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No Need for Words: Participatory Action Research with an Arts-based Peer Support Group

Samantha Boyce
Lesley University, samanthaboyce18@gmail.com

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No Need for Words: Participatory Action Research with an Arts-based Peer Support Group

Capstone Thesis

Lesley University

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Samantha Boyce

Specialization: Expressive Arts Therapy

Thesis Advisor: Kelvin Ramirez, PhD, ATR-BC, LCAT
Abstract

The Arts and Peer Support Group (APSG) is a free, open-studio style expressive arts therapy group for adults living with Severe Mental Illness (SMI) guided by clinicians and informed by a recovery orientation to mental health care for SMI. This capstone thesis used an arts-based participatory action research paradigm to explore the value of an expressive arts therapy group for adults living with SMI. The researcher of this capstone thesis hypothesized that an expressive arts therapy framework could be combined with innovative approaches to the recovery orientation, such as mutual recovery, which has encouraged systemic change in society’s perception of SMI in addition to the traditional focus on supportive care for the individual living with SMI. The theoretical basis of expressive arts therapy, that the creative process can foster personal and community growth (International Expressive Arts Therapy Association, 2017), is well aligned with the values of the recovery orientation, which supports an individual’s self-directed path to recovery through social support and collaborative illness management (Leonhardt et al., 2017). Arts and Peer Support Group members and clinicians participated in a series of art-making sessions dedicated to exploring the group dynamics of the APSG, as well as assessing the possible benefits and deficits of the group. The researcher of this capstone thesis engaged in a reflective parallel artistic process and concluded that the arts were uniquely positioned to help create a community of individuals who found common ground through artistic expression and support for mental health advocacy.
No Need for Words: Participatory Action Research with an Arts-based Peer Support Group

Introduction

Serious or severe mental illness (SMI) is a designation that encompasses various diagnoses, including schizophrenia, schizoaffective disorders and major depressive disorder (Ruggieri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). Not only do individuals living with SMI experience physical and mental symptoms, but they may also experience functional difficulties in daily living and community engagement (Sanchez, Rosenthal, Tansey, Frain & Bezyak, 2016). It is well documented that individuals with SMI are subject to stigma (Corrigan, Kerr & Knudsen, 2005; Corrigan & Rao, 2012), and that individuals living with SMI experience microaggressions by both the general public and mental health professionals (Gonzales, Davidoff, Nadal & Yanos, 2015). As such, treatment for individuals with SMI can often require complex and innovative approaches that are capable of addressing the multiplicity of issues faced by this population.

Treatment for individuals with SMI has undergone many changes over the years, beginning with the isolation of people in psychiatric hospitals, followed by deinstitutionalization and psychopharmacological treatment (Braslow, 2013). The past several decades have seen a shift towards a recovery orientation for treatment of people living with SMI (Ahmed et al., 2012). Whereas earlier treatment models tended to focus on pathology and the management of chronic symptoms while ignoring the prospect of functional improvement, the recovery orientation takes a strengths-based, person-centered psychosocial perspective that emphasizes improving quality of life, increasing social inclusion, and generating a sense of agency among those living with SMI (Shepherd, Boardman & Slade, 2008). Under the recovery approach, rehabilitation requires social support, social competence and active participation by both the
individual and the treatment team (Sanchez et al., 2016). Thus, this method of treatment aims to support the whole individual and might involve several components beyond the patient-psychiatrist relationship, especially in the realms of social support and inclusion.

Within the recovery approach, peer support offers a model that addresses the aforementioned need to develop social support for individuals living with SMI. Peer support models of group therapy emphasize empowerment in an egalitarian atmosphere that contributes to the individual’s overall wellness, including their aspirations, strengths, social life, etc. Peer support groups are based on the inherent value of giving and receiving support in an inclusive and welcoming setting with others who have experienced similar challenges (Schon, 2008).

Despite the general positive regard for peer support from qualitative studies (Ahmed et al., 2012; Schon, 2010), a recent meta-analysis of quantitative studies found little evidence for the effectiveness of peer support (Lloyd-Evans, et al., 2014). However, this did not provide conclusive evidence against peer support because, as the authors noted, many of the studies in their meta-analysis did not follow standardized theoretical models or have clearly stated goals, making it difficult to compare effectiveness across peer support groups. More recent studies have taken up the mantle of better operationalizing the nature of peer support outcomes and have attempted to come to a consensus on the beneficial core elements of peer support (Burke, Pyle, Machin & Morrison 2018a; Burke, Pyle, Machin & Morrison, 2018b). Therefore, peer support could be considered a valid aspect of treatment for individuals living with SMI but would benefit from further standardization of the various approaches to peer support.

Despite the overwhelming support among those in the mental health service industries, recovery-oriented treatment has also come under criticism in recent years. Braslow (2013) argued that in an effort to decrease cost, managed care has come to define recovery as a mental
health outcome, rather than a subjective, life-long process. As a result, the author argued that recovery had become a system that transformed patients into consumers responsible for their own recovery. Additionally, Braslow (2013) suggested that the current system has not allowed for the idiosyncrasies of an individual’s recovery journey because it was built on the premise that progress is measured by an individual’s movement from intensive reliance on the system to minimal reliance on services. The ideal effects of recovery-oriented treatment, and peer support specifically, include an increase in social connectedness, a decrease in self-stigma, an increase in subjective quality of life, among others, and are intended to be ongoing, long-term treatment goals (Burke et al., 2018b). In essence, Braslow’s (2013) history of the recovery movement highlighted that mental health services have not effectively focused their support on the individual’s personal growth, empowerment and community engagement, or the reduction of social stigma for individuals with SMI.

