as a therapist that it’s not such an issue.”

In response to the notion that a sense of sameness might pose a hindrance between the clinician who identifies as an artist and his or her client, one respondent reflected, “Yes, it has

happened, but I can't recall the situation. I remember it as a lesson learned, even if it's exactly the same experience..." About a quarter of respondents spoke about shared qualities between the clinical social worker and the self-identified artist in terms of using themselves as an instrument. One participant, who worked as a musician before becoming a clinician, also discussed some of the challenges of identifying with the client:

You want to join with them in that way, so sometimes I find it challenging to bite my tongue [not tell them] a fair amount. Some of it is a little frustrating, because I see them trying to make it and so to not have my experience of disappointment come into the room [is hard]. They're doing what they want to do but not getting where they want to be [speaking of the community of musicians]. If you want to be a musician a lot of it isn't up to you. It can be a heartbreaking profession, and so sometimes I have strong internal feelings toward them.

The same respondent further defined the characteristics of a distinct population:

Therapists are a distinct population... what we're drawn to; what matters to us and how we relate to other people. By virtue of choosing this as our life's work, I think it's a distinct population, and you can imagine certain characteristics therapists have: capacity for empathy, desire to learn, enjoying relating to other people, caring about what matters to other people, etc.

Two respondents who either had worked in or who had had an interest in theater before becoming clinicians described a connection. As one of them stated:

There is a kind of theater aspect to doing psychotherapy: You are talking about how people behave in the world, how they conduct themselves, how they play their parts in

the world, and how they think about who they are in the world while they're playing their parts...I don't want to push that too far, but I think there's an interest there that I have.

And as the other respondent further noted:

It's a really big part of who I am as a therapist, and partly it's just because of the training one does to be your own instrument as an actor, and that makes me different in certain ways. And this is not different than other relational therapists who see the clinical engagement as one that is collaborative to some degree and as a process that unfolds, and so I frame that in terms of a creative process. There are a lot of parallels in how one uses oneself to be creative and how one uses oneself to be a psychotherapist.

Are there theories or theoretical orientations that apply specifically to work with self-identified artists? All respondents avoided naming a specific theory or orientation as best suited to work with the self-identified artist. Several participants said "psychodynamic and psychoanalytic" approaches are helpful for the use of creative exploration, analyzing unconscious dynamics through free association, and the discussion of artistic works and their meaning. Four respondents mentioned a body-based and somatic understanding of emotional issues as part of the work. One respondent discussed "humor" as a device to "adjust to more latent material." The same respondent perceived cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) as "more closed and structured" and not conducive to work with artists, and provided a clinical example to illustrate this observation:

For example, I have a patient right now who is taking DBT and is furious about it. She's like, 'I cannot fit my feelings into a box on a page!' but at the same time you could argue that it's sort of like a canvas and when you're an artist sometimes you do have to contain your feelings; but I would go as far as to say that with this patient in particular that it

[DBT] was a traumatic experience for her and [the] expectation that you will be able to rate your feelings or contain them.

Another respondent uses mindfulness techniques to help artists understand their “flow state,” which is a term the respondent often heard from clients who identify as artists and defined it as:

[A state of having] full access to creativity and an artistic mind...so for many artists they want to exist in that state all the time, and if not, they become incredibly distressed. I have come to understand that the flow state is a profound level of focus on the creativity. You have enough energy to access it, and then there's this profound focus where they really get busy making art. That's a confluence of many factors, and when I explain that to them they start to understand that that experience is not sustainable 24/7 because we get tired, distracted, and life happens. So one of the clinical implications is helping people to get back into that flow state, [so] mindfulness and teaching them flow state exercises is something I use primarily with artists.

The same respondent also feels frustrated about discussing “the brain” and how it works with these clients:

A lot of artists have a hard time accepting that the rules of brain science and being a human species applies to them. Going back to that ‘special tribe of people’...very often they want to deny reality which may have a functional purpose but letting go of that one specifically is very hard for artists.

In terms of conceptual thinking being a common attribute among clients, another respondent reflected:

Yeah, you have to go down the rabbit hole sometimes and be able to come out of it and be like ‘Wait, this is what we’re working, right?’ and ‘Let’s see it through...’ I’m also

really theoretical, so it's hard for me, because when someone else is theoretical we can be up here [respondent points to her head]...and we're not doing the work...or I feel we're not doing the work. And also I really get along with my [self-identified artist] clients, so I don't want it to get chatty...and I don't. I'm good at that now over years...because it can be very chatty. It can be like 'Oh I did this and it was great'...and I can say 'Oh I saw this piece and it was wonderful'...but that's not why they're there."

