Creative programs in community settings in Victoria: How providing opportunities to engage in the art-making process improves self-esteem, builds social support networks and encourages communication

by

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ABSTRACT

BACKGROUND: Almost anyone working in arts-based interventions has an intuitive understanding of the health and social benefits associated with this work, attributing outcomes to the role of the facilitator, the creative space, the social element, and the art-making process. Local creative programs exist in abundance in health organisations, community centres, neighbourhood houses, schools and learning centres in Victoria, providing opportunities for participation in creative activity. However, we have lost the historical belief of art as a healing tool and in the value of engaging local communities in creative activity if we do not give voice to the participants of these less publicised, smaller, local art programs and explore their experiences of engaging in the art-making process (Dragon & Madsen 2015).

AIM: The aim of the research was to investigate if the process of engaging in creative activity in art programs delivered in the community could achieve the outcomes of improved self-esteem, increased social support and enhance communication.

RESEARCH METHOD*:* A mixed method sequential design of four phases was conducted to evaluate the outcomes of 20 art programs delivered in 13 community centres in Victoria. Quantitative methods included standardised assessment scales, namely the Rosenberg Self-esteem Scale and the Social Functioning scale. Qualitative methods used were interviews with program facilitators and interviews with 13 participants.

RESULTS**:** Statistically there was a significant increase in self-esteem but not in social interaction as a whole. However, qualitative results highlighted the participants' positive experiences of building social support networks as well as building self-esteem.

CONCLUSION: While contributing factors are attributed to positive outcomes in art-based interventions in the literature, this research found that these factors were embedded within the art-making process which is central to the engagement in creative activity. The art-making process exists in every arts-based intervention as well as in the art programs of the current study, in spite of the lack of resources, the difference in programs and limited conventional methods. This research supports those advocating for the use of arts in promoting health to seize every opportunity to provide engagement in the art-making process because of potential benefits.

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Oral Presentation: 'The benefits of arts programs in community settings in Victoria', The Art of Good Health and Wellbeing, International Arts and Health Conference, 11 – 13 November 2014 National Gallery of Victoria, 180 St Kilda Road, Melbourne.

Oral presentation: 'Benefits of Engaging in Creative activity', The 11th International Conference on the Arts in Society, University of California, Los Angeles, USA, 10-12 August 2016.

1. INTRODUCTION

I am an artist, a qualified art therapist and a social worker and I have practiced in all three roles over many years. As an art therapist, I am always intrigued and appreciative of how art-making within a therapeutic alliance creates an atmosphere for insight and change. As an artist, I have used the power of art-making in my personal life and to influence those around me to participate in creative activities. As a social worker, I seize every opportunity to use the arts in my practice to empower clients, build resilience and confidence. I have witnessed how engagement in creative activities in these small-scale, low-key art programs I deliver give participants a sense of pride in their work, an opportunity to share their skills and an avenue for building social connections. The common element in all three roles is the use of art and the opportunity for others to participate in the art-making process. It is this conviction in the benefits of the arts that led me to undertake this research study to show that any arts-based intervention that provides participants with the opportunity to engage in an art-making process has the potential to achieve positive outcomes.

In this study, a mixed methods approach is used to investigate specific outcomes of self-esteem and social interaction achieved from engaging in creative activities in community based-art programs in Victoria, Australia. The current study also explores the use of art as a means of communication. The literature reviewed is based on the broad international practice of arts-based interventions from art therapy to community arts. However, the current research specifically focuses on group art programs delivered in community centres in the state of Victoria. Arts-based interventions exist internationally and in Australia in diverse settings, facilitated by professionals of different disciplines, using a variety of methods, structures, materials and resources. Thus, comparing these interventions is impossible without first identifying the similar contributing factors that exist in all arts-based interventions and how these factors influence participants' experience of the art-making process.

1.1 RESEARCH QUESTION

The overarching question that guided this research is:
Creative programs in community settings in Victoria: If the contributing factors exist in these programs and how does providing the opportunity to engage in the art making process improve self-esteem, build social support networks or encourage communication?

1.1.1 RESEARCH OBJECTIVES

The following objectives were devised to guide examination of the research question:

1) Measure the change in self-esteem and social interaction that builds social supports, achieved from engaging in creative activity in a group setting;
2) Explore the relationship between variables in program structure such as facilitator, art materials and art space and benefits reported by participants associated with participation in art programs;
3) Identify features of program structure that are effective in producing changes in self-reported communication, self-esteem and social benefits;
4) Identify if/how contributing factors of arts-based interventions impact on the art- making process and the effectiveness of the intervention;
5) Explore the potential of local community-based art programs to achieve the outcomes identified in the literature and as an effective means of promoting wellbeing for all who participate in the art-making process.

1.1.2 THEORY AND PHILOSOPHY

This research is based on the claim that therapeutic[1] benefits of art-making can be achieved by engaging in the process of creating art within a group environment (Van Lith 2015; Skaife 2001; Sandmire et al. 2012; Reynolds 2012), delivered with diverse

[1] I discuss the 'therapeutic' nature of the art-making process in this dissertation according to the definition of 'therapeutic' as 'having a beneficial effect on the body and mind' and 'producing a useful or favourable result' (Miriam –Webster Online dictionary 2015).

resources in various program structures and by different facilitators. Arts-based interventions have several factors that contribute a positive impact on those who participate, such as the art 'space', the facilitator's role, the art materials used, the social element and, most importantly, the art-making process. However, this concept—while tested in a variety of art therapy models in health settings (Dickson 2007; Oster et al. 2006; Ball 2002; Mills & Kellington 2012; Drapeau & Kronish 2007; Gussak 2009) as well as in large-scale community art projects (Lamb 2009; White 2006; Allen 2008; Argyle & Bolton 2005; Vick & Sexton-Radek 2008; Trzaska 2012)—has rarely been tested in primary, community, group art programs that are known to exist extensively throughout Victoria. This research is based on the assumption that the same benefits can be achieved in these local settings, acknowledging that human beings will experience participation in a variety of ways. Thus, pragmatism is the most suitable paradigm, as it embodies the philosophy that underpins this research regarding the multiple realities and meanings in human experiences in art-making, and that knowledge is based on the reality of these experiences (Onwuegbuzie, Bustamante & Nelson 2010).

Pragmatism has been widely championed by researchers as the most suitable paradigm in mixed methods as it has the ability to connect theory and data (Wheeldon 2010). Pragmatism does not favour any particular method but uses the most appropriate research method to study the phenomena and acknowledges the unpredictability of research involving human nature (Feilzer 2010). Pragmatism allows the linking of practice to theory and practical strategies as employed during the course of this research to determine the appropriate methods in order to answer the research question.

1.2 BACKGROUND AND CONTEXT OF STUDY

A broad background on the field of *arts in health* is provided here to outline the overall context of the field as it has developed around the world and primarily in Australia. As this research focuses on the delivery of art programs in Victoria, Australia, a background on the promotion of health and wellbeing in the state and nationally provides an

understanding of how *arts in health* developed in this country and how opportunities for creative engagement are provided in the local community. The focus on holistic health and wellbeing is relevant to the importance of this research as well as the contribution of self-esteem and social support to promoting health.

1.2.1 THE FIELD OF ARTS IN HEALTH

The arts in general terms encompass the fields of culture, history, arts education and the creative arts. The creative arts is a broad umbrella of music, writing, literature, poetry, dance, digital art, drama, visual arts, theatre and much more, all of which have their own benefits on the wellbeing of those who participate in any capacity. History shows the arts have been used in various forms with people with a mental illness in ancient Egypt, Africa, China, Greece, and India (Henderson & Gladding 1998). The idea of art as a healer and a way to communicate are illustrated by ancient images, cave paintings, dance and chants that were used to unify the body, mind and spirit and to restore health (Graham- Pole 2001). More background on the history of arts as a tool for healing is provided in the literature review contained in Chapter 2.

In more recent times arts interventions implemented in health and primary care environments are referred to as '*arts in health'* or 'art therapy' that unfortunately differ in their meaning in the countries they are practiced and the disciplines that facilitate these programs. The University of Sydney in Australia describes *arts in health* as a blossoming movement of the arts that values its contribution to health and wellbeing and advocates for its incorporation into healthcare (http://sydney.edu.au). The Arts Council of England uses the term 'arts and health' and defines it as all art-based activities that aim to improve health, improve healthcare environments and provide opportunities for social connection (Jermyn 2001). In the United Kingdom, *arts in health* is embedded into healthcare systems as the Department of Health recognises and supports the contribution that art makes to health and wellbeing (Arts Council England 2007). In the USA, while *arts in health* is thriving, it is difficult to define because of the diverse range of practices, the

collaboration with other disciplines, the variety of healthcare settings, and the different recipients and facilitators (Dileo & Bradt 2009). Those involved in the delivery of these programs come from various disciplines and hold assorted titles such as hospital artist, artist in residence or art therapist (Dileo & Bradt 2009). In addition to the lack of definition of the practice, the term 'art therapist' is sometimes attributed to any professional or volunteer worker with no educational credentials in the field, with the common denominator being the use of art materials in the interventions (Ulman 2001). Dileo and Bradt (2009) further attribute the lack of recognition of the discipline of *arts in health* in the US to the unclear definition of the term, the non-existent establishment of the profession as a distinct discipline and the lack of research. Countries like Germany, Austria and Switzerland take an approach that is quite different to the British model and art therapy is integrated into the fields of education, medicine and art psychotherapy (Herrmann 2000). In Germany, for example, this relates to the concept of social pedagogy and training for the profession is incorporated into the disciplines of other professions such as remedial education and educational sciences (Herrman 2000). The ambiguity of the profession and the field of *arts in health* have led to variations in the approach of delivering arts-based interventions to promote wellbeing as well as the aims or benefits. Different historical traditions, political environments, health legislations and cultural contexts will naturally lead to diverse practices of arts-based interventions. Thus, there are many different approaches to using *arts in health* and there is not one comprehensive common theoretical basis except for the common belief that art has the power to heal.

For the purpose of this research*, arts in health* is defined as the use of the arts in any medium delivered in a multitude of ways—which includes community art programs, participatory art projects, arts-based interventions, and art therapy— that seeks to improve the health and wellbeing of those who participate in the creative activity or have access to the arts (National Alliance of the Arts, Health and Wellbeing 2015). While there are community art projects or interventions with a variety of aims, this research focusses on the use of visual arts aimed at improving the health and wellbeing of individuals and communities. In the theoretical discussions throughout this

dissertation, I explore the benefits of creative engagement in a variety of arts activities but focus on research carried out in the visual arts and the active participation in the art-making process.

1.2.2 *ARTS IN HEALTH* in AUSTRALIA

The specific focus of this research is based on art programs delivered in community centres in the state of Victoria, Australia, and therefore warrants further exploration and understanding of the field of *arts in health* in Australia and more specifically in Victoria. A background on the professional development of the field as well as an understanding of how art programs are delivered in Victoria is essential in situating this research in its context.

In Australia*, arts in health* developed through two primary streams: 1) the establishment of art therapy as a profession; and 2) artists involved in community development through promoting participation in the arts. Art therapy began informally in Australia as early as the 1950s by artists such as Guy-Grey Smith employed as an art therapist in hospitals in Perth, Western Australia (WA), and Eric Cunningham Dax who employed artists to work in hospitals in Victoria (Westwood & Linnell 2011). Post-war Australia became a centre of thriving creative work in all areas including art by people with a mental illness, initiated by UK Psychologist Eric Cunningham Dax. Dax introduced psychiatric art to the Royal Park Hospital in Melbourne in the 1960s (Walsh 2008) and the Dax Centre still exists today within the grounds of the University of Melbourne with over 15 000 works of psychiatric art (The Dax Centre, 2012).

Western Australia incorporated creative arts into their mental health care and established the first public funded art therapy program at the Claremont Hospital in Perth in 1968, known as the Creative Expression Centre for Art Therapy (CECAT). CECAT employs art therapists and artists offering a wide range of art programs such as open studios, group art programs and art education (Walsh 2008). Occupational Therapists (OT) played a large role in the use of art as therapy in psychiatric hospitals

in Victoria between 1879 and 1959 based on the concept that when patients occupied their hands and minds in positive practical activities it could be therapeutic (Westmore 2012). The decline of the use of art by OTs has been suggested to be due to the lack of evidence (Thomas et al. 2011; Harris 2008). Australia's approach to mental health is dominated by the medical model and alternative therapies such as the arts still lie on the margins of the health system and struggle to be legitimised as a psychological intervention (Westwood & Linnell 2011).

In the 1980s, Australians in the field trained in the UK and the USA and returned to establish an emergence of art therapy as a profession with increasing opportunities for formal qualifications in various educational institutions. As the field developed into the 1990s, Annette Courier, a UK trained Australian art therapist, played an important role in setting up the Australian National Art Therapy Association (ANATA). ANATA was founded in 1987 and officially became Australian and New Zealand Association of Art Therapy (ANZATA) in 2009 (ANZATA 2016). The Association today establishes standards of art therapy training and provides information on research and professional development, recognising that all art forms have the potential to enrich lives. ANZATA clearly differentiates the therapeutic use of art, and emphasises the therapeutic relationship within which it is practiced, but also claims that art therapy includes art-making with an emphasis on the process of creating and the development of interpersonal relationships through this process (ANZATA 2016). Art therapy is practiced in hospitals and health care centres and is gradually gaining momentum as a therapeutic intervention in Australia, but it still has not received the professional recognition it has in the UK and the USA, with a small number of projects being researched in the field. Some relevant research initiatives are discussed in the literature review section on Australian research in the field in Chapter 2.

Parallel to the emergence of art therapy, the *arts in health* movement in Australia also progressed in conjunction with community development to address the social determinants of health (Wreford 2010). The 1980s witnessed professional and government bodies being set-up to address the promotion of *arts in health* which included focus on arts sponsorships, national conferences and publications on the

evaluations of community arts projects that impacted on social inclusion (Wreford 2010).

The Australia Council for the Arts is the Australian Government's arts funding and advisory body that funds a range of arts activities, delivers original research and advocates and supports the arts sector (Australia Council for the Arts 2009). Arts Access Australia, established in 1974, is funded by the Australian Government through the Australia Council for the Arts to facilitate access and increase opportunities of employment and engagement in the arts for people with a disability (Arts Access Australia 2016). Arts and Health Australia (AHA) is another significant body responsible for the promotion of all forms of creative participation and does not single out art therapy nor community arts but encourages the use of the arts in promoting community development and wellbeing. AHA is a networking organisation for those who work in healthcare, arts, education and community in programs that enhance wellbeing through engagement in creative activities. AHA advocates for arts and health practice, supports research and evaluation of arts and health programs and facilitates policy change to encourage the development of the arts in healthcare in Australia (Australian Centre for Arts and Health 2016). These various arts organisations are instrumental in promoting the use of the arts both nationally and within smaller communities and contribute to research in the field.

