Enhancing Participation in Social and Healthcare with Art Based Methods - in the Crossroads of Open Practices and Ethical Boundaries

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Abstract

Art and health field contains several distinct areas of practice: Arts in social or healthcare settings; Community arts and participatory art education; and, Arts therapy. The cross disciplined work in promoting well-being with arts based methods has been growing for the last 10 years in grass root practices, and it has recently become recognized also politically in Finland. There is over 50 years history of art educators and artists making art with patient groups in hospitals, outpatient care or social care institutions, as well as professional art therapy training and practice. In spite of this long history, there are still notable tensions between professionals working within the field. Professionals trained in art therapy are concerned with ethical issues and patient safety, whereas artists oppose limited ways of defining and using art. These border zones are places for both restrictive and enriching encounters. In this paper I aim to address the contemporary situation of these areas in the light of historical development. I will discuss ethical issues of arts based practices, where knowledge and skills are needed in both art and human sciences including social, psychological and physical aspects. I will also consider the research of efficacy in enhancing well-being and preventing or curing illness.

KEYWORDS: Art, health and wellbeing, art therapy, ethical practice

Introduction

Even though financial inequality has grown in Finland for the last 20 years, a welfare society still exists. Internationally, a long history of research indicates that equally shared economical welfare may be the major factor effecting our wellbeing and health. Both physical and mental illnesses increase when financial inequality grows. (Wilkinson & Pickett, 2009.) Experienced inequality is also an emotional stressor which impairs wellbeing at work (Sulander, Helkama, Elovainio & Arffman, 2011). These topics are naturally strongly connected to political and

economic power questions, and thus also intertwined with the use of art in promoting social inclusion and wellbeing. These important issues indicate the wider context of this paper. However, this paper aims, in particular, to focus on how art is used to influence wellbeing and health.

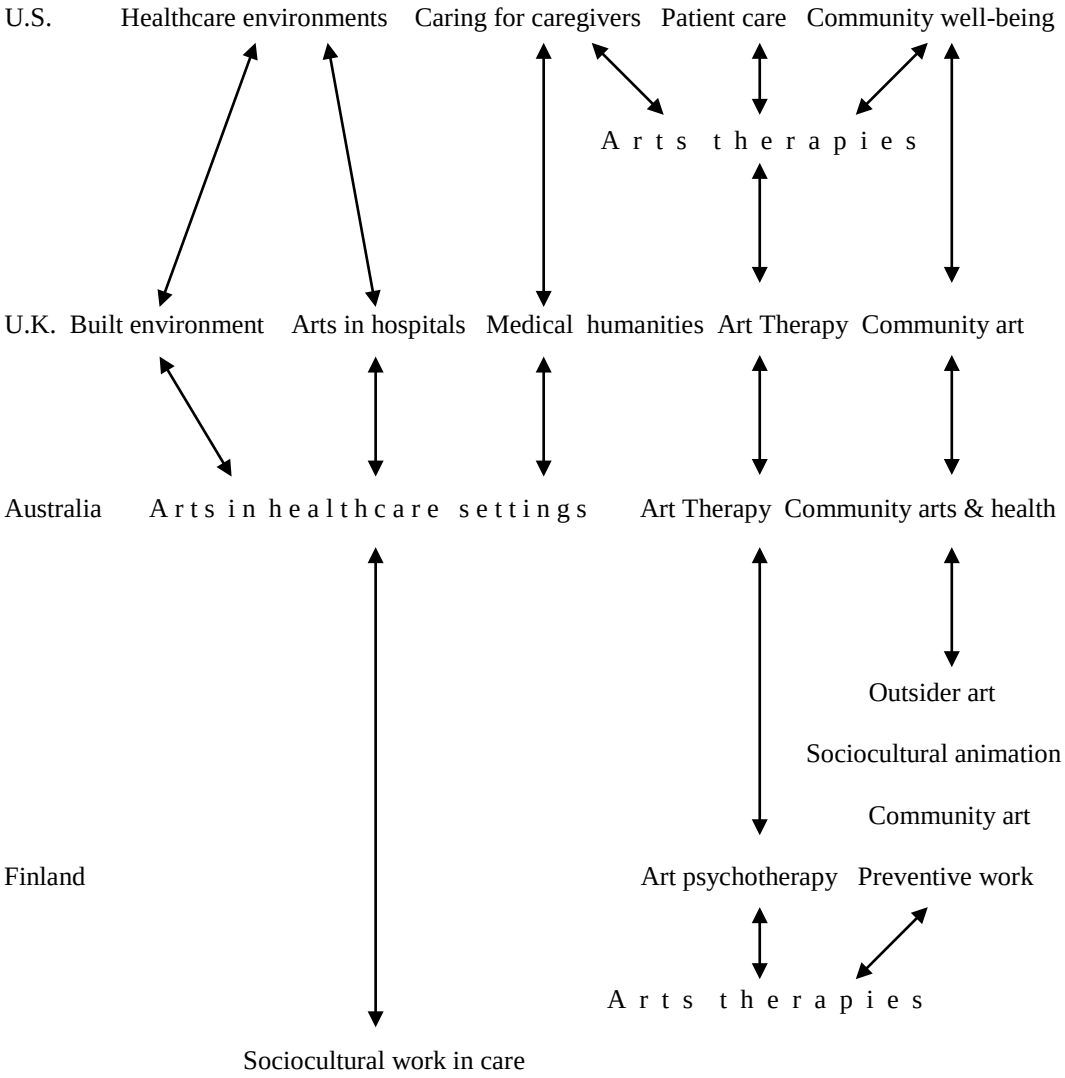
It would be simplifying and idealistic to believe all art is inherently enhancing wellbeing, healing or curing illnesses. Rather, it can be claimed that at the base of all ethical practices, there is the understanding that art can as well be superficial, manipulative, anxiety provoking, or even traumatizing depending of the motives and ways it is used. When using art for empowering, socio-cultural animation or therapy, it is central to hold this understanding in the awareness. Similarly, like in all human attempts to help or cure other people, there is the possibility - in spite of good will - to end in deteriorating results. This paradox illustrates, why it is crucial to examine current theories and practices critically. Understanding of the knowledge acquired from variety of disciplines helps to build productive and ethical research based practices.