Two respondents referenced the use of Donald Winnicott's (1965; 1971) psychoanalytic theories in clinical practice:

Actually, Winnicott wrote a lot about creative process, and it's one of the things that drew me to him, and one of my actors suggested we read "Playing and reality." I remember that true self/false self...I think there are many people who are drawn to the arts because there are important internal experiences that there wasn't space for or an opportunity to process and express early in their life. Again, this is true of many people and everyone to some degree, but with people in the arts there is for whatever reason a more intense pressure to find a way to be seen and heard...but there's also a tremendous risk depending on the family dynamics of what those fears would be—but a risk that you'll be co-opted in some way that someone else will point to what you produced and claim it as their own in terms of the recognition or that you'll be shamed in some way or that you'll reveal yourself in such a way that there's no longer a sense of safety. So it's a balancing act between revealing and yet staying hidden, and art can do that because there's the kind of container—painting, a character on the stage, in different ways are the same thing—there can be a fear of: 'Am I concealed enough?' Will people see something

about me that will then be used against me, or spoiled, or things like that. And never really knowing for sure...

The other respondent stated, "I write about this stuff...and I've used Winnicott a lot who talked about creativity being important in development of self." She then further noted a relational approach as useful: "Relational work is absolutely a good approach for working with artists. One of the things I find most useful in working with artist is that they appreciate the interchange — the back and forth and intersubjectivity of the way that I work."

Finally, it is interesting to note that only one respondent acknowledged a connection to social work training: "I think the social work orientation is very important because it views the person within their situation; the economics of that need for survival [of artists] are specific to social work."

Summary

The qualitative data in this chapter represent the views of 13 clinical social workers about their professional practice with people in treatment who are self-identified artists. All participants agree that the "artist-client" is, in fact, a type and expressed great satisfaction in working with this type of client. While they could not categorize all artists into a distinct population, all but one answered "yes" to the question of practice implications for clinical social work. These implications include an understanding of the person's identity as unique, recognition of the person's struggle to make a living and to afford clinical services (which often requires special accommodation), a need to be seen, an openness to therapeutic work and use of self, differential diagnosis for use of psychotropic medication, and a propensity for misuse of substances to create art (in some but not all clients). Several respondents debunked the perceived stereotypes of artists as "narcissists," "crazy and loose," "attention whores," and people who

“think of themselves as special.” The following chapter will discuss the implications of these findings for clinical social work practice and suggest further areas of research and exploration.

CHAPTER V

Discussion

This study explored whether there are practice implications for clinical social work with people who self-identify as artists. Thirteen participants who were licensed clinical social workers at the time of study contributed to this research. They were accessed through purposive sampling that included snowball techniques beginning with targeted recruitment (letters and emails describing the study, see Appendix C; listserv postings, see Appendix D; and direct emails, see Appendix E). Due to the sparse professional literature available (both conceptual and empirical) concerning social work practice with the self-identified artist, I used a qualitative approach to research this topic hoping to capture a nuanced picture of specialty practice with this type of client. The study's findings are not, therefore, generalizable but they reflect on the nature of specialization as it pertains to a distinct population and as such, add to the literature on social work practice. The idea that people can become part of a so-called special population, for whatever reason, is a concept that remains unquestioned in the field of social work. With that in mind, the literature review (Chapter II) attempted to cast a critical eye on what specialty clinical social work in fact means and how it is or may be conceptualized for practical (practice) purposes. Thus, the research of this study used the concept of *self-identified artist*—defined broadly in scope and meaning—to contextualize the discussion of specialization.

Through 13 interviews with clinical practitioners who believe that they include in their caseloads for practice people who consider themselves artists (as opposed to artistic or creative types), the study captured what might be called an “underrepresented” perspective of what it is like to work with this population. Although the study was admittedly small in scope, it still yields new ways of understanding this type of client, and ways of working with them that might be

specific to this specialization emerged from the analysis. Significant findings seem to be as follows: a natural receptivity to exploratory therapeutic work, a rather easy openness to feelings, an apparently keen ability to make use of the unconscious, and a proclivity to somaticize feelings.