Novel approaches have attempted to resolve these issues in the treatment of SMI and to complement the existing benefits of the recovery framework. Among these, expressive arts therapies have been shown to improve social connectedness, psychological well-being, motivation and self-care among individuals living with SMI (Saavedra, Arias, Crawford & Perez, 2018; Van Lith, 2015). Expressive arts therapy is an action-oriented form of arts-based psychotherapy that uses an intermodal approach to respond to human suffering through various artforms, including visual art, music, dance, movement, drama, poetry and creative writing (Knill, Levine & Levine, 2005; Malchiodi, 2005). The use of the arts to promote healing among the physically and mentally ill has long been documented throughout human history (Malchiodi, 2005). The modern field of expressive therapies has its roots in the use of music therapy with veterans during World War I and gained traction in the 1930s and 40s when the value of using
the arts therapeutically with individuals living with SMI became increasingly apparent (Malchiodi, 2005). Because the expressive therapies orientation already espouses the core values of the recovery approach, including a focus on self-expression, active engagement in the therapeutic process, and a resource-oriented and growth-based personal therapeutic journey, it can offer a focused lens through which to view the nebulous realm of existing treatments for SMI.

Expressive therapies also offer the additional value of the use of the imagination and mind-body connections (Malchiodi, 2005). Imagination, which is at the basis of all art-making, can foster new perspectives and alternative ways of being (Knill, Levine & Levine, 2005). The mind-body connection is particularly salient in the expressive arts therapies; recent neuroscience research has shown these modalities to ameliorate trauma responses, initiate relaxation and possibly repair poor attachments (Malchiodi, 2005). Therefore, the expressive therapies are uniquely positioned to support the maintenance of functional living through self-expression, direct engagement between individuals and their own treatment, encouragement of healthy change and growth through the use of the imagination, and possibly also address past trauma due to the rootedness of the expressive therapies in the senses.

Although there is limited extant research on the combination of recovery approaches to treating SMI with expressive arts therapy (for example see, Allan, Barford, Horwood, Stevens & Tanti, 2015; Spandler, Secker, Kent, Hacking & Shenton, 2007), there is extensive research to support the use of expressive therapies with individuals living with SMI (for example see, Saavedra et al., 2018; McCaffrey, 2018; Van Lith, 2015; McKeown, Weir, Berridge, Ellis & Kyratsis, 2016; Lipe et al., 2012; Baines & Danko, 2010; Spandler et al., 2007).
In light of this evidence, this capstone thesis sought to increase understanding of the value of an expressive arts therapy framework within a peer support group for adults with SMI by investigating the efficacy of expressive arts therapy in a peer support group with individuals with SMI called The Arts and Peer Support Group (APSG). The Arts and Peer Support Group is an ongoing open art therapy group in central North Carolina organized by a non-profit art therapy organization for adults who self-identify as living with a serious and persistent mental illness. This capstone thesis used an arts-based participatory action research approach to explore the dynamics of the APSG group in a collaborative process that reflected the values of recovery and peer support models in conjunction with the theoretical underpinnings of expressive arts therapy. Through this approach, the meaning of the group for long-standing group members and facilitators, and the role of power dynamics and boundaries in the group’s structure was investigated in order to learn about the nature of the community created by the APSG.

The following section provides an overview of the extant literature on the aforementioned topics in order to illustrate the processes inherent in treatment of SMI. Further, the merits of expressive arts therapy in an open-studio group therapy format will be shown to be a valid approach that takes into consideration the stigma faced by this population and the value of attending to power dynamics in the group setting.

**Literature Review**

Individuals affected by serious mental illness account for 4.2% of U.S. adults with rates climbing to 5.6% among women and 7.5% among adults who reported two or more races (National Institute of Mental Health, 2017). Not only do these individuals face overt discrimination and stigma, including notions that they are inferior or dangerous (Treichler & Lucksted, 2018; Corrigan & Rao, 2012), but they also face microaggressions that can take a toll
on an individual’s sense of self-efficacy and self-worth (Gonzales, Davidoff, Nadal & Yanos, 2015). A particularly pernicious aspect of the stigma faced by these individuals is self-stigma, which occurs when an individual “internalizes society’s negative beliefs about marginalized groups one belongs to” (Treichler & Lucksted, 2018, p.149) and can have lasting detrimental effects on mental health and general well-being. Because of the pervasive nature of SMI and its associated symptoms, it has been complicated and challenging to properly support individuals living with SMI.

**Treating SMI: The Recovery Orientation**

Historically, treatment for individuals with SMI has followed the medical model, which emphasizes psychopharmacological symptom management and generally does not accept recovery as a possible outcome (Ahmed et al., 2012). The recovery orientation, introduced as an alternative to the traditional medical model of treatment for individuals with SMI, emerged after deinstitutionalization in the 1960s and the community-based care and psychopharmacological era of the 1980s (Braslows, 2013). Early supporters of the recovery movement argued that recovery was dependent upon an individual regaining a sense of control over their own lives through social and community support (Anthony, 1993). More recent conceptualizations of recovery have regarded it as an individual’s unique biopsychosocial journey which must be supported by the mental health system. Shepherd, Boardman and Slade (2008) asserted that the goals of recovery include helping individuals regain their place in society and becoming empowered through their connectedness with society. The recovery orientation has significantly revolutionized treatment of SMI and in the past few decades has taken over as the most prominent approach to treatment of SMI (Leonhardt et al., 2017).
Despite its recent popularity, the literature surrounding the recovery orientation has not always been clear in its operationalization of terms and constructs. For example, in a review of the literature on recovery and SMI, Leonhardt and colleagues (2017) stressed that it is important to properly operationalize the term ‘recovery’ because it is often used both by those perpetuating a medical model of treatment and those who consider themselves to be ‘recovery oriented.’ The medical model, which has still been pervasive despite overall shifts in the landscape of mental health care, has used an objective conceptualization of recovery, focusing on symptom reduction and psychosocial benchmarks (Leonhardt et al., 2017). Recovery oriented clinicians have viewed recovery in subjective terms, relying on the individual to assess what recovery means for them and focusing on the process of identity development (2017). This disconnect between outcome-oriented and process-oriented perspectives on recovery is important because it has impacted the outcomes that have been measured and the conclusions that have been drawn regarding the efficacy of the recovery orientation in the treatment of SMI. Leonhardt and colleagues (2017) found that it is crucial for care providers to offer space for the client’s nuanced reflections in a non-hierarchical relationship with the provider. Given the varied interpretations of the term recovery and the complex and interrelated nature of symptoms of SMI and subjective wellness, it is clear that more research is needed to further elucidate the nature of the recovery process and the mechanisms of change that help support individuals living with SMI.

