Art Therapy Research in Practice

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ART THERAPY RESEARCH IN PRACTICE

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Contents

List of Figures and Tables

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Figures

Tables

Plates

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Introduction: N=1: Practitioner Research in Art Therapy

This book aims to inform readers about the latest evidence from innovative art therapy research. It shows how, through engaging with research that derives from clinical work, practice and research can mutually inform one another in lively, interesting and useful ways. Projects range from the microanalysis of interactions between clients, their art and the art therapist to investigations of art therapy services and an unpacking of the inside story of a Randomised Controlled Trial (RCT).

The book is divided into three parts addressing art therapy research with children, with people who have learning disabilities and adults. Chapters follow the same structure, each author beginning with 'how it all began' before going on to situate their research in a critical context and describing the research methods they chose to investigate their particular research question. Methods of data collection and analysis are outlined, several contributors discussing innovative use of visual methods and case study approaches to their research. Each chapter concludes with authors' reflections about the influence of their research on what they do, articulating a reflexive loop that moves from practice to research and then from research back into practice.

A distinguishing feature of this book is the collaboration between the editor and the contributing authors. When the chapters were in final draft, authors in Parts One, Two and Three met, having read each other's chapters, to discuss their research with each other and with me; these were recorded, transcribed and sent to the authors for comment. Our conversations identified themes across the chapters and explored and elaborated the research findings particular to each part of the book. As our meetings and conversations progressed it became evident that key themes resonated

across the book as a whole. These were to do with the art in art therapy: its communicative power, its capacity to contain important material that can remain unspoken and the importance of art's physical materiality in relation to bodily experiences. A key theme was the current political context of art therapy provision in Britain. Three editorial commentaries, situated at the end of each part of the book, draw on these conversations, relating contributors' research to the wider art therapy literature and, given our discussions, to government policies too. The nature of these and the many other exchanges that I have had with the contributors about their chapters and the commentaries has made my editorial role an enjoyable and collaborative one. I thank them for this and for their patience with my editorial obsessions. I would also like to thank our Commissioning Editor, Nick Reynolds at Peter Lang, for publishing our 'intriguing' book.

It has long seemed to me that art therapists are natural researchers. Practitioners will have acquired many of the necessary research skills of observing, describing, documenting, distilling and interpreting data in their everyday clinical work. Critical reflection permeates the daily routine. Gathering clinical data from different sources is nothing new. All of this makes research an accessible, empowering and eminently do-able activity that can be incorporated into art therapists' routine practice. I suggest that every art therapist has the potential to become a practitioner researcher, to be a single subject: the N=1.

Art therapy practice generates many rich and compelling questions. Practitioner research gives art therapists an opportunity to investigate these questions, to examine particular preoccupations, to explore processes and phenomena that have caught the eye and to spend time with a particularly interesting topic or case. What characterises practitioner research is, as McLeod (1999) has said, an intensive analysis of a particular aspect of practice, an emphasis on enhancing practical understanding of clinical work and high levels of investment in a topic. This is plain to see in these authors' narratives of their research experiences when they describe how they travelled from a deepening curiosity about someone or something to the emergence of findings that have real implications for art therapy practice and service provision. They demonstrate, for example, the importance of the physical materiality of art-making in art therapy with children (Prokofiev, Chapter One; Hosea, Chapter Three) and adults (Mahony, Chapter Ten;

Skaife, Chapter Eleven). They show how art therapy 'fills something in' for children who have developmental deficits (Prokofiev, Chapter One; Herrmann, Chapter Two) and enables thought for those with learning disabilities (Damarell, Chapter Five). Contributors evidence the significance of all the communications in art therapy (Tipple, Chapter Six) and the outcomes of a Randomised Controlled Trial which demonstrated the effectiveness of group art therapy with people diagnosed as schizophrenic (Jones, Chapter Eight). They unpack the relationship between poverty, mental health and art therapy (Wood, Chapter Nine) and explore art therapy services for people with severe learning disabilities and children in mainstream education (Ashby, Chapter Seven; Stirling, Chapter Four).