Findings in Relation to the Literature

Since very little is written in the professional literature about clinical social work with artists, the literature review (see Chapter II) focused broadly on social work accreditation and specialty practice as it pertains to distinct populations. Looking back at the process of accreditation in social work practice in the United States, it is evident that endless areas of specialization are offered as postgraduate courses and training programs, while few sources outline how this relates to utilizing practice skills in real-world settings. In addition, growing issues of affordability (Martin, 2014) and whether post-qualifying programs prove to be helpful is still out for debate (Moriarty & Manthorpe, 2014). With this in mind, the calls for more research on accreditation and its use in clinical practice, as well as acknowledging critical thinking as an important skill for a competency based education (CBE) by the American Psychological Association Task Force (2006), acted as factors to creatively consider and produce research on people in social work treatment who self-identify as artists.

In the case of this study, all participants reported that specialty practice was not offered in any of the social work graduate programs they attended. Despite this being the case, each participant acquired specialty skills in postgraduate training, often used to market a niche focus that included “work with artists.” It is relevant to note that social work as a profession requires clinicians to enroll in continuing education throughout their career and that the courses and training programs that these participants enrolled in still varied widely. In the next section, I

outline how the practice implications for work with the self-identified artist relate to specialty skills.

Implications for Practice

The professional literature that describes artists and psychotherapy outline several themes that were in fact referenced in interviews with participants. For example, being “brave” and “courageous” were attributes that participants frequently ascribed to the artist-client. This was echoed in Graves’ (2009) writing on an artist *taking risks* as an “engagement with the unknown” (p. 76). Also, the sense that the artist-client engages in the unconscious more easily than the “general public” was noted by several respondents and relates to Rogers’ (1954) description of the artist as “open to their experience” and able to produce a “product” that is unique to creativity (p. 253). In fact, one respondent reflected in some depth on the unique quality of an artist to employ creativity in her art and also within a therapeutic space:

What they do that makes them unique...is making their life endeavoring something creative, and because I have my own personal experience [as a former musician] maybe I’m projecting this; but what I envision is that this is someone who has the capacity to explore their feelings and who strongly believes in expression and ideally self-exploration as part of that. It tells me that they will be invested and committed to the work, because they walk in (to the room) understanding what it’s like to sit with your feelings. They’re already invested in the process by virtue of how they work and the value they give to expression. It doesn’t mean they’ll be verbally expressive but that they have the capacity for expression... and that’s not something you can count on when someone comes into the room.

Another participant referred to primary process thinking in a clinical example, which mirrors what McWilliams's (2006) believes artists to be more familiar with than the general public:

I will encourage them to bring in their work, or I'll go to some of their gallery shows or exhibits. I work with a composer who I've gone to hear some of his music. And it's so cool; it's a completely different experience. I use that, and I'll always use that because *so much of their psyche and emotional life is non-verbal*. You can say that about anybody, but the difference is their taking that part of themselves... So, for example, *with primary process in ego psychology, there is a part of a psyche you can't verbalize*, and I think artists aren't conscious that they're doing this... but I think they're taking part of themselves and, for example, putting it on a canvas to make it more visual to work through it in a way that you wouldn't necessarily get with working with an accountant. It's this wonderful experience you get to see. It also poses a lot of problems.

In a similar vein, participants frequently referred to an unusual aspect of working with an artist-client that was not noted in the literature review, such as viewing the work of an artist-client in public and in session. Participants felt unanimous that discussing a client's art helped to move the treatment forward but that it also posed issues of maintaining professional boundaries and ability to hold "the frame" (which refers to the contractual elements of psychotherapy, such as a consistent length of time for sessions). Since there appears to be an absence in the professional literature on this specific type of experience, the following examples (left out of the findings chapter) may offer insights into areas for further research.

Experiencing the artist-client's work. About half of the participants found holding the therapeutic "frame" with artist-clients who share their work (either materially while in session or as an event the client invites the clinician to) to be problematic. As one participant stated, "It

makes the work so much richer, and you can understand your patients better if you deviate from the frame—of course, with a lot of exploration.” This seems to imply that ruptures to the “frame” may happen and are difficult to process but that ultimately, deviations may produce a deeper understanding of the client.