In Victoria, the state government is primarily responsible for the delivery of healthcare, working in partnership with the federal government. This is similar in the arts. The Victorian Health Promotion Foundation (VicHealth) began formally supporting the arts as early as 1987, establishing partnerships with organisations to promote community wellbeing through art activities and implementing research in the field. VicHealth works in partnership with communities and organisations to implement a broad range of projects including social activities and the arts aimed at improving mental wellbeing. In VicHealth's Action Plan 2010–2014, the Victorian Government, in recognising the power of the arts in promoting health, committed to providing opportunities for all Victorians to participate and have access to the arts. According to VicHealth Arts Strategy (2014–2017), facilitating access to creative

engagement allows people to be connected and reduces loneliness, taking the stance that the arts give people the opportunity to gain new skills, express themselves, communicate shared experiences and improve health and wellbeing (http://www.vichealth.vic.gov.au). VicHealth supports participation in the arts by working in partnership with both large and small organisations to provide access to participation in the arts for all residents.

As an example, VicHealth launched the Community Arts Participation Scheme (CAPS) in 1999 to promote mental health and to support the development of arts and health partnerships (VicHealth 2003). Another strategy implemented by the Victorian government is Creative Capacity Plus, launched in 2003 to create a dynamic arts sector that is accessible to all with strategies to engage whole communities (Hutchinson 2007). Creative Capacity Plus was a policy by Arts Victoria to engage creative communities, develop artists, ideas and knowledge as well as create a culture of participation in the arts for all Victorians, informed by the belief that the arts are a powerful catalyst in building stronger communities (Hutchinson 2007). The 2014 VicHealth's Innovation Challenge: Arts called for new ideas to involve people in active and participatory arts activities to achieve physical and mental wellbeing and allocated funding for these projects to be implemented (VicHealth 2014). Another government body dedicated to championing and supporting the State's creative industries – that includes the arts, culture and design - is Creative Victoria. This body focuses on a wide range of creative and cultural organisations, supporting the development of local and professional artists and ensures all Victorians benefit from this creative sector (Creative Victoria 2016). There are other arts-specific bodies in Victoria that use the arts to promote cultural diversity and to increase opportunities for creative engagement to maintain cultural heritage and identities. Arts About Us 2010– 2015 is a program by VicHealth to initiate discussions around race-based discrimination and share aspects of culture through art. In giving voice to those who have experienced discrimination, arts activities are designed to challenge attitudes and beliefs within the wider community that have the potential to undermine diversity (VicHealth 2014). Multicultural Arts Victoria (MAV) is an important body in the development and promotion of culturally and linguistically diverse (CALD)

contemporary art over four decades. The organisation supports career development in the arts and community engagement for CALD communities (Multicultural Arts Victoria 2016). The existence of these various state art organisations specific to the State of Victoria ensures further development and a continuing interest in the use of the arts in community engagement, combating social exclusion and promoting health and wellbeing for all Victorians (VicHealth 2014; Creative Victoria 2016; Multicultural Arts Victoria 2016).

With the setting up of professional art therapy bodies and the government encouraging the use of arts in promoting health in the community, art programs in various forms began to expand, delivered by a variety of organisations. In Australia, while every State has their own arts and health policies and infrastructure, art programs are delivered in a variety of settings catering to local community demand and targeting social inclusion and community participation. Organisations in Victoria that have participated in this research include community health centres, neighbourhood houses, community learning centres and not-for-profit organisations. A further explanation on the various organisations is put forward here to provide a clearer context on the delivery of these art programs.

The changing focus of mental health care in Australia, beginning from the 1960s to move towards a more holistic model of care in the community, heralded the establishment of community centres in several metropolitan and rural communities that offered diverse programs for rehabilitation, and in some of these centres art is a part of these interventions to improve wellbeing (Walsh 2008). The value of art programs has not been overlooked by health professionals of other disciplines in many community health centres that continue to offer art programs to their service users as part of their allied health services in these settings. While art programs have been running in many community health centres in Australia for many years they are not an integral part of *arts in health* policy (Woodhams 1995).

Neighbourhood Houses are not-for-profit centres partly funded by the Victorian Government, through Neighbourhood Houses Victoria, formerly the Association of

Neighbourhood Houses and Learning Centres (ANHLC), to run a range of programs for local communities. Neighbourhood Houses Victoria (NHVIC) is the peak body for the Neighbourhood House and Learning Centre sector in Victoria. The ANHLC was established in the early 1970s and currently has over 370 registered organisations in Victoria, with the key vision of empowering local communities by providing opportunities for participation and learning. The ANHLC encourages research investigating positive outcomes of Neighbourhood Houses community development practice to ensure these are recognised as key community development organisations. These Neighbourhood Houses provide both recreational and learning programs that meet community needs and rely on government funding, Department of Human Service (DHS) grants, income from low-cost activities as well as donations and volunteer input (Neighbourhood Houses Victoria 2016; Department of Human Services Victoria 2016). These Neighbourhood Houses host a variety of creative classes as part of their regular programs and provide local communities access to engaging in creative activities.

More specific not-for-profit organisations are bodies set up by philanthropic funds to run art programs catering to a more targeted clientele such as people coping with a physical or mental illness and more vulnerable communities.

1.2.3 FOCUS ON HOLISTIC HEALTH AND WELLBEING

The focus on health and wellbeing has shifted from concentrating entirely on physical health to consider other factors that contribute to a more holistic view of health, because the state of one's wellbeing can have great effect on one's physical health or influence the recovery from one's ill-health (Lane 2006). In the Social Model of Health (SMH) framework the social and environmental determinants of health are addressed in order to improve health, which differs from the Medical model that seeks to cure an illness (Ryan 2004). One of the determinants of health included in this framework is access to resources including social supports that minimises one's risk to ill-health (Ryan 2004). The most recent VicHealth Action Plan 2013 re-iterates this approach and states that health is more than being free from disease but

incorporates a state of physical, mental and social wellbeing (VicHealth 2013). The UK National Health Service recognises that health is partly influenced by social factors and undertakes a more holistic approach that takes into consideration the provision of opportunities to engage communities in leisure and artistic activities (Bungay & Clift 2010). In the US, the National Prevention, Health Promotion and Public Health Council developed strategies to improve the wellbeing of individuals, families and communities that focused on a quality and meaningful life through active living, mental and emotional wellbeing (US Dept of Health & Human Services 2011, p. 8). In VicHealth's (2013) response to the Victoria Mental Health Strategy Discussion paper, the board supported the strategy of improving mental wellbeing by strengthening people's resilience through social connection and involvement in arts and sports clubs. VicHealth's 2015–2018 Mental Wellbeing Strategy (2015) named positive arts environments, opportunities for social connection and connected communities as some of the assets for building resilience.

There has been growing debate around the larger context of social capital, social cohesion and social inclusion and its influence on health and wellbeing (Davisdon 2015). Social inclusion is highlighted as a main social determinant of health and wellbeing in VicHealth's Mental Health framework (VicHealth 2013). According to this framework, social capital concepts include outcomes such as supportive relationships and involvement in group activities (Johnson & Stanley 2007). Tsukada (2007) broadly defines social inclusion as creating conditions in society that embraces everyone and suggests that the arts play a significant role in achieving this. The terms social network, social support, social isolation and social integration are often used interchangeably in the literature on the impact of social networks on health (Berkman, Kawachi & Glymour 2014). However, this research study focusses on the building of social relationships that potentially provide individuals with supportive social networks. I explain the different terms briefly in order to understand social networks and social support within the broader field of social inclusion but proceed to focus on social support which this research is based on.

Social inclusion policies promote the building of social capital (VicHealth 2013;

Tsukada 2007). Social capital refers to the social structures and resources generated through social connections which can be accessed by individual members or communities of that social network (Davidson 2015; Kawachi & Berkman 2014). Kawachi & Berkman (2014) further explain that social support is embedded in social capital as a resource that members draw upon and use to share information through these social connections. Davidson (2015) differentiates between social networks – as the *amount of* interaction and frequency of contact – and social support which he describes as pertaining to the qualitative nature of these social interactions. This research focusses on these two aspects of social inclusion as identified by Davidson (2015) that promotes social participation in building social support networks which Lin et al. (1979, p.109) defines as 'support accessible to an individual through social ties to other individuals, groups and the larger community'. In summarising how social networks impact health, Berkman, Kawachi and Glymour (2014) state that social structures determine the extent and characteristics of social networks and in turn these networks provide opportunities for social support, social engagement, access to resources and social influence, which then impact health through psychological, physiological and health behavioural pathways.

The interest in social support affecting health has been debated since the early 1980s, particularly in regards to the role supportive relationships play in the rehabilitation of illness, promoting behavioural changes and encouraging new challenges (Cohen & Syme 1985; Davidson 2015). Social support seems to acts as a buffer against the onset of an illness or negative psychological responses to life consequences and changes (Lin et al. 1979; Cohen & Syme 1985; Berkman, Kawachi and Glymour 2014). Some of the health-related effects of social support are the ability to lower stress levels, raise self-esteem, encourage and support healthy behaviour (Davidson 2015). Social support enhances self-efficacy, promotes functional coping skills, influences mood and perceived wellbeing (Davidson 2015; Berkman, Kawachi and Glymour 2014). Social support includes emotional, instrumental or practical, appraisal and informational support (Berkman, Kawachi and Glymour 2014). Furthermore, Reblin and Uchino (2008) suggest that those providing support also feel valued and experience a positive affect which may result

in improved health.

The value of positive self-esteem and one's social support network to one's overall wellbeing are considered for evaluation as potential outcomes in this research as they are identified as key factors in improving health and wellbeing (VicHealth 2009). Self-esteem is defined as a sense of self, self-determination, identity, self-worth and a belief in one's own qualities and strengths (Franklin 1992; Marcussen 2006). Self-esteem affects our mental health and wellbeing and low self-esteem is a psychological risk factor that can potentially lead to ill-health (Stinson et al. 2008). Good self-esteem is considered a coping resource and a buffer against psychological distress (Stinson et al. 2008; Marcussen 2006) and has been proven to play an important role in adolescent mental health, especially in regards to personal care and safety (Torres, Fernandez & Maceira 1995). When a person's self-esteem is low, he or she becomes vulnerable to stress and anxiety. Furthermore, there is an association between low self-esteem and reduced opportunities for social interaction (Reitzes & Mutran 2006). Supportive social networks influence emotional states such as self-esteem and social competence (Berkman, Kawachi and Glymour 2014).

While many of these issues have only more recently been examined from a public health perspective, social workers in the health field have long worked within the social systems theory that recognises an individual's social support network of connections and relationships will influence that individual's experience of an illness or social problem (Payne 2005). While the general systems theory started from a mechanical model, the field of social work adopted a more psychological and sociological version of this theory that considers that a person's system – amongst other environmental factors – consists of other individuals, groups and communities that may serve as agents of change (Forder 1976). This theory considers the person in her or his environment, including their social support network, their interaction with the environment and community that supports the system (Friedman & Allen 1994). Just as interpersonal transactions within the general systems theory promote growth and maintain equilibrium (Forder 1976), social workers acknowledge that an individual with a supportive social network of family and friends will navigate

through the issues and problems encountered more easily than someone who is isolated. Membership in social networks provides regular social interaction that may result in increased sense of stability and control (Cohen & Syme 1985). Davidson (2015) suggests that emotional support and advice from others leads someone to re-evaluate their circumstances and reduces stress, and that it is possible that those with few friends engage less in community and have low self-esteem.

Berkman, Kawachi and Glymour (2014) point out that not all social networks are beneficial, and that some can also have negative impacts of health damaging behaviours. However, Davidson (2015) states that 'in general people benefit from social support and are harmed by social isolation' (p.143). In this dissertation, I use the term social supports to refer to support accessible to individuals within a social network or group as defined by Lin et al. (1979, p.109) and how these support networks can be enhanced by social integration, social functioning, social participation, social interaction and pro-social activities.

In the review of the literature on the social impact of the arts, Barakeet (2005) cited increased self-esteem and confidence; increased social and creative skills; and stronger personal networks as some of the most common outcomes. In the following two sections on the background of this study, I discuss further the national and international development of arts in promoting health.

1.3 SUMMARY OF DISSERTATION

In this chapter I have set the background on which the research was undertaken. This dissertation examines the extant literature related to *arts in health* in Chapter 2, particularly research that focuses on the use of art in improving self-esteem, social supports and art as communication. Chapter 3 discusses and justifies the choice of methods used, outlines the mixed methods design used to guide the data collection and analysis that forms the core of this research. The results of all four phases are provided in Chapter 4 and are presented in the chronological manner with which the data was gathered and analysed. Chapters 5 and 6 cohesively draw out the meaning of these

results. Firstly, the main factors that contribute to benefits within community-based arts programs are explored in Chapter 5 with further analyses of how these factors influenced participants' experiences. Secondly, I argue in Chapter 6 that these factors need to be considered within the art-making process as a whole and that this is central to the engagement in creative activity, and the key to the health benefits of these programs. Finally, in Chapter 7, I advocate for the need of the continued delivery and evaluation of art programs in local communities that provide opportunities for engagement in the art-making process and make a number of recommendations for further investigation ofcommunity-based arts programs in Victoria and discuss the implications for similar programs elsewhere.

KEY POINTS – Introduction

• The ambiguity of the practice of art therapy and *arts in health* and the burgeoning of various forms of arts-based interventions;

• The growth of *arts in health* in Australia through the professionalisation of art therapy and the promotion of community arts projects with social aims;

• The focus on social supports in building social networks through social participation in community-based art programs.

• The importance and contribution of self-esteem and supportive social networks to promote health and wellbeing.