In this paper I focus on those conditions essential for enabling therapeutic art experience. First, I sketch roughly the spectrum of practices and general division of the field. I then dive deeper into how therapeutic use of art has developed. I will touch questions of how the therapeutic qualities of art activities can be described, and what are the necessary conditions for therapeutic art experiences. Finally, I discuss how the effective practices are intervened with the practitioners' skills and enlighten these ideas with the research conducted in the field of psychotherapies and art therapy..

Drawing lines - defining areas

The context of art, health and wellbeing is wide and consists of many overlapping areas of practice. The varying social and economic cultural traditions as well as professional practices and required qualifications in art and healthcare have their effects on how the field is defined in different countries. The Society for the Arts in Health Care (SAH), based in United States, describes it as the integration of arts into "wide variety of healthcare and community settings for therapeutic, educational, and expressive purposes". They divide the fields of focus in to healthcare environments, caring for caregivers, patient care and community well-being. They do not explicitly include art therapy in the fields but it is widely presented in their biography and members of the group. In Britain, however, Angus (2003, p. 42) divides art and health into the following five categories: 1. Built environment, 2. Arts in hospitals, 3. Medical humanities, 4. Art therapy (i.e. art psychotherapy), and 5. Community art. In Australia, Wreford (2010, p. 9) classifies the area using instead a more simplified distinction of areas into: Arts in Healthcare settings; Community Arts and Health; and, Arts Therapy (i.e. art psychotherapy). Similarly in Finland, Liikanen (2010, p. 27) defines also three fields: 1. Preventive work which includes outsider art, socio-cultural animation, empowering and community art, 2. Caring and Rehabilitative work, which includes both arts therapies and socio-cultural work integrated in care and rehabilitation, and, 3. Medical and Psychiatric work denoting art psychotherapy.

Figure 1. Sketch of overlapping art, health and wellbeing fields:



As the sketched map reveals (see *figure 1.*), there is no clearly separated areas or even consistent definitions across the countries. Still, there are some common grounds and general lines that aid in building coherent overview of art in health and wellbeing. Next I aim to clarify these main lines although leaving the area of built healthcare environment outside my focus.

Arts in healthcare and hospitals

Arts in healthcare settings or arts in hospitals cover everything from paintings on the hospital walls to singing sessions in elderly homes or mental health patients visit to movies. These art activities can be divided in participatory workshops or more passive experiences of receiving art as an audience. The aims of these practices vary between actively using art at the service of health improvement to presenting "pure" art for new audiences without

particularly focusing in health effects (Angus 2002). Still, there can be implicit expectations of possible effects on wellbeing. Professionals who work in this area can be artists who bring their art work into hospitals or healthcare settings or carry out an art project within hospital, but on the other hand activities and workshops can also be organized by care personnel interested in the use of art. These professionally different starting points can possibly bring tensions to the ways how art in general is determined, how its effects to patients are perceived or valued, and what are regarded as aims of the activities.