On the other hand, there were contradictory feelings about attending a client’s public event, such as an art opening. Should the clinician attend the opening when the client would be there or later on, when the client would not be present? One participant described this salient issue as follows:

It is a tricky thing, and so I don’t always go. I’ve been invited to shows. I tend to go for a specific period of time, because I want to show respect if I have the time in my schedule. I’ll go with a friend; I’ll never go with my partner, because that’s not on the table... And if it’s an opening I’ll go on opening night so the focus is not on me. There will be a million people there... Or if it’s a film premiere I can just go... I had an artist who had a one-woman show and she invited me to it, so I went... I don’t hold lines arbitrarily. I believe in honoring and respecting my clients and their work. So to me it’s like artwork that we did together... And they’re able to manifest in the way that they see fit, so I’m happy to support that.

Another elaborated on this kind of shared artistic experience as a relational kind of intervention:

I can go to their shows and see them...[It’s] rewarding, because it’s fun but also provides a window to see them, which I can bring into the room, and I can say, ‘I saw you...[sing, act, etc.] and it seems [like this] to me...how did it seem to you?’ It’s a whole other part of their world I can bring into the work that I can’t do with a banker...I can just get their

perception. This way I can get a glimpse into their world in a literal way, a non-intrusive way.

One participant discussed the parameters that she puts in place for this kind of experience, “[We] discuss before and after...but it’s unbelievable to see them in their zone...[There’s an] agreement to sneak out, not say hi...[We] set parameters/rules, but the knowledge that she was there and [I was] watching was kind of cool.” Finally, another participant who also brought up this situation contrasted it with the rest of her clients:

I don’t think that most other clients want you to come see their work, and this has happened to me more than once. It happened with my dancer clients, my actors, musicians, and visual artists who have local shows...Some of them (not all them) want to know that I’m seeing that part of them by coming to see them perform, or their art...so that makes them a little different. Lawyers never ask me to come to court to watch them, or teachers don’t ask me to come into their class.

This same respondent went on to describe a time when she was invited to see a client perform in a play and felt conflicted about attending. She wondered if this kind of situation relates truly to being artist or if its particulars just have to do with their work:

Well this is a first, this play. I have gone before to see a client’s show, but I go when they’re not there so I can say, ‘Yes, I saw your show. It was really interesting, tell me what it meant to you...’ But this one, I’ll have to decide what to do...like for example, if I go to a play I would want to bring someone with me, and I wouldn’t want to lie to my husband or friend who I ask to take with me, so I would have to say to my client, ‘Well if I go to your play, which I would like to do, and I were to go with someone, are you comfortable with me saying: I was invited to this play by a client who has said I might

enjoy the play?' ... And if he does not give me permission, which he will, but if he were to say 'No, I'm not comfortable with that,' I would have to think about that, because I'm not comfortable making up a story, and I don't usually go to theatre by myself, so it's a little complicated. But really it's like, *Isn't this interesting that my client has this need for me to watch him be this part of himself who he thinks of as the real part because he's asking?* ... [H]e wants me to see that and I would like to do that; I'd like to see that. And I think he feels that I'll understand him on another, deeper, level if I can see him immersed in his art. And that's very reasonable. I will do it if I can, I don't know if I can but I will try. *And if the therapist can't see that, what are they treating? Just one aspect of themselves.* And I suppose it's not that different from people who say, 'Well I'm a parent and the real me is when I'm with my children and you've never seen me with my children so you don't know who I really am.' So you know, maybe it's not that different. And finally, it is important to note that when it comes to the client's selling his or her art, a participant described how this differs from other clients due to an emotional component being an intrinsic part of their work:

[The] identification with their work is very different with that person whose work is say, being an orthodontist... They feel good about their work, but it's not like the painter who feels like the person who buys their work is taking a little bit of their soul away; I know some visual artists who won't sell their work to people they don't like! The orthodontist I know will put braces on anyone.

On a somewhat related note, a respondent who barter with artist-clients for psychotherapy noted how the experience of selecting a client's artwork in exchange for services facilitated a profound connection. This included a kind of vulnerability in terms of the client learning something about

the clinician and her tastes. The participant explained, “[I] go to the artist’s studio to choose the artwork, and there’s a connectedness that’s very different. It’s professional, but I go into their world and see what’s there... I get to choose, so they also learn something about me that they wouldn’t [otherwise] know.”