2. LITERATURE REVIEW

This chapter provides a narrative overview of the literature on the benefits associated with a wide range of *arts in health* interventions. It explores research studies, art therapy, government initiatives, community art programs, and the theories that attempt to understand the therapeutic value of the art-making process. In the background, I draw on the exploration of art as a healing power both in history and in current trends to strengthen the claim on the benefits of engaging in a creative activity. While acknowledging the place of art therapy and the need for regulated guidelines in the dominant discourse on the benefits of *arts in health* interventions, in this narrative review I provide an alternative perspective to the potential positive benefits achieved from the multitude of ways that opportunities are created for engagement in creative activities, in spite of limited resources. Particular attention is paid to the factors that contribute to positive outcomes present in most arts-based interventions as drawn from the literature. The emphasis is given to the art-making process as the common denominator in every art intervention which has the potential to be therapeutic, independent of, but also complementing other contributing factors. I further explore research studies that indicate the outcomes of art as communication, increased self-esteem and social interaction that builds social supports, which is central to my thesis. In the last section, the focus is on research carried out in Australia, as this provides the most relevant context for this dissertation.

A search of the literature on both art-based and health-based research databases, including CINAHL and ProQuest through academic libraries, was conducted to find publications that explored the nature of art as a healing power, theoretical studies on the benefits of engaging in creative activity, and research conducted on creative programs and community-based art projects. Keywords used in the search included 'art therapy', 'art as therapy', 'arts in health', 'community arts' and 'group art programs'. Official websites of state and government bodies, arts councils and other relevant arts bodies were perused for official publications and reports on *arts in health* initiatives and frameworks. This narrative literature review draws on journal articles from relevant art

and health fields worldwide and books published in the field. Articles and books were also manually selected and retrieved from cited articles during the initial search until a point of saturation was reached. Literature located on research in the field was published as early as 1978 up to 2016 while literature tracing the use of art in history dates back to 1955. While much of the research is from the United Kingdom and United States, studies from Australia, Canada, Europe and Asia are also explored. Studies that looked at the benefits of art in the environment were excluded as this review is specific to active engagement in the creative activity. While this research focuses on group art programs in community organisations that have therapeutic, skills-based and social goals, the review includes research in art therapy and community arts participation in order to demonstrate the value and benefits of participating in the arts, the art-making process and the use of art as a communication tool. The literature highlights the evidence and theory that participating in the arts and the art-making process promotes health and wellbeing, including benefits such as facilitating communication, increasing social support and improving self-esteem.

This review includes a range of research studies that utilises a spectrum of quantitative, qualitative and mixed methods research designs to investigate the outcomes of arts-based interventions. Researching the arts within the health setting poses challenging issues in terms of methods and paradigms, which is further complicated by the complexity of interventions within a variety of settings, diversity of program structure, multiplicity of clients with different health issues and individual experiences (Clift 2012; Daykin et al. 2008; Galloway 2009). While *arts in health* practices are increasing, the pressure to develop its evidence base is also increasing, not only to determine if arts activities have measurable benefits but whether they are also cost-effective (Clift 2011). Ultimately the effectiveness of art programs in health can only be proven by rigorous evaluation and research (Staricoff 2006). This literature review incorporates research on diverse arts-based interventions and the variety of research methods used to identify outcomes, and examines its strength of evidence, specifically in relation to the current study. Although considered to be the 'gold standard' of rigorous research (Barry 2006; Gilroy 2006, p. 11), the literature search located few Random Controlled Trials (RCT) conducted in the field of *arts in health* (Crawford et al. 2010; Bell & Robbins 2007;

Lyshak-Stelzer et al. 2007; Richardson et al. 2007). The literature review located more qualitative than quantitative studies, with case studies being a popular research method. Individual research studies looked at specific aspects of the intervention, attributing outcomes to participation in the arts, the building of therapeutic alliances between client and therapist, and the social value of the art project. While these interventions are designed for the target group experiencing barriers to optimising health, some commonalities of increased self-esteem (Prescott et al. 2008; Reitzes & Muran 2006; Stinson et al. 2008), social connectedness (Argyle & Bolton 2005; Drapeau & Kronish 2007) and arts as a means of communication (Davis 2010; Lark 2005; Lev-Weisel 1998) were reported.

2.1 HISTORY AND DISCUSSION OF THEORY IN THE LITERATURE

Before the establishment of art therapy as a profession and the promotion of community arts projects to combat social exclusion, engaging in creative activity existed as a means to promote wellbeing. The idea of art as a way to heal and a means to communicate traces back to ancient times, as illustrated by images, cave paintings, dance and chants that were used to unify the body, mind and spirit and to restore health (Graham-Pole 2001). In Paleolithic times art was essential and celebrated life and was infused into daily life and this has thrived through history because 'we thrill to witness what humans can accomplish' (Booth 1997, p.5, 15). Morphy (2008, p.109) describes how Australian aboriginal art by the *Yolngu* people in the 1970s used art as a vehicle of communication to express complex relationships between people, nature, life, death and ancestors. Art-making has always been a form of human behaviour and it is what makes us different from other species because visual expression is deeply rooted in the human capacity to think, feel, express and make sense of the world (Learmonth 2009). Winnicott (1971) backs this to state that when the opportunity to be creative is lost, everything that is real, personal and original ceases to exist. This ethological theory of arts as essential to human development is fully supported by Dissayanake (1988). According to Dissayanake (2000, p.4), art is a part of culture and fulfils the human need to make the ordinary special (Camic 2008), but also has the ability to transport us from ordinary reality 'to an undesirable realm'.

As evident in the following examples, art has been recognised and used as a tool to promote health and wellbeing for more than a century, although its legitimacy as a therapy has been primarily from the mid-twentieth century. In 1841, WAR Browne, the superintendent of Crichton Royal Hospital in Scotland, encouraged creative activity, stating that doing artwork imparted healthy vigour and established tranquility, allowing an atmosphere for reasoning and awareness (Guttmann & Regev 2004). In 1941, Puerto Rican artist Wayne Ramirez forewent his career in New York as a professional artist to work with emotionally disturbed children in homes and treatment centres. Ramirez stated that his work was a way of helping these children 'get along, get involved in teamwork and become more positive in their behaviour', which, a psychiatrist observed, was 'therapy indeed' (Potash & Ramirez 2013, p. 170). Ramirez became the first registered art therapist in the United States in 1963. Between 1930 and the 1950s, American artist Mary Huntoon believed in the power of art and encouraged hospital patients to engage in creative activity, insisting that the healing power was in the 'process' of creating art (Wix 2000). In 1973, an independent entity of the Catholic Church in Chile called *A Vicarage of Solidarity* began a social art program that supported women to create embroidery on sack cloths (Reyes 2014). Initially started as a workshop to generate income, the creative activity turned into an outlet for these women to depict their experiences and a space for mutual support that built participants' self-esteem and confidence for the future (Reyes 2014).

Much of the exploration behind art as a healing power can be historically traced back to Freud's psychoanalytical theory of the unconscious and Jung's idea of the archetype. Freud's theory in relation to an art intervention explains that memories locked into the unconscious mind lose their ability to be verbally expressed and art is a tool that enables those thoughts to be brought into the conscious mind (Meissner 2000). Jungian concepts of the collective unconscious and the exploration of the archetypes and symbols accessed through creative expressions, again further bring forth psychoanalytic theory of symbolic representation of the unconscious. Art therapy pioneer Margaret Naumburg (1955) substantiates this, stating that the unconscious mind speaks in symbolic images and that symbolic imagery in art has psychological relevance. Collie, Botorff and Long (2006) refer to this as an ongoing process of story-telling of one's life to

create meaningfulness and a sense of purpose which may have been disrupted during challenging life events. Alternatively, Hyland-Moon (2014) disputes psychoanalytical theory as a limited perspective that all art-making is the expression of the unconscious or emotional ventilation, and suggests that people create art for a variety of reasons, whether to claim cultural identity, explore unique interests, create a gift, socialise or simply to feel good about themselves. The earlier theories on arts participation have been expanded, disputed, supported and discussed by more current researchers and practitioners in the field of more formal *arts in health* initiatives and is discussed below (Wallace et al. 2014; Betensky 2001; Waller 1993; Lachman-Chapin 2001; Hyland-Moon 2014)

While aware of this historical background, in this dissertation I focus on the literature that explores the act of participating in the art-making process, that traces the entire act of engaging in creative activity, beginning from the choosing of colors and materials, to immersing in the art-making process, being present in the space and group environment and finally to giving tangible form to the expression, with each stage of the process having its own value. A person who chooses to participate in a visual art-making process of deciding on colors, restructuring design and creating is compared to actively engaging and considering issues in one's life (Skaife 2001). Participating in the process of choosing art materials to create something with one's own hands encourages exploration of boundaries (Stephenson & Orr 2013) and in becoming comfortable with the medium, a sense of ownership and empowerment is being developed (Wilson 2002). McCosh (2013, p.127) describe the artists' creative process as a sublime sensory experience of new possibilities of creativity that generates feelings of wonder and elation. During this process, new insights and new knowledge are formed and the initial apprehension of what will develop, gradually transforms into delight and wonderment when new ideas emerge (McCosh 2013. The artist makes choices that are followed by consequences and develops the skill of focusing on the positive option (Booth 1997, p.118). Guttman and Regev (2004) compare this action to making choices in life and dealing with the options and consequences those decisions bring. Furthermore, as the art is being produced, the image or product emerging, or the final artwork, can bring forth considerable insight and revelation to the creator (Argyle & Bolton 2005; Lev-Weisel 1998; Collie, Bottorff & Long

2006).

Thus, the art-making process is highly important and significant as it is present in every active engagement in the arts and has ignited researchers' curiosity in exploring what happens when one is actively engaged in that art-making process. Hass-Cohen and Carr (2008), both art therapists and psychologists, state that art-making organises the complexity of people's interactions and facilitates the expression of these emotions and their relationship to others and the environment, suggesting there is a connection between creative engagement, mental states and emotional experiences that influence the wellbeing of those engaged in the process. This paradigm shift that links the practice of art therapy to clinical neuroscience – that uses scientific instruments to delve more deeply into what happens to the brain when engaging in creative activity – is further explored by Bolwerk et al. (2014) who used *f* MRI brain equipment to understand the functional activity of the brain with retirees who participated in creative activity. These researchers found the visual art production led to improved brain activity and interaction, improved psychological resilience, reduced negative emotions and increased self-awareness. This neurological understanding of art therapy was tested by art therapy student Belkofer who used *f* EEG equipment to record brain activity during his art-making sessions that suggested significant changes in neurological activity (Belkofer & Kanopka 2008). How this change in brain activity influences psychological states has been explained as: having mood- enhancing properties (Bell & Robbins 2007); a time to connect with their inner selves (Van Lith 2015); soothing, calming, distracting one from pain, reducing anxiety, stimulating mental activity and providing enjoyment (Argyle & Bolton 2005; Bauman et al. 2013).

Actively participating in a creative activity has also been likened to 'play' in which adults fantasise and imagine giving life meaning through a creative way of living (Spencer 2012). Argyle and Bolton (2005) suggests that the playfulness of the art-making activity that is spontaneous, self-motivating and relaxing creates social bonds within an atmosphere of deeper expression of experiences. In a study conducted on a local creative program attended by forty-five individuals diagnosed with schizophrenia and depression living in the community, participants reported the non-discriminating space gave them the

confidence to relax and explore creative play without fear of failure and a time to have fun and relax (Lipe et al. 2012).

Another aspect of the creative process that is explored in theory—which is similar to Freud's concept of making the unconscious, conscious—is the embodiment of an experience or problem in a tangible object (Meissner 2000; Florsheim 1955). The opportunity to freely express allows a person to externalise their emotions and experiences into tangible form, which can then be individually explored in depth or serve as a means of communicating to others (Wallace et al. 2014; Betensky 2001; Waller 1993; Lachman-Chapin 2001). Florsheim (1955) links the previously discussed ethological theory on the human need for creative expression and communication and giving it form, stating that art has the most intense ability to satisfy this need. It also is in alignment with Dissayanake's (1988) concept of making the ordinary special, and Hyland-Moon (2014) proceeds to say that in some instances, even if the content of the work is an unpleasant experience, it fulfils the person's need to engage in this creative activity and to discard that experience ritually.

The discussion above highlights the theoretical potential of the benefits one receives when engaging in a creative activity which is attributed to the art-making process. I will explore further the significance of this process when discussing the art-making process that is present in every opportunity provided for engagement in a creative activity.

2.2 BENEFITS OF THE ARTS

There is a broad scope of literature based on research studies that focus on either community art projects in collaboration with professional artists, or arts-based interventions delivered by trained art therapists in health settings. A range of programs have been used in multiple settings with various clientele, such as: substance abusers (Dickson 2007); people diagnosed with psychotic disorders and schizophrenia (Oster et al. 2006; Drapeau & Kronish 2007); sexually abused children (Ball 2002; Mills & Kellington 2012; Murphy 1998); juveniles (Bennink, Gussak & Skowran 2003); migrants (Bermudez & ter Maat 2006); cancer patients (Borgmann 2002; Greece 2003; Oster et al.

2006; Ando et al. 2016); chronic pain sufferers (O'Neill & Moss 2015); adolescents and children with Post-TraumaticStress Disorder (PTSD) (Lyshak-Stelzer et al. 2007; Mallay 2002); people with borderline personality disorders (Morgan et al. 2012); prison inmates (Gussak 2009); children with autism (Epp 2008), with Attention Deficit Hyperactivity Disorder (ADHD) (Saneei, Bahrami & Haghegh 2011) or with an intellectual disability (Trzaska 2012); and homeless youth (Prescott et al. 2008).

The benefits identified through research on programs delivered with the varied clientele above ranged from a greater sense of achievement (Argyle & Bolton 2005; Collie, Bottorff & Long 2006), building creative skills (Dere-Meyer et al. 2011), a means to expressing emotional experiences (Harnden, Rosales & Greenfield 2004), encouraging social interaction (Borgmann 2002; Drapeau & Kornish 2007; Wood 2002), to being a time for pleasure, enjoyment and fun (Bauman et al. 2013). While some research studies were specific in investigating the contributing factors that influenced outcomes, others attributed outcomes to the general participation in the arts-based intervention. I further explore these studies in relation to contributing factors and outcomes.