This research enters the public domain at a time when the demand for 'evidence' of an intervention's clinical and cost effectiveness underpins all provision in the public sector. Building the evidence base of art therapy is more critical now than ever before. In this Introduction I therefore set the scene with a brief outline of Evidence-Based Practice (EBP) that explains the continuing dominance of RCTs. Before you head for the hills please read on to see how these are but a part of the research field and how practitioner research can bridge the research-practice 'gap', particularly through a case study approach to research and the use of visual methods. At the end of this Introduction I map the chapters themselves. I hope that what follows will show how you – the practitioner, the N=1 – can make a contribution to art therapy's evidence base.

Evidence-Based Practice

EBP is a cyclic process which requires that all interventions in health, social, educational and criminal justice systems are based on research that has demonstrated their effectiveness. It requires that practitioners constantly update their knowledge of research so that they can ensure that 'best practice' is delivered that will lead to the best outcomes. Healthcare practitioners are also required to demonstrate that they have actually implemented what the research recommends; this is achieved through two

quality assurance procedures: clinical guidelines – which distill findings from research and make recommendations about treatment – and audit. EBP therefore draws a linear equation between a person, their diagnosis, research and the treatment they receive. EBP pervades the discourses and policies of Britain's public services and increasingly determines the interventions and treatments that are resourced by public funds. In these particularly hard-pressed, credit-crunched times, the pressure to provide empirical research that will support the continuing delivery of all kinds of services has increased, especially those for marginalised groups delivered by specialist practitioners such as art therapists. (See Gilroy, 2006 for further description and critical discussion of EBP.)

Those interventions whose evidence base is well established, such as cognitive behaviour therapy (CBT) have, as a direct consequence of the implementation of EBP in Britain's mental health services, expanded exponentially in recent years, but all is not well in the EBP world as far as art therapy and many other public sector practices are concerned. This is because the only acceptable form of research within the EBP paradigm is a RCT – the 'gold standard' of 'scientific evidence'. Other kinds of quantitative research are of lesser value; qualitative research is usually excluded. This kind of 'big' research occurs in a political arena (McLeod, 1999), requires significant funding and huge numbers of people to be randomly assigned either to groups that receive the intervention or to other, non-intervention or 'control' groups. The results of both groups are measured and compared using standard tests and statistics to see if those who received the intervention do better than those who did not. The method derives from medicine and takes a positivist approach, based on the principles of the natural sciences (biology, physics and chemistry) which assume that the same patterns of response will always occur, given the same conditions. This approach is well-suited to physical treatments and to manualised psychological interventions that consider the body and the mind as organisms; when something goes wrong there is a cause which can be identified and an intervention that can be made to rectify the problem. However, the human mind is highly individualistic and does not always operate in such a mechanistic, cause and effect way, being influenced by relationships, experiences, cultures and socio-political contexts.

The dominance of RCTs in EBP in the psychological therapies (as well as in general medicine, education and social care) is vigorously contested. McLeod (1999), for example, argues that RCTs are privileged because their structure fits bio-behavioural systems of psychiatric diagnosis. Further, as Westen et al (2004) and many others have pointed out, RCTs require particular conditions: clients with a single diagnosis, the use of a manualized therapy and a 'treatment package', often administered for relatively short periods of time that are determined by the project's funding. Their nature also requires practice to be precisely articulated and then delivered exactly as it has been described, in laboratory-like conditions. This means that RCTs rarely reflect the norms of everyday clinical work. Further, clinical approaches that do not accede to medical and behavioural models need other forms of research investigation, not only to identify what is effective but also to understand the processes of interventions that are based in relationship. Nonetheless, clinical guidelines about all treatments, including those for mental health problems, are issued by powerful organisations like the National Institute for Clinical Health and Excellence (NICE, see www.nice.org) and the Cochrane Collaboration (see www.cochrane.org.uk) based solely on RCTs, creating a situation that can lead '... to a state of affairs where the methodological tail wags the clinical dog' (Westen et al., 2004: 642).