A similar “Use of Self.” Another salient topic discussed in the interviews at the time of the study but not mentioned in the literature review is reference to a shared *use of self* between the clinician and the artist-client. That these participants brought it up, despite the fact that it was not discussed in detail in Chapter II, makes it worth discussing a little here, in this chapter.

Participants described a “use of self” as an “interactive” style of working and an appreciation for “symbolism and conceptual thinking.” This concept, *use of self*, refers to a kind of “improvisational orientation” that responds to situations spontaneously through self-awareness and a “willingness to take a risk” (Balachandra, Bordone, Menkel-Meadow, Ringstrom, & Sarath, 2005, pp. 418-419). Normally, this concept is applied to clinical practice (that is, to the practitioner’s behavior vis-à-vis a client). In the case of these practitioners, however, it also seems to apply to their clients. For example, three respondents spoke about the artist-client as using herself or himself as an “instrument” of some kind. The term “negotiation” to describe this skill is applied to the fields of jazz, theater, and psychotherapy that researchers argue give “explicit attention to the skills, habits of the mind, and social context that foster effective improvisation” (Balachandra, et al., 2005, p. 422). Further studies may choose to address this intersection between an artist-client and a social work clinician more closely, especially as it relates to clinicians who either have a background in the arts or identify themselves as artists (10 of 13 respondents described themselves as such during the interviews).

So, are people who self-identify as artists a *clinically distinct population for social work practice*?

In the end, this study reveals that 12 of the 13 (thus, almost all) participants feel that the self-identified artist in social work treatment is in fact clinically distinct. Yet, they also feel that it is difficult to categorize this client as a “type,” which relates to the many forms of art making and artistic identities that are inherent within that definition. At least for this sample of practitioners, all of the people who they related to as clients and who self-identify as artists have a unique *sense of identity* that directly relates to the role of art in their lives. Different symptoms and diagnoses were addressed and used in respondents’ clinical examples, but none seemed to be applicable to all clients alike. Instead, the approach to therapy with the artist-client (and an interest in their particular worldview and creative experiences) was a commonality among participants. To further emphasize the pleasurable aspect of their work with the so-called artist-client, participants not only expressed great satisfaction, but several also offer treatment for “\$0” or “pro bono,” a finding that is notable in and of itself.

Limitations and Strengths of this Study

The questions on the semi-structured interview used for this study (see Appendix F) were designed to elicit a “thick description” (Steinberg, 2004, p. 121) of the experiences that clinical social workers have in their work with self-identified artists. It should be noted, however, that several respondents expressed frustration at having to answer complex questions spontaneously during the interview rather than having had a copy of the interview guide in advance to help them reflect. It would be interesting to see if the data produced significantly different results had the protocol included time for pre-interview reflection. In addition, the 11 questions on the guide often produced similar answers, suggesting that redundancies might have been prevented or at

least limited if the guide had been pretested before the actual study. Conversely, it is also possible that the redundancies may have helped to draw out more detail in participants' responses.

The definition of an artist used in this study was strategic in its emphasis that the clients *self-identify* as such regardless of artistic practice or financial ability to live off their artwork. This allowed for the research to operationalize the term “artist” to explore perceptions of artistic identity, gain perspectives on clinical implications, and understand how this was realized in practice through clinical examples that the participants offered. However, many respondents struggled to discuss all self-identified artists within their practice as a cohesive group. Some even proposed that “sub categories” be created within the definition of “artist” to specify a type, such as musician, writer, or actor. Along the same lines, some also felt that they could answer interview questions more accurately if the artist definition were more specific—if it referred to a particular “type” of artist, for example, suggesting uniqueness even within the so-called “artist-client” group as well as commonality, another valuable area for future research on specialization.

Additionally, whether these clinicians actually heard the client in question self-identify as an artist at some point in the treatment or if they themselves ascribed this identity to them could not be discerned. Therefore, allowance in analysis must be made for this ambiguity. This uncertainty is of particular interest, because many people who make art of some kind struggle with identifying themselves as artists, and the scope of this study could not include this important area of inquiry.

Another limitation of this research is that at the time of study, all participants either worked in private practice or planned to do so after psychodynamic training, which limits the

scope of practice settings. This could be also seen as a strength in that the data provide a comprehensive look at this specific perspective.