**Social Support and SMI.** Greater levels of social support have been found to contribute to significant improvements in quality of life for individuals with SMI. For example, Sanchez and colleagues (2016) conducted a quantitative analysis of one hundred and ninety-four individuals living with SMI using the most recent International Classification of Functioning, Disability and Health (ICF) framework to attempt to understand the contextual factors affecting
quality of life (QoL). The authors found the framework to be a valid predictor for QoL and found that greater levels of social support and social competence are associated with higher QoL and greater levels of stigma were related to lower levels of QoL. Overall, the authors found that social competence is a significant predictor for higher QoL for individuals living with SMI. Similarly, Treichler and Lucksted (2018) found that a sense of belonging can play a moderating role in the level of self-stigma experienced by an individual with SMI, increasing self-esteem and self-efficacy. These studies highlighted the particularly important roles that social competence and social connectedness have in mitigating some of the iatrogenic realities that individuals with SMI endure as a result of the social stigma and isolation inherent with this diagnosis.

**Client-clinician relationship.** The role of the relationship between clinician and client has been the focus of research on the treatment of SMI (Borg & Kristiansen, 2004; Davidson & Chan, 2014). Davidson and Chan (2014), citing Lambert and Barley’s (2012) summary of the research on psychotherapy outcomes, asserted that “common factors” such as the instilment of hope, empathic and nonjudgmental listening, and encouragement and support within the clinician-client relationship account for more outcome variance than specific therapeutic techniques. In order to better understand what service users find helpful in a psychotherapeutic relationship, Borg and Kristiansen (2004) conducted a qualitative study from interviews with fifteen service users with SMI. The themes that emerged included clinicians’ recognition of the service user’s humanity, ability to collaborate and be available to the service user, willingness to shape treatment to the unique needs of the individual and operating on the edge of professional conduct in a *friendship-like capacity* (2004). The helping relationship provides a key role in the recovery process and contributes to the social competence that is critical to an individual’s
recovery journey. Ultimately, this evidence suggests that for individuals with SMI, increasing external supports likely has a particularly protective effect on well-being by fomenting a sense of social belonging that can combat the experience of isolation and stigmatization that is often common among individuals with SMI.

**Peer support.** One common treatment for addressing the need for social support, decreasing isolation and increasing self-esteem among individuals living with SMI has been through peer support. Peer support engages individuals with lived experience of SMI to become ‘peer specialists’ and to provide support and care to others with SMI (Schon, 2010) and has been associated with increased hope, empowerment, and enhanced empathy (Burke et al., 2018a). There are also challenges associated with peer support, especially in terms of the stigma faced by peer specialists in the mental health system and the confusion that can be caused by the ambiguity of their role (Firmin, Mao, Bellamy and Davidson, 2018; Ahmed et al., 2012).

Lloyd-Evans and colleagues (2014) found that while peer support is associated with recovery, more research is needed that will clarify the role of the peer specialist, as well as the approach and goals of peer support. In the years since Lloyd-Evans and colleagues’ (2014) meta-analysis on the quantitative evidence for peer support, Burke and colleagues (2018a; 2018b) put forth two qualitative studies that aimed to address the core components of the mental health peer support role (Burke et al., 2018a) and to gather data to illuminate the costs and benefits of peer support for peer specialists (Burke et al., 2018b). Whereas the authors concluded that the benefits outweigh the risks for peer specialists and put forth a clear framework for the role of the peer specialist, they also noted that their evidence laid the groundwork for quantitative studies to further assess best practices for peer support. Although research has emerged that has begun to delve more deeply into the nuanced nature of peer support, the field continues to evolve and adapt to meet the needs of individuals with SMI.
support, shining a light on the stigma faced by peer support practitioners and the SMI population in general, the sparse literature on how to address these issues has remained limited.

More research is also needed to clarify the various formats that peer support can inhabit and to operationalize alternative forms of peer support in which one or more clinicians are present in the group. Lefley (2009) proposed that a psychoeducational peer support model is another option in the treatment of SMI that builds on the peer support model yet includes the presence of a few doctors, clinicians and medical students to serve as facilitators available to answer questions and provide a consistent presence in the group. As far as the researcher of this capstone thesis is aware, there has been no further analysis or research studies addressing this unique approach to peer support group dynamics.

**SMI and Expressive Arts Therapy**

Despite the aforementioned contributions of the recovery orientation and peer support, at the present moment these approaches have fallen short of providing targeted solutions for the systemic oppression faced by individuals with SMI, as well as moving beyond the myopic perspective of the practitioner and more comprehensively including the voices of the individuals using the system. The researcher of this capstone thesis found that an expressive arts therapy framework showed potential to fill this gap in the literature.

In recent years, researchers have noted the applicability of the expressive therapies to recovery-oriented care for the treatment of SMI (Allan et al., 2015; Lipe et al., 2012; McCaffrey, 2018). Allan et al. (2015) introduced the development of a recovery-based art therapy model called Art Therapy in Community (ATIC) for individuals experiencing serious mental illness and stated that because art therapy helped to improve well-being, motivation and self-care among group members, it was relevant to the recovery approach. Van Lith (2015) assessed the broader
role that creative practices played in the treatment of individuals living with SMI and found that benefits included improvement in “connection to the inner self”, development of “a sense of achievement”, a “motivating force when unwell”, and the creation of a “psychologically safe-space” (p.7). Other studies have found that, in terms of psychosocial indicators, the creative arts contributed to improvement in communication skills, social connectivity, motivation, concentration and subjective well-being (Saavedra et al., 2018; Spandler et al., 2007). Bungay, Munn-Giddings, Boyce & Wilson (2014) conducted a critical review of the literature on the creative arts in healthcare and found that overall, engagement with the arts led to improvement in physical symptoms, mood and greater life satisfaction.