This is not to say that quantitative research in general, and RCTs in particular, cannot and should not be done in art therapy. Indeed I have suggested elsewhere (Gilroy and Lee, 1995; Gilroy, 2006) that art therapists' focus on building a respectable body of rich, descriptive literature and inductive research has been to the detriment of outcome research. This is not to say that inductive research, undertaken by practitioners, should be neglected. Far from it. In my view such research is critical to art therapy's evidence base, not only because it is an essential precursor to the empirical research that EBP requires but also because it has intrinsic worth. Inductive research is cumulative. It builds slowly and steadily. It often involves a personal journey for the practitioner researcher. It accesses the practitioner's tacit knowledge, describing practices, developing theories and exploring new ideas, all the while seeking to describe possibilities and exploring questions that art therapists want to investigate in order to enhance their

practice rather than provide answers to EBP's questions about 'what works'. It is here that the N=1 practitioner researcher has a definitive role to play, doing research that comes from the ground up, which travels, as Westen et al (2004) have suggested, from the clinic – and, in art therapy's case, the studio – to the RCT laboratory.

There are many research methods that can be used in art therapy, as I have described elsewhere (Gilroy, 2006) and summarise below.

- Action: cycles of action and reflection
- Collaborative: co-researching, subjective, experiential
- Case studies: clinical – experimental, descriptive, exploratory, case series; social – the 'bounded' case and/or system
- Ethnographic: observation and description of people and/or events in their natural environment
- Hermeneutic: interpretation of texts
- Heuristic: experiential discovery using self and others Phenomenological: observation and definitive description
- Historical/archival: texts and objects, primary and secondary sources
- Interviews: structured, semi-structured, open
- Randomised Controlled Trials (RCTs) and controlled group studies: measurement of treatment outcomes
- Surveys: questionnaires gathering quantitative and/or qualitative data
- Visual: looking, writing, curating, making

Some entail an enormous amount of data collection and analysis and, usually, several researchers – which can include art therapists (as in Jones, Chapter Eight) – who bring to the research table expertise that goes beyond the routines of clinical work. Others are suited to small-scale, inductive, research. Here art therapists can, like the contributors to this book, draw on their transferable skills and incorporate research into their everyday work, especially when it comes to a case study approach to practitioner research.

Case Studies

A case study is 'a study of the singular, the particular, the unique' (Simons, 2009: 3). In the research traditions of the psychological therapies a 'case' is usually understood to refer to a person or a group; the 'study' is of the background, development, processes and outcomes of therapeutic work, either in a narrative or an experimental form. In other research traditions in the social sciences e.g. anthropology, history and sociology, case studies take different forms; a case study could be of a person or a group but it could equally be of a classroom, an organisation, a service, a system or a country. Generally speaking a case study approach to research is understood as a method through which the particular can be systematically explored. Art therapy draws on all these approaches to case study, there being no 'correct' way of using case studies as a research approach.

Therapeutic work has long been conceived as a research method in psychoanalysis, psychotherapy and counselling. As McLeod (1994) describes, key figures in the history of these disciplines have, through publication of classic case studies, demonstrated the distinctiveness of their approach. These have acted as a starting point for subsequent research, either through the accumulation of further case studies which confirm or challenge the conclusions of earlier work or which lead into larger-scale, quantitative research. A similar model applies in art therapy. However, case studies have been critiqued because of their subjectivity and inherent bias and because of difficulties with generalisation beyond the individual case. In response to such criticism approaches have been developed which differentiate between an 'ordinary', descriptive case study (like that written during art therapy training) and systematic case study research. These methods can readily be applied to a wide range of art therapy research questions by the practitioner researcher. It only requires one: one client or one group, and one practitioner researcher.

In this book practitioner researchers have drawn primarily on the 'clinical' tradition of case studies but they have also used a social science approach to the 'bounded system' of a case (Simons, 2009: 29): of participative