Despite the sparse professional literature on the subject of this study, the core strength of the research relates to the robust experiences of clinical social workers in their practice with the artist-client, providing further reason to explore this area in greater detail. In fact, all participants expressed a great interest in the study and had many ideas to share that went beyond its aim and scope—some have even written on the subject themselves. This evidences a special sense of appreciation for the subject and for the opportunity to consider the potential distinct qualities of the artist-client.

Recommendations for Further Research

The results of this study suggest that further research should focus on practice with artists of different disciplines and variety as well as practice with artist-clients based in different settings, such as hospitals, agencies, and public health clinics. Research in other countries and with artists from different sociocultural locations could also be useful to assess whether the perception of an artist (both by the artist and service provider) varies. Finally, given that the term “artist” is inherently subjective, research that simply seeks a common definition for operational purposes in designing social work studies would be valuable. Clearly, there is already much discussion about what constitutes “art” and “artist,” (though to no satisfactory conclusion), but toward operational definitions for purposes of social work research, such endeavors would continue to enhance the capacity of the field to address specialization practice.

Conclusion

The question of whether there are practice implications for clinical social work with self-identified artists has been at least answered to some extent by this small exploratory study. As

research, it contributes an important investigation into the use of specialization, and in particular, whether self-identified artists constitute a distinct population for purposes of social work practice. The research question led to the exposure of a rich territory of clinical experiences among participants that ultimately named the “artist-client” as clinically distinct and therefore worthy of special consideration despite the complexities related to categorization. Knowing more about this type of client is of value not only to social workers who wish to specialize their clinical practice with artists but may also benefit clinicians who have an interest in the proposed intersections between art making and psychotherapy, noted above as a potential area for further research.

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Appendix A: Informed Consent

2015-2016

Consent to Participate in a Research Study
Smith College School for Social Work, Northampton, MA

Title of Study: The Use of Specialization: Are Artists a Clinically Distinct Population?

Investigator: Camila de Onís

Introduction

- You are being asked to participate in a research study that aims to explore the use of specialization within clinical social work practice.
- You were selected as a possible participant because you are a practicing clinical social worker who works with people who identify themselves primarily as artists.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore whether there are special characteristics (and thus practice implications) of clinical social work with people who identify primarily as artists, and as such, if artists constitute a clinically distinct population.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: To participate in an individual interview with me, the researcher, for 60-90 minutes. With your permission the interview will be audio recorded using a digital recording device and I will be taking handwritten notes; it will not be recorded without your permission.

Risks/Discomforts of Being in this Study

- The study has little foreseeable risk to you, but I will ask you in our interview to discuss your work with artists as a population and/or your professional development around a certain specialty or focus. This is an exploratory study and you will not be asked to discuss anything that you do not wish to discuss for any reason. During the interview you will be free to decline to answer any question I pose and/or to end our interview for any reason at any time. You will also have the right to withdraw your interview from the overall study within two weeks' time after the date of our interview. After that, I will begin to write my report.

Benefits of Being in the Study

- The benefits of participation include having an opportunity to think about whether you find work with artists to be special and as such to reflect on whether or not you believe that artists constitute a clinically distinct population. In addition, your contribution to the study will add to research (of which there is little) on the subject of clinical specialization with artists. Your material will also provide a basis for further study in this area of clinical social work.
- The benefits to social work/society are as follows: Further knowledge about and thus the potential for greater competence in clinical social work services to people who conceptualize themselves primarily as artists.

Confidentiality

- All of your information will be kept confidential. I will be the only person to know about your participation. The interview will take place either at my office, your office if you wish, or a quiet but public place such as a local coffee shop as long as it provides quiet and privacy. In addition, the records of this study will be kept strictly confidential. I will be the only one who will have access to the digital audio recording and my handwritten notes from the interview, with the exception of a potential transcriber, who will sign a confidentiality agreement.
- All research materials including digital audio recordings, transcriptions of handwritten notes, and consent documents will be stored in a secure location for three years according to federal regulations. Recordings will be destroyed after the mandated three years and will be permanently deleted from the digital recording device. All electronically stored data will be password protected during the storage period. Further, all information pertaining to you, including any quotes I might use in the final report will be de-identified so that no one may guess your identity.

Payments/gift

- You will not receive any financial payment for your participation. If you should wish for a light refreshment during the time of our interview, I will be glad to offer such an accommodation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study until two weeks after your interview takes place without affecting your relationship with me or with Smith College. You have the right not to answer any single question as well as to withdraw completely up to the point noted above. If you choose to withdraw I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or telephone within two weeks after your interview takes place. After that date, your information may be part of the thesis and final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study at any time feel free to contact me at [REDACTED]. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at [REDACTED].