2.3 CONTRIBUTING FACTORS

The relevant research literature mentions several factors as important in contributing to an art intervention having therapeutic value and positive outcomes as reported above. Various studies have explored specific aspects of the intervention, attributing outcomes to contributing factors such as active participation in the arts (Argyle & Bolton 2005; Belfiore & Bennett 2007), the building of the therapeutic alliance between client and therapist (Crawford & Patterson 2007; Clift 2011), the careful consideration and provision of the most appropriate materials (Malchiodi 2007), the creation of a safe space (Fenner 2012; Fenner 2011), the social element of the art project (Secker et al. 2011; Hacking et al. 2006), or a combination of these factors. In identifying common therapeutic factors in all interventions, Hubble, Duncan and Miller (1999, p.7) state there are four factors shared by all effective interventions which are: 1) A therapeutic relationship; 2) a 'healing setting'; 3) rational for hope and expectation; and 4) active participation of participant and facilitator. Engaging in the creative activity is given

considerable attention in all interventions and a significant contribution to the process as a whole. In the following, I examine the contributing factors of facilitator, space, material, final product, social element and art-making process, as identified in the literature in order to better understand the contribution each makes to positive outcomes. While it is impossible to distil the influence of each individual factor from other factors or the art-making process, as there is clearly considerable interdependence between the various factors, for clarity of argument I will look at each separately.

2.3.1 THE FACILITATOR AND THE THERAPEUTIC ALLIANCE

In the introduction I traced the growth of art therapy and those that deliver art programs under the titles of art therapist, artist in residence or hospital artist (Dileo & Bradt 2009). While the United Kingdom and the United States have the most developed standards for the art therapy profession, arts-based interventions around the world are delivered by a variety of professions, from mental health workers in Hungary, psychologists in Uruguay, counsellors in Japan, occupational therapists in Finland, to artists and teachers in Bulgaria (Stoll 2005). Research around the role of the facilitator of arts interventions reveals that facilitators come from a range of backgrounds: artists (Argyle & Bolton 2005; Moody & Phinney 2012); art therapists (Van Lith, Fenner & Schofield 2011); counsellors (Whisenhurt & Kress 2013); volunteers (Holford 2011); and teachers (Allen 2008; Echkoff, Hallenback & Spearman 2011). While historically in Australia art-based interventions were carried out by occupational therapists (Westmore 2012), present day facilitators consists of art therapists (Stace 2011), occupational therapists (Harris 2008); nurses and artists (Thomas et al.2011; Johnson & Stanley 2007).This variety of facilitator disciplines informs the interaction and the role played by the facilitator, ranging from that of therapist (Harnden, Rosales & Greenfield 2004; Van Lith, Fenner & Schofield 2011), a teacher of skills (Argyle & Bolton 2005), to observer and fellow artist (Allen 2008; Marshall-Tierney 2014).

In programs that work with particularly vulnerable clients, art therapists emphasise the importance of the therapeutic alliance. For example, in a case study involving

suicidal adolescents, Harnden, Rosales and Greenfield (2004) argue art therapists who have professional training in both the use of art materials and therapy are the most appropriate to work with suicidal adolescents, as they are able to build that therapeutic alliance ensuring acceptance, respect and confidentiality. In this study, therapists are perceived to hold the therapeutic stance of hopefulness, imparting and suggesting this to the adolescent within a safe relationship (Harnden, Rosales & Greenfield 2004). Likewise, art therapists working with eighteen mental health recovery participants in Victoria, Australia, report providing guidance and support through trust and encouragement, and thus forming an important part of the recovery of these clients (Van Lith, Fenner & Schofield 2011). The common attribute of the facilitator that was identified in both the studies above was the ability to build trust with participants within the therapeutic alliance. Within a context of an accepting and supportive relationship clients experience safety and trust allowing them to be open (Bogo 2006, p.64). Carl Rogers influence on social work practice in regards to the therapeutic alliance states the conditions necessary for a facilitator is to be perceived as genuine and congruent, have unconditional positive regard and have empathy (Payne 2005, p.186). Bogo (2006, p.69) further adds that it is the 'warm and caring' quality of the facilitator as being genuinely concerned about the clients' wellbeing and interested in their difficulties or problems.

On the other hand, art therapists in mental health care have also been known to abandon the title of therapist altogether to downplay the connotation of authority and take on the facilitator's role as a guide using a non-directive approach to encourage participants to express their feelings in art (Van Lith 2015). Marshall-Tierney (2014), who has worked as an art therapist in the United Kingdom for over twenty years, questions why many art therapists take a clinical perspective of the therapeutic alliance. Instead, his approach as a facilitator is that of being an artist making art alongside the people he supports in the art programs. In his work with patients in an acute psychiatric setting, and by recording his observations of his patients over seven consecutive weeks engaging in art, Marshall-Tierney (2014) finds that making art together with his patients establishes more equality and engagement in the experience of the creative process. It makes it less intimidating for his patients

and gives him a deeper sense of being more attuned to them. While others have argued that the therapist would not be able to hold the patient in mind and make art simultaneously (Case and Dalley 1992), this view of the facilitator as being a fellow traveler while still maintaining awareness of all participants, is fully supported by art therapy professor, Allen (2008) who, in her community-based art studio in Chicago, favours the role of artist having the primary responsibility of creating a healing setting as defined by Hubble, Duncan and Miller (1999, p.7) and downplaying the focus of a clinical therapeutic relationship.

A few other art programs also elect to have artists as facilitators. For example, one study outlines a small number of artists who were involved in group art interventions in a juvenile setting. The aim of the program was to improve participants' confidence by providing them with the opportunity to engage in a creative activity to improve their skills. The evaluation of the program revealed that the acquisition of skills from artists gives the participants confidence, increases self-esteem and a sense of achievement (Argyle & Bolton 2005), suggesting the facilitators' role as teachers of creative skills. These artists are not therapists but the results of improved self-esteem could be attributed to the therapeutic nature of art-making. In the United Kingdom, art groups run by volunteers are common in many local communities that are self-sustaining and low cost and effectively play a role in improved wellbeing (Holford 2011). In this model of volunteers as facilitators, the focus is not on one person leading the group, but based on mutual support and collaboration in developing skills, which is empowering for participants (Holford 2011). This is similar to self-help groups that blossomed in the 1980s and 1990s, which are psychotherapeutic support groups for people with a common ailment or social issue facilitated and managed by members themselves (Archibald 2007).

The above examples show how the various attributes and approaches of the facilitator contribute to participants' experiences in the engagement of creative activity and influence outcomes in a multitude of ways. Some facilitators place emphasis on the completion of the creative process while others minimise the preoccupation of artistic goals (Ulman & Dachinger 1975). This importance of process

over product brings us to the next important factor being discussed, which is the art material used and the tangible product or artwork created.

2.3.2 ART MATERIALS AND THE FINAL PRODUCT

The choice and provision of art materials to participants of art programs is not consistent in the literature in terms of its importance or the type of materials used. However, the two recurring factors in the choice of materials depend on providing materials according to participants' dexterity (Stephenson & Orr 2013; Elkis-Abuhoff et al. 2013), and the availability of a variety of materials that encourage creative exploration likened to making choices in life and handling the consequences (Guttmann & Regev 2004; Eckhoff, Hallenback & Spearman 2011). Malchiodi (2007) describes how she considers the type of materials she uses in her work with children who have emotional difficulties, stating that the fluidity of some materials is not suitable and so she chooses more resistive materials that provide structure and control and reduces their anxiety. Snir and Regev (2014) agree that the facilitator needs to have the knowledge of the different art materials to ensure participants are able to use the most suitable material to emotionally express themselves. The choice to use recycled materials in art programs run after school with at-risk children, engages students in critical and reflective thinking (Eckhoff, Hallenback & Spearman 2011). It was discussed that these children develop their own solutions to the challenges they face in working with re-claimed materials which further supports student exploration.

There has been relatively little research done on the effect of specific art materials used in arts-based interventions on participant's experience of the process until more recent studies that specifically investigated participants' interaction with art materials. Penzes et al. (2014) state that art materials should play a central role in art therapy assessment, as it allows the therapist to gain insight into participants' mental health through observing their interaction with the material. In this study, interviews were held with art therapists who reported in their observations their clients' interaction with art materials in terms of control, experimentation, familiarity and

choices made. Art therapists in this study went on to assign and document different types of materials that evoke the different reactions (Penzes et al. 2014). Bolt and Barrett (2013, p.4) claim that the type of medium and the character of the material helps participants manipulate and create the form, through the handling and feeling of the material. They further add that the aesthetic image or creative product emerges from this process which then becomes the materialisation of a feeling (Barrett & Bolt 2013, p.64). Corem, Snir and Regev (2015) further explore how therapeutic relationships between therapists and participants influence the participants' attitude to the use of art materials. Two other qualitative studies located were a study on the effect of different art materials on children's level of aggression and self-control (Pesso-Aviv, Regev & Guttmann 2014) and a study on students' responses and emotional reactions to the use of five basic art materials (Snir & Regev 2014). The themes defined in this latter study included: excitement and curiosity in the potential to play; fear of the messiness and loss of control over the material; and the evoking of past memories in relation to the materials. While the first three studies (Penzes et al. 2014; Corem, Snir and Regev 2015; Pesso-Aviv, Regev & Guttmann 2014) mentioned above reported material interaction from the therapist perspective, the study by Snir and Regev (2014) reported on the participants' perspective on their experience of using the art materials, and it was revealed that the art materials did not play a central role as they were more absorbed in the experience of the art-making process.

Alternatively, some art-based initiatives simply provide a variety of materials and give participants the power of choice. Ward (1999, p. 111) states that a participant is drawn to an art medium depending on their sensory requirement, and will choose a type of medium that meets their individual need for healing. In a research study on an art therapy program in the United States aimed at promoting the wellbeing of older adults, participants were provided a variety of art and craft materials and specialised equipment for more specific work such as easels and drawing boards (Stephenson 2013). Innovative ideas, introduced with new materials throughout the program challenges participants to explore their choices and express themselves in many forms through experimentation and pushing boundaries, thus fulfilling their

need for self-expression and giving them a sense of purpose (Stephenson 2013). Providing a choice of materials has its advantages but therapists that place emphasis on verbal discussions that are initiated by the art, provide the simplest of materials to participants to encourage spontaneous expression and focus on creating an image quickly (Malchiodi 2007*).* The fact that facilitators can occasionally play a role in providing the type of materials used highlights the inter-relatedness between these two contributing factors of facilitator and art material.

The practice of art therapy gives much importance to the creative process and minimizes the goal of the final image or product created (Penzes et al 2014; Sandmire et al. 2012; Booth 1997). However, Kahn (1999) states that the artwork produced, has permanent and tangible existence which allows the creator to reflect on its meaning in the future. Van Lith (2015) found participants in his art program to be proud of their completed works as it is seen as an accomplishment to show off to others and that these completed works are precious representations of changes within themselves. Franklin (1992) places importance on the final product, stating that when the art-making is completed, the artwork produced is unique and a powerful tool that represents and validates the person's uniqueness.

Furthermore, the literature reports the final product and image to be the embodiment of participants' experiences (Appleton 2001); a means of communicating (Florsheim 1955; Lark 2005; Michaels 2010); and offered participants a tool for reflection (Collie, Bottorff & Long 2006). I will explore the importance of the final product further when discussing it as a means of expression and communication between artwork and self and public.

2.3.3 THE THERAPEUTIC SPACE

There are two kinds of 'space' that are discussed in the literature: one referring to the physical space where the creative activity takes place; and the other the 'space' or environment that is created by intangible factors. Both influence participants' experiences in an art program. Malchiodi (2007) insists that spaces can be

transformed to create an area suitable for art-making with aesthetic objects or music that can stimulate creativity. Liebmann (1990, p. 80) states that the practical aspects of the space such as clean tables, plants, displayed work, tea and coffee facilities, should not be overlooked.

Through a qualitative study on the visual experience of participants in an art program, Fenner (2011 p. 854) discusses the importance of the physical studio space in which the art-making takes place, and observes that participants are 'stimulated by the sensory and aesthetic experience' of the space. He further explains that the multi-dimensional aspect of the art intervention should consider that participants develop relationships with the physical environment and the materials in the room for the purpose of support. Through interviews, participants reported that the use of light enhances their experiences of freedom and creativity, and that a window with a view of nature gives them more perspective and respite from what is taking place inside (Fenner 2012). When art therapist McNiff (2004) set up his art studio in Danvers State Psychiatric Hospital in Massachusetts, he created a space which he believed was charged with artistic energies and an environment where people could spontaneously and freely express themselves (McNiff 2004). In his work with these psychiatric patients he repeatedly witnesses how the studio space causes different reactions, sometimes even becoming an artistic sanctuary for some of them. While this aspect of the space and its influence on participants' art-making process as observed by facilitators is invaluable, further research is needed that explores the perspectives from the participants' points of view. That is, their experience of the space, and the reactions it causes; specifically, how the physical space influences their engagement in the art-making process and what they perceive as a 'safe space'.

Therapists describe the second type of 'space' as being a consistent space for suicidal clients (Rothwell 2008), a safe space for patients after a stroke to explore difficult experiences, and a trusting space for exploration and experimentation (Van Lith, Fenner & Schofield 2009). Liebmann (1990, p. 81) refers to this therapeutic space as having 'a place to be' and providing the opportunity for an ongoing process of creative functioning and facilitating motivation to those who participate. This is

sometimes known as ‘climate’ in the practice of groupwork which describes a warm and accepting atmosphere that allows emotional expressions without the fear of rejection (Vraa 1974).

Rothwell (2008) further explores ‘space’ in relation to his work with suicidal clients, stating that the space needs to be a space for reflection, a containing place, a safe haven and a neutral space. Art therapists working with a group of children with Attention Deficit Hyperactivity Disorder (ADHD) created not just a working space for these children, but sufficient mental space for them to think, externalise feelings safely and to reflect on their experiences (Murphy, Paisley & Pardoe 2004). Both the above studies looked at the concept of a ‘safe space’ from the art therapist perspective, but there are few studies that look specifically at it in relation to participants’ experience. Through focus groups in a qualitative study, participants in a community-based art program describe the program as being a ‘space’ where they feel free to explore personal issues and begin the process of recovery (Heenan 2006). In the field of psychology, this psychological safety is the belief shared among group members as a safe space for interpersonal risk-taking (Cave et al. 2016). Cave et al. (2016) proceed to suggest that this space can be effectively cultivated when group members are actively engaged in their development and maintenance.