Medical humanities and caring for caregivers

The field of medical humanities described as "the use of arts in broadening doctor training promoting empathy and communication" (Angus, 2002, p. 42) overlaps the area of caring for caregivers described as arts which "give medical professionals new tools for improving diagnostic and communication skills" (SAH). Additionally these areas include art-based supervision which "offers caregivers an opportunity for creativity and self-expression that allows them to healthfully integrate their experiences and emotions instead of carrying them home or into the workplace" (SAH). Developing and delivering these practices is often dependent of the healthcare professionals' personal interests in art. However, it is possible that all art doesn't enhance integration of experiences and emotions, or increase empathy and communication skills. For prioritising and expanding this type of practices, it is important to know, which processes in art have impacts on wellbeing and which conditions are necessary for those effects.

Art therapy

Art therapy "uses the creative process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages" (The American Art Therapy Association, AATA). It can be practiced both in individual or group format within preventive, curing or rehabilitative contexts and aims (Psykoterapiakoulutustyöryhmä, 2003). In spite of some differences between the countries, there are common features in all definitions, which describe art therapy as art making, artistic interaction and reflection of both the process and product in a safe and facilitating environment together in interaction with professionally trained art therapist. The internationally shared aims are development of interpersonal skills and personal insight, enabling change and growth on a personal level, coping with symptoms, stress, and traumatic experiences; and enjoying the life-affirming pleasures of making art. (AATA; The British Association of Arts Therapists, BAAT; Psykoterapiakoulutustyöryhmä, 2003.) Because art therapists work in clinical contexts where they meet patients with ill health, difficulties and impairments it has been crucial for professional associations to create ethical principles which guide the training, practice and supervision of art therapists. There is differences between countries in the basic training required for entering professional training in art therapy, in Britain professional art training is prioritized and in Finland educational, social or healthcare background. In USA requirements differ between states.

Community art

Community art and socio-cultural animation are often done outside official art or society structures, and thus directed to criticise or comment them, and existing inequality or power questions. When the art is done inside a community the aim is often to enhance empowering or change in attitudes. Contrary to the other areas, where practitioners can also be health care professionals, community art is most often carried out by professional artists and art educators. Community art with social goals is not new. Hamilton, Hinks and Petticrew (2003) describe how the socially focused community art practices begun in Britain already in the late 1960s, and aimed to enhance participation of excluded groups of individuals to deal

with issues as class, race and gender. In Finland Hiltunen (2009) has conducted action research in community art which is integrated with environmental art education and aimed to increase social wellbeing in the Lapland area. This highlights well the Finnish practices where community art is often approached from the pedagogical point of view. On the other hand the health oriented community-based approach of art is newer and has expanded rapidly in the past years. Angus (2003) defines it as the use of art to address health and wellbeing, or work in a health context, and describes its indefinite nature and goals in a way which overlaps almost everything previously described. The practices he includes in it are: participative arts, therapeutic arts, health promotion, community development, environmental enhancement, exhibitions and performances and staff development.

Focus in art or human

The overall view of these varying fields of art and health could be structured according to the different ways to approach the issue either from the side of art or human. These approaches vary in the theories in which the practical working methods are based. Practices stressing aesthetic or art-based components and their power on human beings inevitably need open practices for not to lose the creative and transforming powers of art. Contrastingly, when the social, physical or psychological sides of humans are emphasised, the ethical issues and responsibilities including safe boundaries of practices, confidentiality and privacy, come primary. Are these elements in invariably insolvable conflict, or is it possible to find a dialogical balance between them? These questions have been under constant debate in the field of art therapy for the last 90 years. The history of art therapy and its theoretical developments might be able to enlighten for its part the conflicts and encounters between these issues.