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Written Notes and Audio Recording Consent

I, the interviewer, will be taking handwritten notes during the interview as well as recording it using a digital recording device. All notes and audio recordings will be transcribed and transferred into confidential digital files after the interview is completed and stored according to the confidentiality agreement described in the consent form.

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix B: Email Permission Request to Clinical Director

1/20/2016

Smith College Mail - My Thesis



My Thesis

3 messages



Mon, Jan 25, 2016 at 8:29 AM

Hi Christine,

As you are aware from past Smith interns, I have a thesis project to complete during my training at TI for Smith College. I am planning to conduct interviews with clinicians to ask whether they believe artists constitute a clinically distinct population.

For your review, I have attached a letter to TI therapists that describes my project in detail. I would like to interview therapists affiliated with the clinic who fit the eligibility criteria for my project, and plan to put a copy of the letter in each mailbox, with your permission.

Additionally, when the time comes for the interviews to take place, would it be possible to reserve a room in the office to do so? The whole interview should last between 60-90 minutes.

I look forward to hearing from you, and please let me know if you have any questions about my project.

Thanks very much!

-Camila

--

Camila de Onis

Smith College School for Social Work

MSW Candidate 2016

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

 **TI_Thesis_Recruitment_Letter_C.de.Onis.docx**
107K

[REDACTED] Mon, Jan 25, 2016 at 2:10 PM

Sure you can reserve a room, try not to have it be prime times

Christine Grounds, LCSW-R
Clinical Director
Training Institute for Mental Health

www.timh.org

The information contained in this email may contain protected health information and may have been disclosed to you from records protected by Federal (HIPAA) and New York State privacy laws. If so, this is strictly confidential material and is intended only for the recipient. If you are not the recipient named above, then it is requested that you notify the sender immediately.

[Quoted text hidden]

<TI_Thesis_Recruitment_Letter_C.de.Onis.docx>

[REDACTED] Mon, Jan 25, 2016 at 2:11 PM

Letter looks fine

Christine Grounds, LCSW-R
Clinical Director
Training Institute for Mental Health

www.timh.org

Appendix C: Training Institute Recruitment Letter



January 27, 2016

Hello Therapists,

In case you haven't met me in the office yet, my name is Camila and I am a social work intern placed at the Training Institute for Mental Health through April of 2016. As a student at Smith College, I am conducting a research study on specialty social work for my degree requirements and am looking for participants. If you do not meet the criteria to participate described below but know of clinical social workers who may qualify, please direct them my way!

Here is a short summary of my study:

I am planning to interview clinicians who believe that they work with people who identify themselves primarily as artists. Participants in my study will be given an opportunity to talk about whether they believe that there are special characteristics (and thus practice implications) for clinical work with such persons and to reflect on whether or not they believe artists constitute a clinically distinct population. Very little has been written on the subject of clinical specialization with people who identify themselves as artists, and hopefully, this study will provide insight into treatment approaches and interventions that pertain specifically to clinical social work.

To qualify for this study, the clinician must:

- Identify professionally as a clinical social worker, have licensed credentials, and be currently practicing as a clinician with individual clients.
- Identify and/or advertise publicly (via internet, brochures, business card, etc.) that s/he works with artists or has clients who conceptualize themselves as such on their caseload.

*Note: The term "artist" for the purposes of my study applies to **any person who identifies primarily as an artist** (as opposed to someone who is creative or very interested in the arts).*

If you are interested in participating, please contact me at [REDACTED], or if you know someone who may qualify and would be interested in participating, please provide my contact information so they may reach out directly. (Please note: *you are under no obligation to participate*, and your participation is in effect a favor to me as a student. Your work at TI is in no way jeopardized if you choose not to respond.)

Thank you for considering my project!

All my best,
Camila de Onís

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D: Listserv Recruitment Posting

Hello,

My name is Camila de Onís and I am a second-year graduate student at Smith College School for Social Work. I am conducting a research study on specialty social work for my degree requirements and am looking for participants. If you do not meet the criteria to participate described below but know of clinical social workers who may qualify, please direct them my way!