In the literature, some facilitators were described assuming the responsibility of creating a safe space for their clients, such as school counsellors who state providing a comfortable and relaxing physical space makes their students feel less anxious and creates a safe space for expressing painful experiences (Cook & Malloy 2014). Spencer (2012) supports this stating the therapist has to create it by providing structure and containment in an attentive environment. Facilitators are sometimes known to be responsible for ‘holding the space’ which comes from the concept of a ‘holding environment’ initially termed by Winnicott and known in social work practice to mean an environment where there is affirmation of an individual’s worth, so that feelings of anxiety can be explored and understood (Bogo 2006, p.73). Additionally, Liebmann (1990, p. 80) states facilitators should also prepare the physical space that is comfortable for participants as it indicates a sense of care

towards them. This aspect reveals the inter-relatedness of the two contributing factors of facilitator and space. However, as with the lack of research into the perspectives of the participants in regards to their perceptions of art spaces, research that explored the role participants may play in creating these spaces was limited.

2.3.4 THE SOCIAL ELEMENT OF ART-MAKING

Implementing art projects to combat social exclusion is evident in the literature, especially in research focused on community projects (Secker et al. 2011; Hacking et al. 2006; Johnson & Stanley 2007) and *arts in health* programs targeting vulnerable clients providing opportunities for social interaction (Argyle & Bolton 2005; Borgmann 2002; Drapeau & Kronish 2007; Wood 2002). Art-making is used: as a tool in social adaptation for war veterans (Kopytin & Lebedev 2013); to foster social integration with persons with psychiatric disabilities (Lamb 2009); and to improve social skills of autistic children (Epp 2008). While creating art in silence has its own benefits as it allows the person involved in the creative process to focus on their own thoughts and feelings (Guttmann & Regev 2004), the literature supports that sharing and discussions around the art created facilitates communication and social connectedness.

Through in-depth discussions with people with lived experiences of borderline personality, who had difficulties in fostering interpersonal relationships brought about by social anxiety and fear of rejection, it is reported art is the mediator that triangulates connections to other people (Morgan et al. 2012). In another project, data collected from evaluation questionnaires completed by parents of eight children with ADHD, reveals that art-making in a group setting helps these children self-regulate and gives them a meaningful social experience (Murphy, Paisley & Pardoe 2004). In another study, art therapy is used as adjunctive therapy with cancer patients whose social networks have collapsed, and three individual case studies reveals art therapy promotes participants' self-expression thus increasing their coping skills and social interaction (Borgmann 2002). The most common response received in a qualitative study on participants with a disability who attended a Fine

Arts Program was that it provides them a social opportunity to meet new people (Schlosnagle et al. 2014). In the above studies, outcomes are directly articulated by participants of the art programs: people with borderline personality (Morgan et al. 2012); by parents of children who participate in the activity (Murphy, Paisley & Pardoe 2004); and through case studies with cancer patients (Borgmann 2002). Many of these researchers support the call for research that includes the voice of the participant (Dose 2006; Wood 1999).

Another researcher used direct observation and record-keeping over a seven year period on five of his patients with Acquired Immune Deficiency Syndrome (AIDS) for whom social interactions are awkward and found group art-making a meaningful social experience (Wood 2002). For children affected by domestic violence, art-making within a group setting allows members to share a 'visual language' of their experiences enabling connection through meaning-making (Mills & Kellington 2012). While social interaction occurs naturally in a group environment, in his work in mental health care, Van Lith (2015) finds that the non-verbal component of art-making while making art alongside others in a group assists relationship building in an informal and safe social setting.

A Random Controlled Trial (RCT) called the MATISSE study investigated an arts-based intervention carried out with people with schizophrenia recruited from inpatient units, community mental health and social care services in England and Northern Ireland (Crawford et al. 2010). This RCT utilised the Social Function Schedule to measure social functioning among participants. While this was a large scale pragmatic robust study that used an effective measure of social functioning, it did not specifically investigate what aspects of the art-making experience encourages social interaction. As discussed in Chapter 1, social functioning and social interaction give members the opportunity to build their social support networks.

2.3.5 THE ART-MAKING PROCESS

A majority of the literature reviewed claims the art-making process to be essential

and the most important factor in any art intervention. Booth (1997, p.3, p.21) clearly delineates art not as a verb but as a process of looking and doing and not the artwork that is created but in the experience of making it. Drawing on the theories of the process of engaging in art previously discussed (Skaife 2001; Stephenson & Orr 2013; Guttman & Regev 2004; Argyle & Bolton 2005), the benefits of this engagement is reported in the research literature. In a RCT conducted with fifty adults aged eighteen to thirty–recruited from a local university in Pensylvania, US – results detail significant reductions in negative mood and anxiety that is attributed to the production of art in the absence of art therapy protocols and a trained art therapist (Bell & Robbins 2007). In a qualitative evaluation of art programs in three community groups in the United Kingdom, members interviewed reported to have experienced the art session to be therapeutic when they became absorbed in the spontaneous, self- motivating art activity which had a relaxing and positive effect on their mental wellbeing (Argyle & Bolton 2005). In a survey on 24 American artists, results revealed that it was the creative process that fulfilled the need of belonging and meaning and that these artists focused on the process of creating and not on the final product (Dissayanake 2000, p.184). The artists involved stated that the process itself was 'emotionally rewarding and psychologically meaningful' (Dissayanake 2000, p.185).

Studies that highlight the role of the facilitator share the influence of that role in conjunction with the art-making process (Allen 2008; Van Lith, Fenner & Schofield 2011; Argyle & Bolton 2005). In some studies, the art-making process itself facilitated communication between client and therapist, thus strengthening the therapeutic relationship which is central to the therapeutic process (Ball 2002; Banks 2012). For example, an art therapy intervention with adolescents in an intensive care burn unit was evaluated for its benefits of dealing with issues of trauma. The author reports the art-making process offers these adolescents a vehicle of expression for their pain and trauma to facilitate communication with their family members and medical professionals (Appleton 2001). When working at a hospital in Boston, Ulman and Dalchinger (1975, p. 22) relate how patients gain insight more often from the artistic process rather than the verbal discussions. They continue to clarify this by stating

that there exists an inherent healing quality in the creative process where conflict is re-experienced and resolved (Ulman & Dalchinger 1975, p. 22).

In a qualitative study with patients with mental illness, data illuminated how art-making helps participants cope with their illness and resolve conflicts (Van Lith 2015). Participants describe how they connect with their inner selves by becoming immersed in the creative process. Van Lith (2015) further stresses the intrinsic benefits of art-making in empowering people living with a mental illness through an awareness of their artistic identity and self-exploration within the creative process. Drawing on the theory earlier explained on brain activity, it was proposed that actively participating and immersing oneself in creative activity is soothing, calming, distracting one from pain, reduces anxiety, stimulates mental activity and provides enjoyment (Argyle & Bolton 2005; Bauman et al. 2013). As an example, when sixteen stroke patients who attended an art program were interviewed, it was revealed that these patients engaged in the art-making process, experienced mental stimulation, pleasure and enjoyment and reported it to be a source of fun and a time of pleasure (Bauman et al. 2013).

2.4 SELF-ESTEEM AND SOCIAL SUPPORT

In this section of the literature review, I present research studies that focus on the outcomes that are relevant to this dissertation: self-esteem and social support. Thus far, I have reviewed the literature extensively and reported in the previous section, on the wider benefits of engaging in art activity. In Barakeet's (2005) review of the literature, some of the most common cited impacts of arts projects included increased self-esteem and confidence, increased social and creative skills and stronger personal networks. I will now look at a sample of research studies that evidence outcomes of improved self-esteem and increased social supports in a variety of settings and targets (Argyle & Bolton 2005; Drapeau & Kronish 2007; Eades & Ager 2008; Prescott et al. 2008; Bungay & Clift 2010).

2.4.1 SELF-ESTEEM

In the earlier chapter on the focus on health and wellbeing, self-esteem was identified as an asset to improve health. Engaging in creative activity has been evaluated to increase a person's self-esteem and this is supported in the literature describing research studies that examine art-making as an effective means to boost self-esteem. The importance of self-esteem on one's wellbeing is highlighted in much of the literature in health promotion (Prescott et al. 2008; Reitzes & Muran 2006; Stinson et al. 2008). There are studies that identify that people with a chronic illness such as cancer and people with other physical or mental illness are likely to suffer from low self-esteem (Collie, Bortoff & Long 2006; Argyle & Bolton 2005). For example, an art therapy program was implemented for women with breast cancer who reported as having lost their self-value and self-esteem and experienced social isolation (Collie, Bottorff & Long, 2006). Using narrative research methods through in-depth interviews, these women reported that visual artistic expression used in cancer care facilitates emotional expression otherwise concealed, helping them to reconnect with their self-image and recognise their capabilities (Collie, Bottorff & Long 2006).

In a qualitative evaluation on creating art in groups in mental health, interviews with participants revealed that these programs gave them a sense of achievement and validation, which further enhances their confidence and promotes self-esteem (Argyle & Bolton 2005). A study that investigated the efficacy of group art therapy for twenty-six adult psychiatric patients through discussions during clinical sessions with participants, it was reported participation in creative activity enhanced self-esteem and gave participants a sense of being appreciated (Drapeau & Kronish 2007). Art programs were delivered to at-risk youth in the United Kingdom to encourage awareness of self-worth and enhance participants' self-esteem. With the use of interviews, questionnaires, focus groups and personal journals, sixty-four percent reported they experienced greater self- confidence and self-esteem (Eades & Ager 2008, p.64). In the United

States, in a quantitative study over a five year period with 212 homeless youth who participated in art-making, interviews with three of them revealed participation boosts self-esteem and creativity fosters resilience (Prescott et al. 2008). The authors observed that participation in creative activity provides an opportunity to re-shape one's painful circumstances and formulate change – thus increasing coping skills and the ability to address concerns that boosts self-esteem (Prescott et al. 2008). Teenagers with cystic fibrosis were provided with the opportunity to participate in art-making sessions to address body image and self-esteem and art therapists observed that the use of art in this population as a method to re-image the self, gave participants control over the process, thus increasing their self-esteem (Fenton 2000). As they gain confidence in expressing themselves, they feel empowered to face challenges and renew hope (Fenton 2000).

Group art therapy was qualitatively evaluated with the use of case studies, and it was found to improve the level of self-esteem in sexually abused survivors by fostering an increase in self-worth (Mills & Kellington 2012). Low self-esteem was expressed and addressed through image making with children with ADHD, allowing them to express their feelings rather than acting them out disruptively (Murphy, Paisley & Pardoe 2004). Four out of five of the children involved showed an increase in self-esteem. In another qualitative research study based on grounded theory, the effectiveness of an arts-based group to develop self-awareness and self-esteem with children in foster care was examined. Using semi-structured interviews, preliminary findings indicate that art-based methods assist children to become more positive about themselves, develop self-awareness and self-esteem (Coholic, Lougheed & Cadell 2009). In a research study utilising case studies, service users of a community-based mental health organisation reported arts interventions improve self-esteem and confidence and some of them felt encouraged to participate in other activities and paid employment (Heenan 2006). The literature not only shows the importance of self-esteem in addressing a variety of issues experienced by people with a mental illness or those with low self-image, but that it is also a factor that will influence

one's confidence in socialising, thus building a supportive social network. Self-esteem affects one's social interaction and on the other hand one develops a sense of self by interacting with others (Campbell, 1995; Rosenberg 1989).

2.4.2 SOCIAL SUPPORT

In my introduction I discussed the change towards a holistic view of health that included social wellbeing and how social supports minimise risks to ill-health (Lane 2006; Ryan 2004). I highlighted policies and frameworks that addressed the larger context of social inclusion in which sits social support networks that impact on health and wellbeing (Davidson 2015; Kawachi & Berkman 2014; VicHealth 2013). Social participation in group recreation such as art programs provide opportunities for social engagement re-enforcing meaningful social roles in the community and provide companionship (-Berkman, Kawachi & Glymour 2014). Several research studies were located in the literature that addressed the importance of social networks and the use of art in the promotion of social wellbeing (Argyle & Bolton 2005; Drapeau & Kronish 2007; Bungay & Clift 2010; Epp 2008).

In two examples of art programs that were evaluated by qualitative methods, it was found through interviews that creating art within a group enables mental health patients to move towards better community participation, thus diminishing social isolation and strengthening social relationships (Argyle & Bolton 2005; Drapeau & Kronish 2007). In the UK, a program called Arts on Prescription (AOP), consisting of programs facilitated by artists was implemented in the community, with the aim to reduce social exclusion (Bungay & Clift 2010). Various quantitative methods used to study these programs provide evidence that engaging communities in creative activity increases social interaction (Bungay & Clift 2010). Barakeet (2005) explains that participants' creative interests are stimulated when they are involved in art projects and this facilitates further engagement in other activities, thus fostering social connections.

Social interaction can cause great anxiety and emotional stress for children with autism, which can become debilitating as they grow older as these children do not understand social cues, attitudes and emotions of others, and are socially stiff and awkward (Epp 2008). A study using pre- and post-test questionnaires provided evidence of improvement of social skills through the use of comic strips and role play to relax these children in a social situation (Epp 2008). The art activity gives the children an acceptable and appropriate way to participate in a group setting without verbal language, allowing them to function more easily in a social environment (Epp 2008). As suggested by Argyle and Bolton (2005), the playfulness of the art-making activity that is spontaneous, self-motivating and relaxing creates social bonds within an atmosphere of deeper expression of experiences. Interpersonal difficulties such as shyness, inhibition or discomfort, weakens one's social functioning skills and the ability to integrate with others (Rosenberg 1989, p.246).

The use of art-making within a group setting has a rich history in social work practice as it can naturally elicit socialisation and through the process of engaging in verbal and non-verbal communication members gain confidence in collaboration and learn interpersonal skills (Kelly & Doherty 2016). The art process serves as an opportunity to give an individual a sense of confidence and achievement, providing social connectedness within the group (ANZATA 2015).

2.5 ART AS A MEANS OF COMMUNICATION

In reviewing the literature on arts-based interventions, art was used as a method of communication in a variety of ways. In this section, I explore theoretical discussions around the language of art, as well as research studies that report art as an effective method of communication. The literature discusses the use of art as a means of communication at many different levels: communication between client and therapist/professional (Labarca 1979; Gray 1978; Parker et al. 2013; Dewdney, Dewdney & Metcalfe 2001); communication between different parts of self (Dickson 2007; Greece 2003); communication between members of a group (Tucker & Trevinno 2011; Lark

2005); communication between 'artwork' and back to self (Banks 2012: Lyshak-Stelzer et al. 2007); and communication between artist and community (Kelaher et al. 2012; Lamb 2009).