Roots of art therapy, rebellious art educators and artists

The history of professional art therapy started in USA in the beginning of last century first in the field of art education, when psychologist and educator Margaret Naumburg (1966) founded Walden School in 1915 and highlighted the importance of unconscious processes in education. Besides her executive work Naumburg (1966) directed children's free art expression groups and got interested in their spontaneous artistic expression, which she regarded as symbolic speech springing from unconscious, and thus a mean to facilitate personal, emotional and social growth. Later in 1930s she developed dynamically oriented art therapy, based on the idea of spontaneous art expression as a form of Freudian free association, which she used and researched within the field of child and adult psychiatry at the New York Psychiatric Institute. Naumburg (1966) believed unconscious thoughts and feelings emerge in spontaneous art expression, and therapist's task was to help the patient start the process by relaxing body tensions and freely scribbling on paper. Contradictory to the verbal practice of psychoanalysis, she emphasized that therapist should not make interpretations but facilitate and wait instead the patients free associations and own interpretations of images. Although she stressed the importance of artistic expression, Naumburg (1966) thought that previous art training was not necessary for dynamically oriented art therapists. Instead, she considered that knowledge of abnormal psychology and personal psychotherapy together with interest in art, understanding and sympathy for the patient's creative efforts, and belief in their creative potential, were essential.

In Britain, the term art therapy was first used by visual artist Adrian Hill, who after the second world war got possibility besides Edward Adamson and other artists to set up studios in hospitals and started to work with tuberculosis patients and soldiers suffering from

combat fatigue (Case & Dalley, 2006; Edwards, 2004). In addition to having an open studio where patients could come when they wished, Hill also worked in the bedsides of patients. These artists believed in the healing powers of art and also opposed interpreting patients' images. Instead art therapists task was "providing a safe space in the hospital setting in which an unprecedented level of self-expression and self-exploration could take place" (Hogan, 2001, p. 309). They emphasized the empowerment of patients, and wanted to increase their quality of life by offering possibilities in self-expression and self-reflection. They aimed to offer a place with humane atmosphere which could enhance growth and healing and were critical towards mental hospital regimes and restrictive practices (Edwards, 2004; Hogan, 2001) This rebellious attitude which is close to later community arts practitioners approaches had its' effect in professional development of art therapy which Hogan (2001) describes in the following:

> *---this essentially libertarian emphasis on giving the institutionalized and disenfranchised patient a voice militated against the development of art therapy as a profession in psychiatric hospitals. Art therapists were largely critical of psychiatric practices and institutional norms, and the profession's development has been extremely slow compared to that of occupational therapy, for example. (p. 310)*

This early approach to art therapy, which was oriented both in societal criticizing and in personal healing, altered later. Skaife and Huet (1998) describe how these early attitudes and practices were changing by the years of working in hospitals, and art therapists' were slowly influenced of working alongside occupational therapists and other medical professionals. In addition to studio based art therapy the theme-based model of art therapy group work developed and these approaches were influenced by the theories and practices of different psychotherapies. That contributed in the theoretical and methodological developments of art therapy and moved the emphasis from art-based principles towards psychotherapeutic principles. This shift was partly due to true interests in improving the practices and integrating the psychological view better in theory, but it was also a result of attempts to strengthen the professional status of art therapists. Additionally, it influenced the ethical codes in which the private and confidential nature of practices and artworks became prioritized, as well as the aims of art therapy, which focused more tightly on changes in the individual or family level.

In spite of these developments many art therapists still have interests of working in a wider context. In Britain, "group art therapy models using psychotherapeutic theory have developed and this has paralleled the move of art therapy practice to within the community, to a widening client group." (Skaife & Huet, 1998, 1) In USA and Europe the art-based multimodal approach of expressive arts therapy has from its beginning in 70s defined itself "not only as a practice of therapy but as a practice of social change via the arts" (Estrella, 2011, p. 49). In expressive arts therapy the contextual aspect of individuals is stressed, and art is viewed not only as a self-expression but an expression of the surrounding world. Artistic expression goes beyond one self and can thus touch deeply and change the human's way of being in the world (Levine, 2011). On the other hand, even within a practice which focuses on individual aims, there is a possibility that personal changes generate stronger participation in societal context for example by exhibiting artworks done in therapy. Some clients may themselves choose to use their artwork in a political way for criticising "the sociocultural context in which pain, illness, disability, social stigmatisation or inequality are experienced" (Hogan, 2001, p. 24).