In a review of the art therapy literature in mental health, Van Lith (2016) found that therapist transparency and active therapist-client collaboration led to positive outcomes. However, the author also indicated that despite the promise of these findings, more research needed to be done to determine the applicability of these finding to individuals living with SMI. Recently, researchers have responded to Van Lith’s call. For example, Saavedra et al. (2018) conducted an impact study to assess the value of a recovery-oriented expressive therapies workshop. The authors included structured interviews, participant observation, and group discussion and results were grounded in a thematic analysis of the data gathered. In line with the recent criticism of certain recovery approaches that do not effectively incorporate the service user’s perspective, Saavedra et al. (2018) focused on how the expressive therapies promoted well-being and growth for individuals with SMI, rather than merely symptom reduction. The authors found a positive impact on social connections and communication skills and argued that holding workshops in a non-clinical setting with participation from professionals, service users, and community members had a de-stigmatizing effect.
Other researchers found that the structure, setting and method of the expressive arts therapy delivery model could have important effects on clinical outcomes (Allan et al., 2015; Moon, 2002). Allan et al. (2015) analyzed a recovery-oriented closed group that ran for 12 weeks and was led by two clinicians and a peer arts worker who was a former group member. The authors found that locating the group in a community art setting rather than a clinical setting helped members to feel like a part of the larger community as participants built their artistic identity and collaborated with others. The authors also noted that limitations to the study included their inability to explore in depth the “unique staffing” of the group being “delivered by two art therapists plus a peer worker” (Allan et al., 2015, p.24). The authors hypothesized that this structure worked for them because it helped to support a safe environment for individuals who had recently left acute care settings.

The structure of an expressive therapies group can take several different forms, including a traditional group in which an art therapy experiential is led by a clinician, as well as that of an ‘open studio’ group in which sessions are less directive and group members are free to work on their own and process their art with the group at the end of the session (Allen, 1995; Moon, 2002). Within the field of expressive art therapy, it has recently become preferable to use the term experiential rather than the term intervention to describe the actions taken by the clinician and the activities engaged in by the client or group members (K. Ramirez, personal communication, April 16, 2019). It is the opinion of the researcher of this capstone thesis that the term experiential implies a less directive approach and perhaps better describes the action-oriented, process-driven collaborative framework taken by many expressive art therapists. In both traditional expressive arts therapy groups and open-studio style groups, the role of the expressive therapy clinician has most recently been described as a guide rather than an expert in
order to try to level power hierarchies between clinicians and clients (Van Lith, 2016). It is this unique approach taken by many expressive arts therapists that makes expressive arts therapy a well-positioned theoretical orientation to treat SMI, especially considering the aforementioned need for collaborative and egalitarian treatment settings.

Saavedra et al. (2018) based their study on the same framework as Crawford, Brown, Baker, Tischler and Abrams (2015), which stated that engagement in the arts can be a form of “mutual recovery.” Saavedra et al. (2018) argued that when individuals living with SMI engaged in creative practice alongside practitioners and others, it challenged the traditional unidirectional conceptualization of recovery. This community-oriented approach to recovery suggested a more complex, interpersonal form of healing and growth that affected both clients and practitioners (Saavedra et al., 2018). Korsbek (2016) wrote that co-recovery, or mutual recovery, was more realistic than conceiving of recovery in isolation because recovery is a universal phenomenon that also affects service professionals, as well as society. The therapeutic relationship is reciprocal and, therefore, it is impossible for both the therapist and client not to change and grow during the recovery process (Korsbek, 2016). Within the field of the expressive therapies, the theory of witnessing is closely aligned with the concept of mutual recovery. For Barak and Stebbins (2017) witnessing referred to the experience of being in the “empathic presence of an Other” (p.53) who provided validation and an increased feeling of connectedness for the client, whether in relationship with a helping professional, or among group members. In the process of witnessing both the witness and the individual being witnessed will have experienced profound presence and connection (McNiff, 2013). Therefore, collaborative engagement in the arts among individuals with SMI, clinicians, and the larger public might represent a novel manifestation of the concept of mutual recovery within the context of expressive arts therapy.
Individuals living with SMI often face social isolation, experience functional difficulties in daily living, and must cope with both society’s stigma and judgment of those living with mental illness, as well as the debilitating reality of self-stigma (Corrigan & Rao, 2012). The extant literature on the treatment of SMI suggested that therapies should address these issues by improving social connectedness through avenues like peer support, as well as by clinicians employing a recovery-oriented lens to treatment (Burke et al., 2018a; Borg & Kristiansen, 2004).

A review of the literature has shown that expressive arts therapies groups offer a unique and promising approach to treatment for SMI due to their focus on self-expression in the presence of witnesses and community-building (Saavedra et al., 2018). Currently, there is limited research on the connection between the recovery orientation for treatment of SMI and the expressive arts therapies (Saavedra et al., 2018; Allan et al., 2015). This capstone thesis sought to add to the literature by analyzing how a collaborative, peer-driven, open studio style expressive therapies group for adults living with SMI might be mutually beneficial for the individuals with SMI, the clinicians, and the community at large.

Methods

This capstone thesis was conducted with a weekly expressive arts therapy group for adults living with severe or serious mental illness called the Arts and Peer Support Group (APSG). The Arts and Peer Support Group is an open, peer-based group in which clinicians have employed an open studio style approach to expressive therapies and have routinely empowered group members to share their individual art skills with the group. The group was created in 2011 at the bequest of a patient who was about to be discharged from an inpatient psychiatry unit in a hospital and inquired about whether there was a low-cost place to make art in the community that could accommodate his mental health needs (H. Rubesin, personal communication, February 12,
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The group began soon after, as a free and open art-making space for adults who identified as living with SMI. Although the group was initially funded by a small grant obtained through a local university hospital, the group leaders eventually chose to become self-funded in order to avoid being restricted by hospital guidelines. Since then, group leaders have intentionally chosen not to bill insurance or to require formal intakes, referrals, or diagnostic information for group participants. The group leaders intend to maintain an open, free, community-based group that is not beholden to any outside interests (H. Rubesin, personal communication, February 12, 2019).