In her paper on art as a language, Margaret Naumburg (1955) traces early cultural use of art as symbolic language and suggests this method of communicating has been used throughout history and into the twentieth century by contemporary artist use of symbolic context. Naumburg (1955) also compares how symbolism used in the present period has similar elements to the archaic patterns of primitive times, which were visual projections of the unconscious imagery, depicting human behavior and expression. For many years philosophers have referred to art as a language and that each artist speaks their own language. Florsheim (1955) states that people have an intense need to share and communicate and do so by giving form to their expression. He claims that the arts have the greatest ability to satisfy this need. Art, like language, is both expressive and imaginative and every work of art has enduring value because it possesses something for which words cannot express (Florsheim 1955). Macphail (1974) spoke of the historical capacity of art to communicate abstract thoughts that have bridged continents and centuries in time. The visible, tactile end products of art have been powerful tools used to disseminate knowledge through the years of human development, reliant on the capacity of art to communicate (Macphail 1974).

If art is a language then when a dominant verbal language is not spoken by every member of a group, the use of art as a language can bridge those barriers. When verbal communication is difficult or inaccessible to people–such as those for who English is their second language—art can provide an alternative method of communication. In a project involving early learners of English as a foreign language, children were asked to depict how they were feeling daily through drawings and it was found that these children communicate their feelings and moods more easily through visual means (Dancevic 2005). In a phenomenological research study involving international students in Australia with limited language skills, art proved to be effective when used as an aid to express feelings, encourage reflection and facilitate verbal dialogue (Davis 2010). This is an example of art as a means of communication that transcends language and cultural

barriers. Students and migrants explored emotions previously inaccessible because of these barriers (Davis 2010). This notion of art crossing cultural barriers is further supported by Lark (2005) who states that sources of rich information that cannot be verbalised are missed when groups only use verbal language. In groups where people are less able to speak the dominant verbal language, the use of art processes gives them a 'voice' and shifts the power dynamics. The language of art is not word dependent and, as Lark (2005) suggests, when we add this language of images and processes to dialogue, we honour the differences in cultures.

Whether or not we agree that art is a language, and believe as Lark (2005) does that language is not only the written or spoken word but a means to externalise experiences through image, gesture and tone, there is extensive literature on art used as a means of communication through art therapy and community art projects.

2.5.1 COMMUNICATION BETWEEN 'ARTIST' AND FACILITATOR

In the health field today, emphasis is placed on the client-therapist relationship and person-centred practice, which makes communication between client and professional a key factor. Communication, or the lack of it, can be a hindrance to professionals working with young people, people with disabilities and other groups of people who may have difficulty in communicating or expressing their thoughts and emotions verbally. In social work practice, this relates to the facilitator having empathy by being both participant and observer, which entails being able to feel what the members feel but remaining separate to understand the situation (Bogo 2006). Art has the capacity to be used as a catalyst of communication, as a safe method of externalising a person's emotions, giving both client and therapist more insight into a person's issues, fears or trauma.

For example, a registered nurse on her first rotation on an adolescent psychiatric unit worked with a patient who refused to communicate until she introduced drawing into her sessions. Through the use of colours and shared drawings, the patient is able to communicate feelings of hurt, anger and anxiety, which is

crucial to the therapeutic intervention (Labarca 1979). An occupational therapist working in a psychiatric hospital found that art provided her patients with an alternative method of communication, as they are able to express their feelings and fears in images when they find it hard to verbalise them (Gray 1978). Gray further explains that the process of creating art and the images produced become a bridge that facilitates communication between the client and therapist.

In 2012, a student-centred symposium was held in Italy for students of diverse disciplines, ages and interests to explore how and what is communicated through art in medicine and public health (Parker et al. 2013). The key points that emerged were that art serves as a reminder of people's sufferings but also as a testimony to good deeds in the community, and that art can communicate concepts like death and dying, inviting others to share with compassion. The concluding reflections of medical and health professionals were that the arts were important in public health to help in communicating human experiences and in providing a platform for engaging and listening, recognising the link between communication and compassion and how to incorporate it in healing (Parker et al. 2013).

Lisa Banks, an art therapist working with service users in a low secure unit, used art to encourage dialogue, explore meaning and express feelings of fear and isolation, illustrated through a case study (Banks 2012). Again, through qualitative case studies, it was found that the use of art proved ideal for children with PTSD who have limited verbal and cognitive abilities (Mallay 2002; Michaels 2010) and also with adolescents who are uncomfortable with expressing feelings verbally (Harnden, Rosales & Greenfield 2004). In the case of stroke patients, when the ability to speak is severely damaged, art is an effective means of communication (Michaels 2010; Kim et al. 2008; Gonen & Soroker 2000). Art therapists working in a hospital in the US developed an interviewing technique that invites patients to engage in drawing that encourages access to deeper levels of meaning, which further allows them to gain insight into their problems (Dewdney, Dewdney & Metcalfe 2001). Dewdney, Dewdney and Metcalfe (2001)

state that this method of organised interviews centred on patients' drawings facilitated communication between therapist and client and suggests this can also be used by non-art therapists to assist communication when verbal self-expression is difficult.

Sometimes, the art-making process and not the image created becomes the focus of the interaction between client and therapist, thus facilitating communication which aids the therapeutic process (Ball 2002; Banks 2012). Art therapist, Lisa Banks (2012) further describes how her client's experimenting with colors and art mediums during the art-making process helped him become more reflective and she, as witness to his creations was drawn into meaningful communication. For example, an art therapy intervention with adolescents in an intensive care burn unit was evaluated for its benefits of dealing with issues of trauma, and it was found that the art-making process offered these adolescents a vehicle of expression for their pain and trauma (Appleton 2001). In this intervention, a patient's storytelling through the art-making process was non-verbal communication and used as a tool to facilitate communication between the patients, their family members and medical professionals (Appleton 2001).

2.5.2 COMMUNICATION BETWEEN SELF AND ARTWORK

Another aspect of communication explored in the literature is the communication within the individual. Communication achieved through art, not only bridges discussion between client and therapist (Gray 1978) but also communication with other parts of self, whether at conscious or unconscious levels towards a greater recognition of one's true self (Dickson 2007; Greece 2003). It is the opinion of Collie, Bottorff and Long (2006) that making art gives a person a different perspective of their experiences which is revealed to them by their art, through the reflection of painful experiences, memories, thoughts and emotions (Argyle & Bolton 2005; Lev-Weisel 1998). A person's sense of self can be disrupted or 'broken' by a challenging life event and artistic expression communicates and re-examines one's life story to re-establish ' a satisfactory

sense of a valuable, unique and permanent self' (Collie, Botorff & Long 2006, p.795). This theory is further explained by Guttmann and Regev (2004), that the art-making process allows the individual to bring into awareness an inner self, giving it independent existence, that assists them to evaluate and understand their lives.

The literature describes how art therapy and art-making have been used as a method of intervention that uses creative expression to access imagination and experience through visual images. Art therapists and theorists have for many years grappled with how art-making assists this communication internally and externally through the artwork. Banks (2012) explains it as the client being able to see and hear themselves through 'witnessing' the art process and the image, and the discussion that goes around that. Further, creating and giving something tangible form allows one to work through the chaos of grappling with thoughts, beliefs and feelings in the creative process to bring a new image or thought into existence (Lark 2005). For example, art was used as a tool that was appropriate for those with entrenched emotional experiences (Michaels 2010) as it offers sexually abused children a safe and less threatening way of revisiting their trauma (Mills & Kellington 2012; Murphy 1998; O'Brien 2004; Lev-Weisel 1998; Pifalo 2002). This has been noted to be one of the ways of learning to tolerate difficult emotions and process them (Mills & Kellington 2012). The use of art as communication was further explored in the sensitive recollection of trauma in children with PTSD (Lyshak-Stelzer et al. 2007). While it has been argued that re-visiting trauma can have potential negative outcomes, a 'safe space', the use of tactile art material and the enjoyment of the art-making process can aid a positive therapeutic process (Mills & Kellington 2011). A RCT was used to evaluate art therapy with adolescents with PTSD symptoms and it was reported that art enables non-verbal representation of traumatic experiences within a supportive social context (Lyshak-Stelzer et al. 2007). The benefit of this process relies on the person's ability and willingness to let go of old beliefs and be open to the potential of transformation.

2.5.3 COMMUNICATION BETWEEN SELF AND OTHERS IN THE GROUP

The created product or artwork that facilitates communication within a group is not always the image that is created but also the sharing of creating art or the process of working together in a similar activity. Art therapy within a group setting can open up communication between members, enabling facilitators to bring up different issues. Case examples illustrated that art therapy enables intimate and worrisome issues to be communicated and disclosed within a safe environment for psychiatric patients in a group art program (Drapeau & Kronish 2007).

Art was incorporated into a domestic violence prevention group in Mexico, aimed at bridging language and cultural barriers using non-verbal communication (Tucker & Trevino 2011). Art-making offers couples an alternative way to communicate. Art allows the men in the group to express themselves and communicate with their partners and other group members. With the use of images they create, couples are able to communicate challenges and difficulties they face as a couple, as well as their expectations. Therapists note that participants report their feelings through art and that the art-making bridges language gaps between the group members and therapists (Tucker & Trevino 2011). While the prevalence of domestic violence was not investigated due to the research being a short-term study, the research found that communication facilitated an increase in awareness, positive interactions and expression of feelings that strengthened relationships (Tucker & Trevino 2011).

In a group that explored the issues of racism, art was used as the medium of communication and participants created an artistic response to depict their experience of racism growing up, which was then responded to by other members of the group through art (Lark 2005). Participants responded that the use of imagery allows them the opportunity to speak about their experiences of racism in a supportive environment and witness how each piece of news encourages further open expression (Lark 2005). Mothersill (1965) states that art

as a language, must have a subject matter that can be talked about, and that the creator and the public constitutes a language community. This similarly describes the use of art in a therapeutic setting, the art being the thoughts and experiences of the creator and the public is the group or therapist that witnesses the art-making, and ultimately the therapeutic outcomes occur when the art is discussed or talked about.

2.5.4 COMMUNICATION BETWEEN SELF AND PUBLIC

In the literature related to research of arts participation, it was found that many projects around art culminated in public exhibitions as a way of communicating important messages. For example, group participants who explored their experiences of racism through images brought their message through visual dialogue embedded in the art produced. This was shown to the wider public, in an art exhibition to encourage art-based inter-racial dialogue (Lark 2005). Community organisations specifically hold exhibitions of participants' work, to bring social issues and experiences of marginality into the public realm to raise awareness or challenge perceptions (Kelaher et al. 2012). Government organisations utilise the arts to engage the public in civic dialogue or to communicate social issues. As an example, in 2012 the Victorian government engaged the public on the social issues of prison reforms and sexual abuse through the work of three community arts organisations by encouraging participants to share their experiences to the wider public through art, and challenge viewers' perceptions of these social issues (Kelaher et al. 2012).

Although all art is ambiguous and open to interpretation, it does not communicate the same thing to every member of its audience (Parker et al. 2013). While the artist who creates has personal intent in the meaning of their work, the audience interprets it in different ways (Morrell 2011). The communication that takes place between artist and audience through the artwork created has also been termed 'reception theory' or 'reception aesthetics' referring to the process that happens between the viewer and the art created

(Kemp 1998). This is based on the idea that a painting or artwork has more than just the desire to be observed appreciatively, but that a point of communication occurs when a 'dialogue' is initiated between the artwork and the viewer. The art created 'no longer lives in and for itself, but its connections to the outer world' (Kemp 1998, p.184). The message communicated through the artwork is an emotion expressed at a certain time but it can be experienced long after that (Morrell 2011). The message it communicates is relevant only to the individual or community that views it and, although it has the potential to be unclear or ambiguous, the art provokes discussion and challenges stereotypical or lateral thinking among its viewers

In an evaluation of three community art programs, participants reported that the opportunity to exhibit their finished works gives them a sense of achievement in creating something that is valued by others (Argyle & Bolton 2005). Providing opportunities for persons with psychiatric disabilities to exhibit their work in mainstream public venues reduces the stigma of mental illness and increases empowerment (Lamb 2009).

2.6 AUSTRALIAN RESEARCH

While the international literature was reviewed extensively, attention was given to locate Australian articles and research in the field. There is considerably less literature in Australia as compared to Canada, the US and the UK. In Australia, the majority of the research is funded by the government, such as VicHealth, that either evaluate their own initiatives or provide funding to partner agencies to do so. For example, in 2005 research was conducted to explore social capital and social inclusion through community arts projects and it was found that participants' social networks improved. The research was done on three community arts projects, resulting in an official report (VicHealth 2005): a drama and art program with women in prison; a women's circus for sexual abuse survivors; and the Torch Project to understand the impact of participation on mental wellbeing (Johnson & Stanley 2007). It is not uncommon for these large community projects funded by the government to also fund the evaluation as well as publication of

their reports to provide evidence. With the aim of promoting the emotional and social wellbeing of Indigenous people with mental health problems in remote Australia, a community arts-based initiative *Creative Recovery* was rolled out to improve quality of life, promote social cohesion, community participation and build creative skills (Dyer & Hunter 2009). Using a Participatory Action Research approach with mixed methods utilizing questionnaires and storytelling, the major outcomes of *Creative Recovery* included participants being recognised as artists in the community, accessing other training opportunities and increasing participation in community events (Leenders, Saunders & Dyer 2011). Arts Victoria and the Australia Council of the Arts have supported the evaluation of several community-based art projects to strengthen the evidence base for the benefits of community participation in the arts in promoting health and wellbeing (Castanet 2014).

The literature review located some independent research carried out by Australian academics in the field, such as Davis (2010) who took a phenomenological approach based on hermeneutic grounded theory, to investigate how international students studying in Australian universities experience group art therapy. In this project, students for whom English was their second language were finding difficulty adjusting to Australian culture and academic style. Art provided them an avenue to receive counselling without the stigma of mental suffering and the means to communicate deeper feelings that were difficult to put into words (Davis 2010). Gwinner, Knox and Hacking (2009) used a mixed method approach incorporating ethnography, phenomenological and participatory action research to explore how artists who were living with a mental illness experienced stigma and social exclusion and how engaging in art gave them renewed identities as artists. This opportunity to identify as an 'artist' establishes them in a role that is an 'appealing and socially valid role' which is positively regarded by others, resulting in a positive sense of self (Gwinner, Knox and Hacking 2009). Liddle, Parkinson and Sibbritt (2014), utilising surveys as part of an Australian longitudinal study on Women's Health, found positive health outcomes for women in their 80s associated with participation in creative activity. In a study using qualitative methods to explore the value of art programs for homeless adults, the results demonstrated that art promotes community participation through positive experiences

that encourage new identities and roles within the community (Thomas et al. 2011). The art program was a drop-in at a non-government facility for homeless people facilitated by a nurse and an artist, and interviews carried out with participants found art-making a way to interact and express themselves. Group participation encourages interpersonal functioning and social interaction thus contributing towards further social belonging (Thomas et al. 2011).