Art and interaction intervened

In art therapy, as well as in other art and health contexts, art is used in interaction with other person or group. This inevitably binds together the ethical and aesthetical issues even if there often is tendency to emphasise either art or interaction on detriment of the other. Professional art therapists have long debated, whether art making and artistic reflection in themselves are the main effective ingredient in therapy, or if the presence of and interaction with another person is central for the way how art effects. The attitude towards these questions has traditionally divided the professional field into two different orientations: Art as therapy, where the healing power of art is stressed, and; Art psychotherapy, where the human interaction is viewed central. Currently the strong polarisation of these orientations has ceased, and most art therapists see an entirety, where art and therapeutic interaction are bound together and influence one another (Edwards, 2004; Jones, 2005; Karkou & Sanderson, 2006; Malchioidi, 2003; Rankanen, Hentinen & Mantere, 2007). Contemporary art therapy is thus defined as a triangular relationship, where art, patient, and therapist are all equal agents in interaction (Karkou & Sanderson, 2006). For this reason, art therapists' need to have equally deep understanding and knowledge of the multifaceted aspects of human interaction and art, and develop their skills in both areas.

Open boundaries

Everitt and Hamilton (2003) have on their behalf described the experiences and difficulties connected with the ambivalence in professional boundaries within the field of art and health. They citate a community artist:

> *I don't have the professional skills to support people in anything that doesn't involve their artistic work. I'm not a counsellor and I'm not their friend either. I'll be really friendly in the Studio but I'm not a friend. (p. 50)*

Issues of responsibility and capacity to manage with overriding or complex emotions and interaction can arise when artists aim to enhance communication. This can evoke confusion and a question of appropriate professional skills and boundaries. Because the boundaries of user-professional relations in these projects are not often explicitly defined, approaches vary from friendship and shared neighbourhood to the individual workers attempts to frame their area of expertise and level of communication. "While inter-subjectivity in relations fits well with an understanding of community arts as *coming from the people themselves"* (Everitt & Hamilton, 2003, p. 49) it on the other hand "takes the place of objectivity, with workers sharing personal lives with users" (Everitt & Hamilton, 2003, p. 49) and builds a risk for both the professionals and participants who may become involved with overwhelming experiences which intervene with personal life. For solving these risks, the need for appropriate supervision and training is crucial and Angus (2002) suggests that the help of arts therapists and those ethical codes developed within art therapy could increase safety and be beneficial for both workers and participants.

Efficient practices are bound to skilful practitioners

When attempting to understand more of the psychological aspects of social interaction and those conditions needed for it to be beneficial, it is worthwhile to orientate in the research done within psychotherapies. Extensive amount of research regardless of orientation has proved the importance of therapeutic interaction and strong working alliance for the therapeutic change and good outcome (Clinton, Gierlach, Zack, Beutler & Castonguay, 2007;

Duodecim & Suomen Akatemia, 2007; Wampold, 2001; Weinberger & Rasco, 2007). Although there are hundreds of different forms of psychotherapy, the varying methods do not significantly differ in the obtained outcomes. Instead, there is evidence that method of cure cannot be separated from the therapist using it and her/his skills in building the interaction and working alliance. (Leiman, 2006; Wampold, 2011) On the other hand, weak alliance and unskilful interaction can lead up to ineffectual or deteriorating results (Bennett, Parry & Ryle, 2006; Norcross, 2010). Rigid emotionally cold therapists who place themselves above clients by knowing-it-all or staying too abstinent can worsen the patients' condition (Huttunen, 2006; Lehtonen, 2006).

Those therapists who consistently reach good outcomes are flexible and skilful in adapting their interactive style and working methods to the individual needs and qualities of each client (Leiman, 2005; Norcross 2010; Wampold, 2011). The therapist ability to balance emotional and cognitive processes to match with clients' style, as well as skills to recognize and repair ruptures and conflicts in working alliance build an effective treatment (Greenberger & Pascual-Leone, 2006; Ruiz-Cordell & Safran, 2007). There is no reason to suspect, that these findings wouldn't be central also in successful therapeutic interaction using art, even if there presumably is also other effective components that art process brings in to the process.

Skilful practitioners build safe boundaries and artistic freedom

The importance of interaction skills and personality is also recognized in art and health activities, where the responsibility of building a successful project and gaining good outcomes is often placed on the personal charismatic qualities of the guiding artist (Hamilton et al 2003). Charismatic artists can make the activities inspiring, creative and innovative and lower the threshold to participate. Their personal and artistic skills can enable emotionally deeply touching and intellectually challenging transformative experiences for participants. This trust on inherent personal skills and qualities can be either strength or weakness in these projects. Training in pedagogical and therapeutic skills with focus on interaction, self-knowledge and self-reflection, could potentially increase the possibilities to success, and ease the load placed on innate qualities of artists'.