At the time when the research for this capstone thesis was conducted, the group was facilitated by an art therapist, an expressive arts therapist and a social worker, as well as two to three interns. The researcher of this capstone thesis was one of the aforementioned interns with the non-profit organization that has been running the APSG. Van Lith (2016) mentioned that art therapists have tended to eschew their role as expert in recovery-oriented art therapy and have preferred to see themselves as guides. In the APSG, the therapists have guided participants in art-making and weekly check-ins. Due to the APSG’s unique structure as a peer support group in which art therapists and social workers have been present as guides, the researcher of this capstone thesis noted that it made for a unique case study on the role of the clinician, power dynamics, boundaries and the nature of the arts in the service of recovery.

Several of the original group members, as well as some of the original clinicians, have participated each week for the past eight years. The participants in the APSG have included a range of ages, ethnicities, socioeconomic statuses and gender identities. In addition to the physical community created by this group, there has also been a large network of former group members who have remained on the email list in order to be kept aware of what the group is currently doing. Often a group member who had not been to a meeting for several months, or
even years, would attend a meeting just to check in, because the group was seen as a consistent and reliable fixture for them. The researcher of this capstone thesis began attending the group for several weeks before proposing this research project in order to gain access to this established community and to begin to build trust with the group members.

The balance of members to clinicians in the Arts and Peer Support Group is unique, and scant research exists on the impact of different ratios of clinicians and clients (Allan et al., 2015). Clarke (2017) explored the possibility of flat and fluid hierarchies in therapeutic communities that attempt to diminish the power differentials between clients and providers. This goal is aligned with the aim of anti-oppressive, feminist and critical theory frameworks to creative arts psychotherapy research and practice in its focus on finding a way to address the inherent power imbalances in mental health care (Sajnani, 2012; Sajnani, Marxen & Zarate, 2017; Hadley, 2013). Through the use of non-directive group art-making by group members and clinicians, the group has operated through collaboration and shared discovery in the art-making process. The preexisting framework of operation within the group was well situated to an arts-based participatory action approach to research.

Arts-based research uses artistic methods, including dance, visual art, writing, poetry, drama, etc. throughout the research process as the primary form of enquiry (Leavy, 2009; McNiff, 2013). Art is the vehicle through which the researcher and participants clarify research questions, learn information and process and organize the data; the arts are not merely documents or data points, but the method of research itself (Leavy, 2009). Participatory action research (PAR) is an orientation that actively involves the participant in the research process (Minkler & Wallerstein, 2008). This method was chosen for this study due to the historical oppression of individuals with SMI and the subsequent desire to minimize oppressive practices.
in the research process. Through the involvement of group members in decision making, reflection, and analysis, the researcher of this capstone thesis was hopeful to lessen the power imbalance between researcher/clinician and participant/client.

The researcher of this capstone thesis is unaware of any existing literature on the use of an arts-based participatory action research approach to evaluate the nature of a recovery-oriented expressive arts therapy group for adults living with SMI. Earlier studies explored the connection between the expressive therapies and the recovery framework (Allan et al., 2015; Saavedra et al., 2018) and used mixed methods approaches that involved gathering pre and post quantitative data. The researcher of this capstone thesis sought to use a more grounded approach to data collection in order to involve the participants in the research process as intimately as possible.

During one of the APSG group meetings, the researcher of this capstone thesis proposed the idea of a collaborative arts-based research project with the possible goal of exhibiting our artwork in a public setting. The researcher explained that the purpose of this research project would be to reflect upon the nature of the APSG and to use the arts to do so in an organic and non-predetermined way. Group members were given the option to participate and were told that they could determine their level of participation as the process unfolded.

The researcher kept a personal journal and wrote reflections after each group meeting as a method of recording and processing the meetings. In order to engage in an arts-based conversation with group members throughout the research process the researcher chose to keep an art journal and create visual art after each group meeting (see Appendix B for images from the researcher’s art journal). During pre-established once monthly “open mic” sessions of the APSG in which group members have been invited to share something they have been working on outside of group, the researcher shared these personal art reflections with group members as a
form of member checking and to aid in the collaborative nature of the research process. The researcher also used conversations with the three licensed clinicians to collect information and to discuss and contextualize group dynamics.

It was decided by the group that the research project would use drawing to explore the personal value of the Arts and Peer Support Group for group members and that we would conduct this arts-based research over the course of 4 to 5 group meetings, culminating in a group art show in which both member and clinician artwork would be exhibited together. When in the course of the group’s initial conversation about methodology, a group member requested “learning to draw”, and the researcher was reminded of Allen’s (1995) text in which art is defined as a way of knowing. The researcher then suggested to the group that we might think about practicing drawing together and use it as a way of knowing the group. The group agreed to this approach and for the next several weeks the researcher suggested several different drawing activities as themes emerged in the art-making process.

Each session followed the structure that was established in the APSG group prior to this research project. Groups began with a brief check-in from both members and clinicians about how their past week has been and if there are any issues they would like to discuss with the group. Due to the fact that group members have historically attended group sporadically, the makeup of the group was not consistent week to week. Therefore, at the start of each of the group meetings the researcher re-introduced the project and explained the process to the group members. Following this explanation, the group then engaged in the main art experiential. The art experientials that the group engaged in over the course of ten sessions are outlined in Table A1. At the end of each session the group members shared any artwork created and the researcher initiated a discussion about plans for next session.
Artwork was stored after each session in a dedicated space in the studio. The researcher’s weekly written journal and visual art journal was shared with group members during “open mic” sessions of group. Data was organized according to emergent themes that surfaced in the researcher’s written and art journals, as well as art materials produced by the group.