Case study is a popular method of research by Australian practitioners in the field, such as: a case study by an art therapist working with a child diagnosed with Systemic Lupus Erythematosus (SLE) (Stace 2011); a single case study of an eighty-two year old woman with dementia treated by clinicians using art therapy (Peisah, Lawrence & Reutens 2011); and an occupational therapist who used craft as a means of communication to work with an adolescent with mental health issues (Harris 2008). Through observations and reflection of their work with their patients, some of the benefits of using art-based methods with their clients were being able to generate motivation and develop self-identity (Harrris 2008).

Like its international counterpart, the Australian literature explores the growth of *arts in health*, specifically in the treatment of mental health such as the Creative Expression Centre for Arts Therapy (CECAT) in West Australia (Walsh 2008). Mental Health reforms in Australia heralded more holistic forms of treatment and the need for psychosocial modes of recovery, and this meant that some community-based mental health services began to include art-based programs as part of their service delivery. The de-institutionalisation of mental health in Australia in the 1990s brought about the delivery of group therapy and socialisation programs in the community that provided opportunities for social participation in meaningful activities (Savy 2005; Howells & Zelnik 2009).

In another Australian research, a pilot study utilised phenomenological interviews with three art facilitators to explore the contribution of art-making to mental health recovery from the perspective of facilitators of programs in Victoria, Australia (Van Lith, Fenner & Schofield 2009). Facilitators reflected their observations of how art- making activities

provided participants with a transformative experience and assisted the individual to connect with the wider world. In a similar study, the perspectives of 18 participants of programs supporting mental health rehabilitation were explored through interviews, and participants reported art-making gave them the confidence and strength to support their recovery (Van Lith, Fenner & Schofield 2011).

The literature review located articles that acknowledge the lack of research in Australia and the call for more research in the field (Kelly 2010; Van Lith 2011). Kelly (2010) attributes the lack of research to the small size of the art therapy community in the country and the difficulty of evidencing the benefits of the arts in today's evidence-based environment. Putland (2008) further supports this observation, stating that in Australia, evidence remains elusive because of the preoccupation with evidence-based policy. Early literature called for state and local governments to incorporate the arts in healthcare settings and make them an integral part of health policy and practice (Woodhams 1995). Wreford (2010) recognised the growth of community arts and the need to develop a national approach to supporting arts and health. Wreford (2010) advocates for the increased recognition of *arts in health* as an individual practice in the promotion of health.

2.7 OTHER ASPECTS OF THE LITERATURE

The literature search found other aspects of *arts in health* studies that are more tangential to this research, such as arts in the healthcare environment, arts in groupwork and arts-based assessments. The approach of art and design in the healthcare environment has been undertaken by many public hospitals and community healthcare settings with the aim to reduce stress levels and have a positive impact on wellbeing (Daykin et al. 2008). This aspect of the literature was not explored as this research emphasises participation in creative activity.

As this research is investigating art-making in a group context, it is important to include some literature on the benefits of groupwork which I have done so throughout this dissertation. The therapeutic process of art-making combined with group processes, such

as the sharing of information and feedback, contributes to the therapeutic process of change (Crawford & Patterson 2007). Art-making within a group setting allows members to share a 'visual language' that enables connection and meaning-making (Mills & Kellington 2012). While there is limited literature on art programs done in group settings in the Australian community, the social and therapeutic benefits of groupwork is well documented (Yalom 2005; Brandler & Roman 1999). However, literature on therapeutic groupwork used in this dissertation will be limited to the therapeutic benefits of group interventions, as few studies were found specifically on art groups in the community.

Groupwork has been an integral part of social work practice for decades, promoting inclusion, mutual aid, resolution of conflicts, validation and problem solving (Drumm 2006; Brandler & Roman 1999). The power of groupwork lies in its ability for participants' experiences to be witnessed and in turn to witness those of other participants. The therapeutic effects of groupwork have been extensively explored by Yalom (2005, p. 17) as a complex process of the interplay of human experiences within the group, such as installing hope and the development of socialisation skills occurring through role play, interpersonal feedback and recognition of maladaptive behaviours. Arts-based interventions combined with the complimentary beneficial effect of group therapy become a powerful tool in addressing social isolation and the building of self-esteem. Yalom (2005) describes therapeutic groups as a social microcosm for those who participate, allowing individual, interpersonal interaction styles to appear with opportunities to identify and reflect in order to facilitate meaningful self-disclosure and socialisation techniques. Groupwork in social work practice help group members re-examine and establish social roles within a safe and supportive environment and how they react and experience this (Payne 2005). In a project where group art therapy was offered to people with psychotic disorders, case examples illustrate that patients learn to accept their mental illness and become more insightful and readjust to society (Drapeau & Kronish 2007). Mutual aid in groupwork is based on the concept that the sharing of ideas and experiences creates an atmosphere for positive change (Brandler & Roman 1999, p.4– 5). This is similar to self-help groups which act as a support network through which group members provide social, emotional and sometimes material support (Archibald 2007, p.26).

While the search for literature produced articles on the use of art as a diagnostic tool and the interpretation of art, this literature will not inform this research. Art therapists often use art-based tools to assess their clients' levels of functioning and their strengths, coupled with rating systems, such as a diagnostic drawing scale and the Formal Elements Art Therapy scale (FEAT) (Betts 2006). This research will not explore the theory or use of art as a diagnostic tool as there is limited literature and evidence on the accuracy of these arts-based scales to draw upon. It is not the aim of this research to include these areas of arts in health as this research relates to the benefits of active participation in the art-making process and not the interpretation of diagnoses through the art created.

2.8 SUMMARY OF THE LITERATURE AND GAPS IN THE EVIDENCE

The overwhelming outcome in most studies in this narrative literature review collated on various approaches to arts in health interventions show improvement in wellbeing. While there appears to be some conflict between disciplines practicing under different approaches, the majority suggest that the importance of the intervention lies in various factors, including the creative process and the therapeutic alliance. The research available does not specifically suggest nor preclude that art interventions run without art therapy professional guidelines or elaborately funded community projects cannot achieve the reported benefits if it simply allows an opportunity for engaging in a creative activity.

In reviewing the literature, I have drawn out from various studies factors that are attributed as important in arts in health interventions, such as the skills of the facilitator and the therapeutic alliance, the creation of the art space, the choice of materials provided, the importance of the final image or product, and the social element of the intervention. However, few studies articulate how contributing factors are embedded in, or contribute to, the art-making process. The literature rarely explicitly reports or explores what particular attributes of the facilitator, aspects of the art space or type of art material have an effect, and how they individually contribute to outcomes in a participant's art-making experience.

I have also highlighted the art-making process as a common contributing factor in all interventions and suggest it has the potential to be therapeutic in the absence of some or all of the other factors or in combination with other factors. With the variety in structure and delivery of art groups evident in the literature and in this study, it is important to focus on a central aspect of art-based interventions which is the active participation in the art-making process. There is some literature that states the art-making process is therapeutic in itself (Reynolds 2012; Sandmire et al. 2012; Spaniol 2001) but do not claim it is central to the intervention and is effective in producing positive outcomes independently. I have discussed the reported benefits of arts in increasing self-esteem, promoting social interaction and facilitating communication with various target groups in different settings.

There is a lack of research on art programs in community centres that may not be facilitated by trained art therapists or programs that are run with minimal funding that are unable to provide comfortable spaces or extensive art materials, or to employ vigorous evaluation methods of their programs. The need for more robust evidence on the benefits of engaging in creative activity has been emphasised in much of the literature (Geue et al. 2010; Kelly, Cudney & Weinert 2012; Reynolds 2012). More specifically, research on all types of arts-based interventions, irrespective of, or in relation to, facilitator, space, socialisation and materials is needed to explore relational effects of these factors on each other, the art-making process and positive outcomes. While the area on the influence of the therapeutic relationship on participants' outcomes is beginning to receive some attention (Wood 2002) and the effect of different art materials is more recently being explored (Snir & Regev 2013), further research is warranted. For example, Feen-Calligan and Nevedal (2008) suggest further exploration of the relationship between the art-making process and the interactions in the group, and also the relationship between the therapeutic relationship and the art-making process. Corem, Snir and Regev (2015) recommend further studies that explore how trust in participant's exploration of art materials in the art-making process is gained within the therapeutic relationship. Research that illuminates the voice of the participants who actively engage in the art-making process, that determines how they experience this in

relation to all contributing factors of the intervention, is required. Further evidence around this process will contribute to the promotion of arts interventions in promoting health and wellbeing by providing multiple diverse opportunities for engagement in creative activity.

A model of *arts in health* that has not been subject to research as community arts participation or art therapy is the intervention of group art programs in community settings, facilitated by a variety of disciplines within a 'safe' environment for therapeutic outcomes. These are arts-based group programs in community centres, which have been overlooked in the broader field of *arts in health* as a way to promote wellbeing and not just simply recreation or a form of diversion. This dissertation posits the thesis that if the contributing factors and the art-making process exist in every arts-based intervention, albeit in varying degrees, then these community-based art programs have the potential to fulfil the benefits outlined in the literature. If the outcomes like those the literature suggest can be reached by allowing the creative process to happen, then it is hypothesised that creating art in groups in community settings facilitate communication and promote self-esteem and social support.

Arts-based interventions are delivered in a multitude of ways in Australia, some providing all of the contributing factors and others that may not, but always providing an opportunity to engage in a creative activity. Creative programs exist in abundance in health organisations, community centres, local neighbourhood houses, schools, organisations and learning centres, sometimes facilitated by volunteers with the simple desire to share their talents or their own personal positive experiences of engaging in creative activity. Art programs are conducted in less therapeutic spaces or makeshift studios, such as community centres and neighbourhood houses that respond to the need of the local community. Programs are run with found or recycled materials that are delivered on the premise that the experience derived from exploring colours, techniques and designs in the art-making process has the potential to deliver the therapeutic outcomes outlined in the literature. Such programs lack the hype of large community projects, and the funding that comes with it to deliver programs, but still successfully cater to local communities and those who are interested in participating in creative

activity.

If this model of arts-based interventions is showing evidence of therapeutic outcomes, then it should be included in the evidence base of *arts in health* to encourage the implementation of arts-based interventions in promoting wellbeing. While Dileo and Bradt (2009) suggest that specific practices within the field of *arts in health* need to create their own body of literature in order to distinguish between the different effects and interventions, I argue that although the healing power of art traces back to history, the field of *arts in health* is a relatively 'young' and growing systematic method of intervention in healthcare, especially in Australia, and therefore, until a large collective body of evidence is reached, research should be aimed at building such a body of evidence that profiles the overall value and beneficial impact of the arts in improving wellbeing. Only then can research be branched out into more specific targets, practices, approaches and settings. An integration of research efforts between various disciplines will produce a greater justification of the need for the arts to be an integral part of community care.

KEY POINTS – LITERATURE REVIEW

- Tracing the use of art as healing power in history;
- Exploring the theories of the art-making process in history and through to current theories;
- Identified factors in art-based interventions that were attributed to influencing positive outcomes;
- Research studies explored the outcomes of self-esteem and social supports from participating in art interventions;
- Research that explored art as a means of communication
- Australian research studies by government bodies and academics in the field;
- Identified the gap in the literature on research in community-based art programs.

3. RESEARCH METHODOLOGY

When embarking upon this research project, I realised that situating a research topic within the *arts in health* field was going to be a challenging one in terms of research methodologies because of the ongoing debate over the most appropriate research method for this field. The current study explores art programs that are delivered in community centres in Victoria, evaluating them for specific therapeutic benefits that will potentially contribute to the evidence base of *arts in health*. The aim of the research was to investigate if engaging in art improved a person's self-esteem and increased their social support and to identify the contributing factors that effected this change.

In this chapter, I discuss the ongoing debate around the levels of evidence in arts research, weigh the suggested theoretical frameworks, and explore the methods and tools that have been used to investigate outcomes in the *arts in health* field used to date, and their suitability to the research question. I present the epistemology and philosophy that guides my research, the chosen research methodology and research tools that were employed to undertake research of art programs in the community, and explain how the data was analysed. I further present in detail the aim, data collection and analysis in each phase that was used and finally provide some reflection on the process, its benefits and limitations.

Artists, art therapists or anyone who has used art as a therapeutic intervention know from experience that arts-based interventions promote wellbeing. Macnaughton, White and Stacy (2005) state it is strange that while practitioners are convinced that delivering *arts in health* programs are beneficial, they do not claim it improves health, and suggest that perhaps this is because there is no hard evidence to state these claims. The call for more rigorous research is reverberated throughout the *arts in health* field (Daykin et al. 2008; Dileo & Bradt 2009; Fraser & al Sayah 2011). While the practice of *arts in health* is increasing, the pressure to develop its evidence base is also increasing, not only to determine if arts activities have measurable benefits, but that they are also cost-effective (Clift 2011). While research in music in health is burgeoning, few of the other

creative therapies have followed suit (Dileo & Bradt 2009) and each discipline needs to have its own body of literature. Ultimately, the effectiveness of art programs in health can only be proven by rigorous evaluation and research (Staricoff 2006). While art-based approaches and community arts participation have been shown to improve health, researchers acknowledge the challenges of carrying out research in the field of *arts in health* and the difficulty of measuring health improvement by conventional measures (Macnaughton, White & Stacy 2005), of generating methodological frameworks suitable for researching the arts, or if there is even a methodology that can address the complexity of arts interventions.

In exploring art programs in community organisations, this current research faced a number of challenges because of the variety in the structure of these programs and the multiple possible outcomes from engagement in creative activity. However, the study focused on three possible outcomes: communication, self-esteem, and social interaction. The research is further complicated because the programs are not exclusively art therapy, nor are they community art projects run by professional artists. The programs comprise of a variety of art programs that have therapeutic goals, social goals or educational goals and they are run by trained or experienced facilitators and peer-led volunteers who are not necessarily art therapists or professional artists. The complexity of variables in program structure of community- based art programs, and individual experiences of engagement in creative activity, warranted an exploration of research methodologies to find the most suitable method and design that would address these complexities and answer the research question.