Here is a short summary of my study:

I am planning to interview clinicians who believe they work with people who identify themselves primarily as artists. Participants in my study will be given an opportunity to talk about whether there are special characteristics (and thus practice implications) for clinical work with such persons and to reflect on whether or not they believe artists constitute a clinically distinct population. Very little has been written on the subject of clinical specialization with artists, and hopefully, this study will provide insight into treatment approaches and interventions that pertain specifically to clinical social work.

To qualify for this study, the clinician must:

- Identify professionally as a clinical social worker, have licensed credentials, and be currently practicing as a clinician with individual clients.
- Identify and/or advertise publicly (via internet, brochures, business card, etc.) that s/he works with artists or has clients who conceptualize themselves as such on their caseload.

*Note: The term “artist” for the purposes of my study applies to **any person who identifies primarily as an artist** (as opposed to someone who is creative or very interested in the arts).*

If you are interested in participating, please contact me at [REDACTED], or if you know someone who may qualify and would be interested in participating, please provide my contact information so they may reach out directly.

Thank you for considering my project!

All my best,
Camila de Onís

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix E: General Recruitment Email

Hello,

My name is Camila de Onís and I am a second-year graduate student at Smith College School for Social Work. I am conducting a research study on specialty social work for my degree requirements and am looking for participants. If you do not meet the criteria to participate described below but know of clinical social workers who may qualify, please direct them my way!

Here is a short summary of my study:

I am planning to interview clinicians who believe they work with people who identify themselves primarily as artists. Participants in my study will be given an opportunity to talk about whether there are special characteristics (and thus practice implications) for clinical work with such persons and to reflect on whether or not they believe artists constitute a clinically distinct population. Very little has been written on the subject of clinical specialization with artists, and hopefully, this study will provide insight into treatment approaches and interventions that pertain specifically to clinical social work.

To qualify for this study, clinicians must:

- Identify professionally as a clinical social worker, have licensed credentials, and be currently practicing as a clinician with individual clients.
- Identify and/or advertise publicly (via internet, brochures, business card, etc.) that s/he works with artists or has clients who conceptualize themselves as such on their caseload.

*Note: The term “artist” for the purposes of my study applies to **any person who identifies primarily as an artist** (as opposed to someone who is creative or very interested in the arts).*

If you are interested in participating, please respond directly to this email, or if you know someone who may qualify and would be interested in participating, please provide my email ([REDACTED]) so they may reach out to me directly.

Thank you for considering my project!

All my best,
Camila de Onís

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix F: Semi-Structured Interview Guide

Title of Study: The Use of Specialization: Are Artists a Clinically Distinct Population?

Investigator: Camila de Onís, Smith College School for Social Work

The purpose of this study is to explore the use of specialization in clinical social work practice. You are being asked to participate because you are a clinical social worker who works with people who identify primarily as artists. The questions below are intended to help me understand whether there are special characteristics (and thus practice implications) for clinical social work with self-identified artists.

1. How would you describe the type of setting in which you practice?
2. How would you describe your theoretical orientation?
3. Do you have any clinical specialties? If so, what are they?
(Probe: How would you describe the skills that apply to specialty work?)
4. Were any specializations offered either as a discrete course or as part of the overall curriculum of the social work school you attended?
5. Did you train (not in school) in any type of specialty or receive certification for a particular specialty in a post-qualifying program?
(Probe: If affirmative, probe how incorporated into practice.)
6. How would you describe your experience of working with someone who identifies primarily as an artist?
(Probe: How would you describe this type of client in clinical terms (i.e. conceptualizations and case formulations, interventions, common characteristics, etc.)?)
7. Do you believe that there are clinical implications for working with people whose primary self-image is that of an artist? (If affirmative, seek examples.)
8. Do you believe there are certain theories or theoretical orientations that apply to social work with someone who identifies as an artist, regardless of the client's presenting problems? (If affirmative, probe how incorporated into practice.)
9. Do you find any aspects of working with people who identify as artists to be either particularly challenging and/or satisfying?
10. Do you have a personal interest in art or art making?
(If affirmative, probe how it relates to work with people who identify primarily as artists?)
11. Would you describe people who identify primarily as artists as a distinct client population? If so, why? If not, why not?

Appendix G: HSRB Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 1, 2016

Camila de Onis

Dear Camila,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

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

Maintaining Data: You must retain all data and other 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.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Dominique Steinberg, Research Advisor