The anticipated culmination of this research study was intended to be a public exhibition of client and clinician artwork. The researcher of this capstone thesis also hoped to collect brief surveys from exhibition viewers regarding their reaction to the exhibition, as well as preconceived notions about individuals with SMI. However, due to the limited time frame and scheduling difficulties the present study was unable to include the exhibition phase of the project.

**Results**

Three major themes were observed in the researcher of this capstone thesis’ journal writings, journal images and group collaborative artwork over the course of the research study. These themes were: engagement in the creative process, power dynamics, and community building. Within each of these thematic phenomena, both limitations and positive outcomes were observed.

**Engagement in the Creative Process**

The first observed theme, engagement in the creative process, seemed to be integral to the character and identity of the group and was directly remarked upon by group members and clinicians several times throughout the research process. Not only did group members consistently express interest in exploring a wide variety of art forms during group sessions, but they shared updates from their personal artistic practice with the group. Familiarity with using
the creative process to express, make meaning, and cope with challenges was a commonality for both group members and clinicians.

Leading up to the research sessions, the researcher felt anxious to introduce the idea of conducting research about the group to the group for fear of making group members uncomfortable. In addition, the researcher was concerned about changing the existing structure of group sessions by talking about research rather than making art. The researcher was conscious of the historical exploitation of oppressed groups in psychological research and therefore did not want to perpetuate this in any form. Figure B1, from the researcher’s visual art journal, was made about the researcher’s struggles to find a way to bring up the topic of research. When the researcher shared this image with group members during an open mic session, several members nodded with understanding and one group member remarked that it is often awkward before art-making, and that the artistic process has helped them find meaning and calm. The researcher experienced this shift personally and documented this emotional transition in Figure B2, which represented the researcher’s emotional experience of one of the APSG group meetings. The lines at the top of the image are indicative of a rapid heartline, representing anxiety when operating within the cognitive realm of explaining and expressing the research process verbally. After transitioning into the affective and sensory realm of the creative process during group art-making, the frantic lines smooth and melt into a calm seascape, representing comfort. When the researcher shared these anxieties transparently with the group after using art-making to explore emotional reactions to the process, the researcher was able to feel more a part of the group and experienced the ameliorative effects of artistic self-expression in a supportive environment. After the researcher found creative flow and calm during the drawing portions of the sessions, cognitive integration was possible during the final sharing portion of group because the art
became a container for the complexity of meaning experienced. A group member mentioned to the researcher that art acts as a container that makes expression easier. It occurred to the researcher that the researcher’s drawing of an object that represented APSG created after session 1 was a large water container. Without intention, the artistic process yielded a potent symbolic representation of the group.

When the researcher introduced the second drawing experiential, one-minute blind contour drawings of each other (see Figure B4), the researcher again felt slightly uncomfortable and distant from the group members. However, the researcher intentionally emphasized the fun, low-stakes nature of blind contour drawings with the hope that this would set the tone for participation. Once the group entered into the art-making phase, there was non-stop laughter and the researcher felt entirely comfortable. Several group members remarked on the intimacy of looking into a partner’s eyes while drawing them. The researcher found that this intimacy felt safe and comfortable because it was created in the spirit of getting to know each other through drawing, and the entire group had been participating. Group members and clinicians noted that laughter has been a fundamental part of this group’s dynamic. For the researcher, laughter felt natural and was indicative of the researcher having been fully present and fully a part of the group. Laughter felt like a physical manifestation of the intimate mental and emotional connections between participants.

During the third drawing session, in which the researcher introduced self-portraiture, several important dynamics arose. The researcher noticed that self-portraiture was an intimidating activity for many people due to the intimate and sometimes challenging experience of looking deeply at the self. In this instance it was important for the researcher to be flexible and affirm the requests of group members who chose instead to draw someone else, or to use collage,
or to draw abstractly. The researcher’s drawing, Figure B5, captured the uncertainty the researcher felt when group members initially balked at the idea of self-portraiture. When the researcher shared this image with the group and received nods of support, the researcher felt that once again, the artistic process was a unifying force that enhanced connection and understanding among participants. Members who had initially seemed reluctant to engage in the process reported feeling glad that they trusted their instincts to adapt the directive to their own needs and ultimately enjoyed the experience.

**Power Dynamics**

The second major theme, power dynamics, emerged for the researcher during most sessions at APSG. As discussed in the first section of the results, the researcher often felt uncomfortable initiating conversations about research and felt more comfortable when all participants, including this researcher, were involved in making art together. In addition, the researcher noticed varying levels of verbal disclosure from clinicians during the verbal check-in period. On average, group members shared more intimate details about their lives during check-in, but everyone participated equally during the art-making. Figure B7, created in response to session 3, illustrated this researcher’s feelings about group dynamics. The spheres in the left circle represented the researcher delivering instruction and discussing research, with the larger circle symbolizing the researcher, and the spheres in the right circle represented the group dynamic when engaged in art-making, with all participants equally close to one another.

When the researcher first proposed a participatory art research project to the group, the researcher noticed feelings of tension and discomfort. Members appeared to the researcher to have been quieter than usual. A veteran member of the group requested more information about exactly how we would be doing the research and when the researcher responded that we would
be using art to explore the meaning of the APSG, the member responded clearly that they would like to learn to draw better. This direct request for direction helped the researcher to conceptualize the researcher role as one that might be more directive without being insensitive to the needs of the group; taking the role of a guide.