Art therapists believe that there is need for specific professional training and knowledge especially if there is aim to enable both safe and beneficial use of the arts with vulnerable clients (Karkou & Sanderson 2006, 273). They trust in the healing and therapeutic impacts of art, but see it also as a process which can become either powerfully positive or destructive force (Karkou & Sanderson 2006; Moon 2010). However, it is sometimes evident that excessive emphasis on guard and caution concerning psychological factors can make the interaction and use of art more rigid and normative, while at the same time losing the creative transformative powers, spontaneity and authentic presence (Levine 2011; McNiff 2011). The ethical concerns of potentially abusive practices and need to protect clients have occasionally lead practitioners to build strong and maybe too restrictive boundaries, which has increased the risk of freezing in outdated habits far away from alive and dynamic art processes (Levine 2011). For enabling best outcomes, there is thus a need to constantly search for optimal balance between open but not abusive or blurred and safe but not rigid professional practices.

Art-based therapist Bruce Moon (2010) emphasises the equivalent presence of both emotional safety and anxiety in order to achieve full therapeutic benefit. Moderate amount of anxiety works for patient as a change motivating force if emotional safety is simultaneously experienced. Feeling of safety creates space for developing trusting relationships within which exploring and expressing their innermost feelings and thoughts is possible (Moon

2010, 11). However patient's confidence is often fragile and easily extinguished, which is why artistic expression can increase the level of anxiety easily too high, leading them to feel exposed and vulnerable (Moon 2010, 16). It is also natural to feel defensive when unfamiliar or self-revealing ways of expression are encouraged. Moon considers, that by explicitly presenting and reliably holding the structure and boundaries of the group and artwork, while at the same time being open to whatever there is need to express, "a sense of safety inevitably emerges" (Moon 2010, 20). Art therapists must be willing to face and accept various painful, disturbing or anxiety provoking expressions in order to the art to be transformative, healing, or meaningful experience (McNiff, 2011; Rankanen, 2011).

Evaluating harms and benefits

In the field of art, health and wellbeing, the positive effects are often praised and no attention is paid to negative experiences or outcomes. Art seems harm free and the potential benefits obvious (Hamilton et al. 2003). The quality of art can also be valued over health or wellbeing effects:

> *Many practitioners emphasize that the quality of the art produced is most important, otherwise it will not do anyone any good. There is a tension between the production of good quality art and the production of a particular effect. If art is to have any effect it must maintain its own integrity. (Angus 2002, 14)*

Contrastingly in art therapy, all kinds of expressions are accepted and their quality is not evaluated. Instead the unfinished, ugly, bland or anxiety provoking art expressions are all valued and their meanings are searched and reflected with equal interest compared to pleasing or successfully finished works. Often the unpleasant image carries the most important therapeutic possibilities, if it can be accepted and respected as it is. This accepting and respecting attitude enables all kinds of experiences and emotions to be expressed and worked through thus effecting the personal change aimed in therapy.

In psychotherapy and medicine, the effects of given treatments are often measured by comparing the changes in patients' symptoms using randomised controlled trials. There is already a good body of outcome research growing within the fields of art therapy and medical research of art activities. Promising results have indicated positive effects on both subjectively and objectively perceived health and wellbeing (Cohen, 2006; Cohen et al. 2006; Gilroy, 2006; Konlaan, 2001; Reynolds, Nabors & Quinlan, 2000; Slayton, D'Archer & Kaplan, 2010; Väänänen et al. 2009). Even though outcome research has grown, some artists working in the area of art and health have debated against the necessity to evaluate arts effects on health:

> *It may seem at best churlish (and positivism gone mad) to expect the arts to justify their existence on scientific grounds, and of course the arts have value irrespective of any presumed health effects (Hamilton et al., 2003, p. 402).*

In spite of these doubts there are at the same time others who stress the importance of evaluative research. In order to use art for increasing wellbeing, health or social participation, and for further develop the activities, research based knowledge is needed (Hamilton et al. 2003). Another question is, whether outcome research alone is sufficient for evaluating art's effects on health and wellbeing. I claim there is also a need for systematic process research that aims to understand which elements in art and interaction contribute to the changes and gained effects. Both forms of research are equally important for evaluating the possible harms or benefits that art and health practices can have. In the future, the knowledge gained

from both outcome and process research can hopefully help to develop a rich field of diverse research based practices which integrate in a balanced way the creative freedom and ethical boundaries.

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