During the first research session (see Table A1 for an outline of research session content) there was some confusion about whether to draw objects that reminded group participants of APSG, or to draw any object that called to us in the space. This was an indication of the researcher’s initial struggle to make concrete decisions for the group. The researcher was cautious not to disempower participants and wanted group members to participate in the decision-making process. The researcher learned that some structure and direction is beneficial because it allowed for more creative freedom within the proposed guidelines. Once the researcher made a decision, which in this case was to allow each person to choose either one of the two interpretations, there was less confusion and the process was more fluid. In our discussion at the end of this session the researcher reflected on how the object the researcher chose, an empty water jug (Figure B1), was indicative of both an object that was interesting to draw, and a symbol of the meaning of the group for the researcher. Primarily, it was the first object that called to the researcher in the space. At the same time, its former function as a water container reminded the researcher of the sustaining power of APSG, because like water, it sustains a community of artists. For the researcher, this was a reminder that as a researcher coming in to an existing group, it is important to trust the culture of the group. The preexisting culture of this group was one in which group members chose how and when to participate, as well as one in which group members would often introduce and teach the group about an artistic technique in which they had some expertise. The researcher was therefore taking on a role as a
temporary guide which already existed within the group and was equally inhabited by clinicians and group members.

Several of the researcher’s reflection drawings contained images of circles (see Figures B6, B7 and B9). When the researcher created the reflection drawings, the researcher attempted to capture the energy of the group visually. Often, the researcher created a bird’s eye view of the shape of the group, meeting around the large rectangular table in a circle. Figure B8 is an example of one of these bird’s eye view drawings in which the different colors, patterns and shapes are indicative of the researcher’s sense of the various group members’ presences. Group members expressed to the researcher that they feel like all participants are all on the same level in the APSG. The researcher noticed that perspective is an important feature of many of the reflection drawings. Those that were created as if from a bird’s eye view, looked down at the shape of a circle from above and were often reflections on the group’s energy and dynamic. Other drawings, especially Figures B1 and B2, were created at the horizon level and these depicted the researcher’s emotional state during group sessions in a linear progression of time. When the researcher was focused on playing the role of a leader, the horizontal, linear images pervaded, along with feelings of discomfort and anxiety. When the researcher was engaged in group artmaking, the resulting artistic reflections were more composite, and bird’s eye perspective emerged in the images. As the research process progressed, there were less horizontally oriented images created by the researcher and more synthesizing, composite images. The researcher of this capstone thesis hypothesized that this might be a function of having become more integrated into the fabric of the group and having felt more deserving of leading the group in experiences.

**Building a community**
The final portion of the research process involved an intermodal experiential in which participants were invited to reflect in writing or visual art about the meaning of the APSG, or, for new members, the meaning of “making art in community.” The last element of the experiential involved members co-creating a group poem and drawing. The researcher designed this experiential to be collaborative so that the final artwork would give the researcher some indication of interpersonal dynamics. At various points throughout this experiential, different members offered suggestions for the direction of the project. For example, a new member requested that in their absence the following week, the group would ensure that when the poem was glued down on the image, there was a particular layout followed. Another group member suggested the method by which we distilled the words from each member’s writings that would comprise the group poem.

Evidence of the strength of the APSG community materialized at several points throughout the research process. Since the researcher began attending the APSG, members and clinicians often shared information about local art events, exhibitions and community scholarships. The APSG group extended beyond the group members who are physically present each week into the digital realm with the weekly email update that has historically been sent to around 35-40 members, guardians and allied professionals. Three members who had not been to group for months, or even years, and came to group during the ten weeks when this capstone thesis research was underway independently expressed how valuable it was that the APSG meets regularly and that they can rely on keeping up with the group through the weekly email.

One group member, who came only for the last session of the research process and hadn’t been to group in several months, reported feeling inspired by our group poem and asked if they could use some of our words to create another poem. The member then chose to read this poem
in public at the organization’s annual fundraiser, in front of over 150 members of the community, as a way to communicate the importance of the APSG. In a sense, the researcher of this capstone thesis felt that this outcome was an unintended but perfect conclusion to the arts-based participatory action research that was employed in this study. The occurrence led the researcher to truly appreciate the direct action possible when individuals feel empowered through the arts and their community.

Early on in the research process, the researcher remarked in the researcher’s written journal that part of what seemed to interest some group members to participate in the research project was the notion that information gathered about the workings of APSG might help inform other groups and thus help more communities to build an arts-based group like APSG. Activism through community outreach in support of mental health awareness is a core part of the APSG’s ethos. Therefore, there was immediate interest when the researcher suggested that the group put up an exhibition with the artwork created during the research phase. Although the exhibition did not take place as of the completion of this capstone thesis, planning was underway and group members were involved in discussions regarding how to display the artwork and how to define the identity of APSG with the community.

Discussion

This capstone thesis provided preliminary qualitative evidence of the value of a participatory action research framework for assessing the value of a recovery-oriented expressive arts therapy group for individuals living with SMI. Themes related to the role of the creative process in promoting self-care and self-efficacy, power dynamics, and community building emerged in the researcher’s art reflections and written journal. These themes connected to the central tenets of the recovery orientation to treatment of SMI which include personalized
treatment, an egalitarian client-clinician relationship, social connectedness and a sense of belonging (Borg & Kristiansen, 2014; Castillo et al., 2018; Treichler & Luckstead, 2018). This capstone thesis contributed to the limited extent research that has applied a recovery oriented expressive arts therapy theoretical framework to treatment for SMI (Allan et al., 2015), as well as the literature that explored participatory art as a means of social action for individuals living with SMI and their community (Saavedra et al., 2018).

The open-studio style expressive arts therapy group in this capstone thesis provided a novel framework through which to explore the merits of an arts-based recovery-oriented group therapy treatment for SMI. The value of using this approach was particularly apparent in the unifying effect that art-making had on the group dynamic, helping clinicians and clients to feel connected as equals through the artistic process. In addition, the open-studio structure provided a setting in which members and clinicians could share expertise in various artforms and subvert traditional leadership roles in group therapy. At several points throughout the research process different individuals took the lead by offering drawing, poetry, and logistical advice. The researcher of this capstone thesis hypothesized that by members taking on leadership role within the group, benefits such as a greater sense of personal agency and an increased sense of belonging might arise, as is suggested in the peer support literature (Schon, 2010). Both group members and clinicians noted the heightened feelings of intimacy fostered by the blind contour drawing activity (see Figure B4), evidence that certain art experientials might be particularly beneficial in pursuit of encouraging an atmosphere of closeness and strengthening community.

The researcher of this capstone thesis’ training in expressive arts therapy proved to be valuable because group members had varying comfort levels with different art forms. The group included individuals with strengths in various art forms including: sculpture, poetry, creative
writing, dance, drawing, painting, printmaking, collage, drama, mixed-media, fiber arts and photography. The researcher of this capstone thesis incorporated a multi-modal approach by having suggested visual art, writing and poetry during the research process. Some group members reflected on the power of finding words to describe the experience and reported feeling appreciative of a particular group member’s talent for weaving words together.

In essence, through the unifying effect of art, this group operated as a hybrid peer support, open studio and group therapy phenomenon. These blurred structural boundaries involved uncharted power dynamics that were at times difficult to navigate, as documented in the aforementioned visual art reflections (see Figures B1 and B2). The researcher of this capstone thesis hypothesized that the clinician’s role in such a group is closest to that of an artist-therapist guide whose task it is to help frame art-making and the group members’ artist identities something larger than merely aesthetic. Questions that arose around self-disclosure, boundaries and the clinician’s role might be valuable directions for future researchers to better understand this unique group dynamic.

A modified peer support group model in which clinicians participate in the group activity could further the aims of mutual recovery. By leveling traditional hierarchies of power in group therapy, the structure itself challenged common stigmas and prejudice associated with individuals living with SMI. Although this capstone thesis was unable to include data from a public exhibition of the participatory artwork created by the APSG, it would be useful for researchers to explore the role that public exhibition of participatory art projects might have in furthering the aims of mutual recovery and mental health advocacy. While Saavedra et al. (2018) researched the impact of participatory art workshops in non-clinical spaces, such as museums, their study did not address group dynamics or arts-based advocacy for mental health awareness.
The Arts and Peer Support Group members actively participated in communicating what they value about the APSG at a public fundraising event for the expressive therapies non-profit organization that runs the group. The members have also participated in panels in academic settings describing life with SMI for social work students and have planned to participate in the art exhibition related to the present capstone thesis. Social justice, community outreach and advocacy have historically been important aspects of the APSG identity and were apparent throughout the research process. Future research should explore the effects of client art exhibitions to examine whether community engagement plays a role in reducing social stigma of individuals living with SMI. More research is also needed to illuminate the role that social justice advocacy plays for individuals living with SMI.

While more research is needed to continue to validate arts-based mixed peer/clinician therapy groups for adults living with SMI, this capstone thesis provided strong qualitative evidence that it is a viable approach and suggested several avenues for further research. This capstone thesis found that group members valued belonging to a strong community of artists and that the artist identity helped to flatten the traditional group therapy hierarchy of clinicians and clients. The creative process itself was found to be healing for both group members and clinicians and seemed to lay the foundation for the identity of the community created by the APSG itself. Ideally, further research would expand the APSG model in other geographic regions and would further investigate the role of the clinician, the value of public art exhibition of client artwork, and whether a mutual recovery framework mediates the effects of stigma in the SMI population.
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Appendix A

Table A1

*Outline of APSG Group Meetings Dedicated to Research*

<table>
<thead>
<tr>
<th>Session #</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group members walked around the studio space and chose an object that called to them or reminded them of the APSG in some way. Members drew this object in order to get to know it and then shared with the group.</td>
</tr>
<tr>
<td>2</td>
<td>Group members created one-minute blind contour drawings of each group member in rotating pairs using ink pens and markers.</td>
</tr>
<tr>
<td>3</td>
<td>Group members were invited to use the blind contour drawing technique to create a self-portrait. Members then elaborated on their line drawing using various materials including chalk pastel, oil pastel, watercolor, colored pencil and charcoal.</td>
</tr>
<tr>
<td>4</td>
<td>Open Mic: The researcher shared art journal and reflections on the research process up to this point.</td>
</tr>
<tr>
<td>5</td>
<td>The researcher asked group members to reflect directly on the meaning of the APSG, or if they were new members, the topic “making art in community” either in writing or in visual art. Next, the researcher asked those who had written to conduct a soft scan of their writing and circle a few words that stand out to them. Individuals who chose to use visual art were asked to list a few words that come to mind when looking at their artwork. Then, group members passed around these lists of words and each member placed a check mark next to the words that resonated with them most. We created a final list of words using the three words on each person’s list that received the most check marks.</td>
</tr>
<tr>
<td>6</td>
<td>From the word list the group created a collaborative poem. Based on members’ inspiration from the poem, the group then began to create a large collaborative artwork into which the words of the poem were placed.</td>
</tr>
<tr>
<td>7</td>
<td>Continuation of the group artwork.</td>
</tr>
<tr>
<td>8</td>
<td>Open Mic: The researcher shared updated art journal with the group, continued group artwork.</td>
</tr>
<tr>
<td>9</td>
<td>Continued group artwork.</td>
</tr>
<tr>
<td>10</td>
<td>Finalized group artwork and discussed research process, as well as plans for exhibiting the artwork.</td>
</tr>
</tbody>
</table>
Appendix B

Images from the Researcher’s Art Journal

*Figure 1.* Image from researcher’s art journal titled “Speak!”

*Figure 2.* “From Tense to Calm Through Art”, researcher’s art journal drawing.
Figure 3. Researcher’s drawing of an object in the APSG space from session 1

Figure 4. Researcher’s drawing of group members using blind contour technique from session 2
Figure 5. Researcher’s self-portrait from the third drawing session

Figure 6. Seeing and Being Seen; Holding and Being Held.
Figure 7. Traditional Versus Arts-based Research

Figure 8. Engaged in the Art-making Group Energy Drawings

Figure 9. Researcher’s Reflection Drawings Containing Circles