This research is based on the premise that therapeutic and social benefits can be achieved by participation in arts-based interventions, within a safe environment facilitated by a variety of trained professionals and amateurs, as is outlined in the literature on *arts in health*. While these outcomes have been reported in a variety of art therapy models in health settings and also in large community art projects, it does not include primary community-based group art programs that are known to exist throughout Victoria and in wider Australia. Glasgow (2013) claims that research enables us to extract what we know from the practice of *arts in health* and apply this back to

other areas of practice—which, in this current research, is community-based art programs.

3.1 EPISTEMOLGY AND PHILOSOPHY

In my literature review on the exploration of art as a healing tool, I discussed Dissanayake's (1988) ethological theory of art as essential to human development, and that it fulfils our need to make the ordinary special. Winnicott (1971) had also proposed that when the opportunity to be creative is lost, everything that is real, personal and original does not exist, and there is an impulse to create a thing that has shape and form for others to witness. My search to find a suitable methodology to answer the research question was guided by these early pioneers of art as therapy and, recognising that art-making is a deeply entrenched human experience, I endeavoured to capture it through further exploration of participants' experiences of engaging in art-making. Furthermore, American philosopher John Dewey (1858-1952), while stressing the importance of individual experience, also states that this does not develop in isolation but within a human environment (McDermott, 1973, p.57). Guided by Clandinin and Connelly (2000), who support Dewey's work that understands experience as individual to every person but still within a social context, it was necessary to include the value of the data collected from the voices of facilitators, as well as participants and their experiences of the art-making process. John Dewey's philosophy understands the importance of the individual as 'the vehicle of experimental creation' and stresses the necessity of thought and reflection in the process of investigating its meaning (McDermott 1973, p.57).

As a social worker, art therapist and artist I have used art personally and in my practice and have witnessed the therapeutic and social benefits of art-making. I am intrigued by the early theorist proclaiming art as essential to human existence (Dissayanake 1988; Wiinnicott 1971) and with Booth (1997, p.48) that states art-making is driven by the energy of yearning which is a fundamental human instinct to strive for more satisfaction, more understanding of the unknown and to feel alive. I adopt, as Greene (2007, p.20) suggests, 'a mixed methods way of thinking' that recognises multiple ways of seeing, hearing and making sense of the social world and seek a richer understanding of the

complexity of human experience. Thus, the practical and consequential characteristics of pragmatism appeals to me as a researcher. However, I am mindful to make a stance which will influence – but 'not in a deterministic way' – the decisions I make in planning and conducting this research (Greene 2007, p.87) and to be open and receptive to the results of all phases of the inquiry as it is undertaken.

By drawing on my own experience and on the existing knowledge in the field, I identified the factors that contributed to positive outcomes in arts-based interventions. I also drew from the literature the factors that contribute to the art-making process, but it is not known if these factors exist in community-based art programs, and if they do, whether or not they affect participants' experiences of the art-making process to deliver similar outcomes of increased self-esteem and social support. This research sought to use this knowledge to investigate if these same factors of facilitator, art space, art materials and socialization existed in the delivery of art programs in community settings and how they contributed to participants' experiences that resulted in positive outcomes. The focus was on the art-making process as it is considered to be the common denominator in all arts-based interventions. In formulating my research question and designing the research method to undertake the research, I was influenced by Tashakkori and Teddlie (2010) who likened mixed methods research to everyday problem solving, which is identifying issues, focusing on efforts to solve them, then formulating the question to drive the research activity that is about to be undertaken. I began this process by examining research methods used in *arts in health* practice.

3.2 DISCUSSION OF METHODS

The integration of arts in promoting health has naturally elicited the call for more rigorous research and objective measurements in the field (Staricoff 2006). In spite of the uniqueness and challenges of undertaking research of arts in a health setting, it is the ethical responsibility as professionals in the field to be involved in research not just for the benefit of the clientele we support, but in the sharing of knowledge with peers (Carolan 2001). Wood (1999, p. 51) states that what draws us to undertake research in this field is the 'belief in the power of art'.

The call for Evidence-Based Practice (EBP) – defined by Gray et al. (2012, p.157) as a 'research informed, clinical decision-making process' – has infiltrated from the medical domain of evidence-based medicine into the fields of nursing, human services and the social sciences. Jennings and Loan (2001) summarise research within the EBP process as predicated on rules of evidence that espouses critical research appraisal, sophisticated techniques and synthesised information that informs practice. Clift (2012, p. 123) states that the need for EBP research is incontestable, and believes that 'robust controlled designs with clear outcome measures' are essential. However, Broderick (2011) questions if the arts practice in health settings is trying to be understood by biomedical discourses as EBP re-establishes medical dominance just when society is now veering towards a social model of health. The inclination towards EBP suggests that unless the research is a Randomised Controlled Trial (RCT), the research would have no value in the health field. The art therapy profession is against acceding to the medical model of EBP, which advocates the use of RCTs, and the rules of EBP which are 'explicit hypothesis, reliable, valid measures, random measures and blind experiments' and predominantly quantitative methods (Wood 1999, pp. 52-53). Gray et al. (2012) found that some of the barriers to the implementation of EBP in social work and human services are attributed to the lack of understanding of the process, agency resources, staff time and the preference for more experiential forms of knowledge.

Researchers in the *arts in health* field argue for a move towards a more wide-ranging approach to demonstrate the effectiveness of the practice and have put forward their own levels of evidence (Wood 1999; Gilroy 2006). Table 1 below compares the difference in levels of evidence for EBP between the National Health & Medical Research Council (NHMRC) (2013) and that which is suggested by Gilroy (2006). If arts-based interventions cannot be measured by methods that constitute EBP, then, as Gilroy (2006) suggests, *arts in health* should have its own basis for what is 'hard' evidence. While not discounting the enormous benefits or the necessity of EBP, Gilroy argues against acceding to the EBP framework of methods but challenges art therapists to develop an evidence base that is appropriate to the discipline, as outlined in Table 1.

NHMRC LEVELS OF EVIDENCE for EBP	ART THERAPY LEVELS OF EVIDENCE
I A systematic review of level II studies	**I(a)** Evidence from at least one RCT, or evidence from at least one controlled, experimental or quasi-experimental study **I(b)** Evidence from other research, for example, case studies, phenomenological, ethnographic, anthropological, art-based and collaborative studies
II A randomised controlled trial	**II** Evidence from other academically rigorous texts
III-1 A pseudo randomised controlled trial (i.e. alternate allocation or some other method) **III-2** A comparative study with concurrent controls: ▪ Non-randomised, experimental trial ▪ Cohort study ▪ Case-control study ▪ Interrupted time series with a control group **III-3** A comparative study without concurrent controls: ▪ Historical control study ▪ Two or more single arm study ▪ Interrupted time series without a parallel control group	**III** Evidence from expert committee reports or opinions, or clinical experiences of respected authority or both
IV Case series with either post-test or pre-test/post-test outcomes	**IV** Evidence from local clinical consensus or from user representatives
National Health & Medical Research Council (NHMRC) (2013)	Gilroy (2006)

Table 1: NHMRC levels of evidence as compared to Gilroy's level of evidence for art therapy.

At one end of the debate are artists, art therapists and art researchers who are determined to keep the research true to the practice of *arts in health*; and on the other, there are those who believe that for arts to remain in health, we have to conform to the standards set by the health profession. Belkofer and Kanopka (2008) conducted a research study using imaging technology to investigate art therapy practices and to obtain a neurological understanding of the hypothesis that drawing and painting would affect brain activity, believing that this would provide light as to the 'how' and 'why' art is powerful. This time-consuming study was done on a single participant, but the authors suggest that this method could be further explored with larger groups and comparisons made before and after interventions (Belkofer & Kanopka 2008). This extreme of

researching the effect of the art-making process using a scientific approach, RCTs and other time consuming activities, such as establishing control groups, require commitment from participants and a team of researchers and resources (Macnaughton, White & Stacy 2005; Staricoff 2006). Tesch and Hansen (2013) add that the factors associated with *arts in health* are difficult to define and thus difficult to measure, and further question whether a deeper understanding of an aesthetic experience can be measured by empirical means. Yet, Edwards (1999) notes that it appears to be implied by the NHMRC (2013) and supporters of a scientific approach (Belkofer & Kanopka 2008) that unless valid measures, sufficiently large samples and random allocation of subjects are part of the research design, then it does not meet the criteria of evidence-based research. Unless *arts in health* movements produce 'appropriate evidence' for its benefits, it will not achieve funding and without funding it will struggle to produce evidence of effectiveness (Macnaughton, White & Stacy 2005; Dose 2006).

Alternatively, Staricoff (2006) claims that valuable insight into health and social benefits associated with participation in creative activity can be achieved by a well-designed qualitative research. Gilroy (2006) places some of these qualitative designs in her level 1(b) of evidence, such as case studies, phenomenological, ethnographic, anthropological, art-based and collaborative studies. Although Clift (2012) believes that EBP is the way forward, he also recognises qualitative methods are the preferred method for arts-based research because they capture the experience of participants (Bungay & Clift 2010). The emphasis placed on RCTs and other quantitative studies associated with 'higher' levels of evidence as outlined by the NHMRC means there is no place for the voices of participants and practitioners, and thus risks minimizing the vitality of the art-making process (Woods 1999; Edwards 1999). It is argued here that both quantitative and qualitative approaches are necessary. The case study research method is often used in qualitative research in art therapy, to follow the experiences of change of participants throughout the course of their art-making processes, such as research undertaken with cancer patients (Borgmanm 2002; Greece 2003). According to Gilroy's level of evidence, case studies constitute evidence-based practice, and Edwards (1999) advocates that case studies have the potential to examine art-based practice with rigour and pay attention to individual stories. Research using ethnographic methods of enquiry is another method

that observes persons' experiences and examines engagement (Houston & McGill 2013), and Barry (2006) argues that ethnographic forms of evidence challenge the biomedical notions of evidence.

As researchers in the field of the social sciences, we are called to resist the temptation of reducing human beings and their experiences only to strict standard measures and statistical analysis, but also to value and listen to stories and beliefs that shape our society and understand what it is to be human (Dissayanake 1988; Winnicott 1971; Clandinin & Connelly 2000; Tesch & Hansen 2013). While not against the use of quantitative methods, a combination of both quantitative and qualitative methods will provide empirical evidence as well include more experiential forms of knowledge (Wood 1999). If quantitative measures alone are insufficient to address the complexity of arts-based interventions, and qualitative methods do not match up to the level of evidence required by the health field, the mixed methods approach offers an alternative to researching *arts in health*. There are those like Wood (1999) who agree with Gilroy that the *arts in health* field follow its own kind of evidence and preserve the arts' descriptive and theoretical research but also include forms of empirical evidence and standard outcome measures, without acceding to the strict ideology in relation to the medical model of EBP (Gilroy 2006). Considering the move towards a holistic approach to improving health (Lane 2006; Ryan 2004; VicHealth 2013; Bungay & Clift 2010), there needs to be more partnerships between art and health fields and bridging of the gap between artists and scientists (Cameron et al. 2013). The *arts in health* field is the coming together of both arts and health—and mixed methods is a methodology that has the potential to bind common ideas from both fields of practice (Tashakkori & Teddlie 2010).

The mixed methods approach offers insights that cannot be achieved by quantitative methods alone and can be used to better understand the complexity of social phenomena (Greene 2008). Carrying out a research project that encompasses both qualitative and quantitative methods addresses the complexity of researching arts-based interventions, and the combined effect of two options produces a greater value than the individual ones (Hall & Howard 2008). Not one method is superior to the other but together they capture, explore and describe multiple realities (Luyt 2012).

Researchers in the field have experimented with other methods in arts-based interventions such as the 'theory-based evaluation' used to explain causal attribution in understanding the impact of arts on social change and encompasses both medical and traditional forms of research (Galloway 2009). Several other methods have been suggested, such as descriptive research, developmental research, observational research, survey research, heuristic research and many more (Carolan 2001). Perhaps more importantly than various creative methods, there has to be justification of the methods being used and an understanding of the concept underpinning the practice of *arts in health* (Staricoff 2006). Most researchers agree that whatever theoretical framework or research method used, the chosen paradigm has to be described and how this will affect the research is conducted must be stated (Alise & Teddlie 2010). The point stressed is that whatever the method used it needs to be underpinned by a theoretical framework, and that the researcher needs to give reasons as to why that method is chosen and how it guides the research. A framework that is integrated in design, analysis and discussion can act as a map that helps researchers navigate through all phases of the research process (Evans, Coon & Ume 2011).

Pragmatism has been widely championed by researchers as the most suitable paradigm in mixed methods (Wheeldon 2010; Feilzer 2010; Onwugebuzie, Bustamante & Nelson 2010). It emerged as an alternative epistemological framework brought about by the variety of research designs and approaches, and allows for multiple interpretations of experiences within a single process (Wheeldon 2010). Pragmatism does not favour any particular method, but uses the most appropriate research method to study the phenomena and acknowledges the unpredictability of research involving human nature (Feilzer 2010). Pragmatism helps link practice to theory and employs practical strategies to determine the appropriate methods. Pragmatism gives importance to the research question and makes decisions on the use of methods that will best answer that question (Teddlie & Tashakkori 2012). The pragmatic philosophy that underpins research has a high regard for multiple realities and meanings in human experiences, and knowledge is based on the reality of these experiences (Onwuegbuzie, Bustamante & Nelson 2010). This makes it suitable to research that looks at human experiences in engagement in

creative activity. Glasgow (2013) states that pragmatism is an ideal approach for primary care settings with issues involving practitioner, service users and policymakers who value client-centred outcomes, and is well suited to community settings. Pragmatism is a distinctively American philosophical tradition that is based on basic philosophical beliefs that relate to the nature of the social world and highly regards the reality of human experience (Greene 2007, p.83).

A multi-stage research design that uses both qualitative and quantitative research methods is well-supported by pragmatism (Tashakkori & Teddlie 2003). A mixed methods approach conducted within the pragmatism framework serves as an eclectic method that allows a selection of techniques from qualitative and quantitative strategies to investigate the phenomena, through an integration of methods (Teddlie & Tashakkori 2012).

3.3 ETHICAL CONSIDERATIONS

The research project took serious consideration of ethics in all areas of its implementation, as the intention to work with service users had the potential to present situations of ethical problems. The researcher was mindful of client confidentiality and providing safe environments. The National Statement on Ethical Conduct in Human Research (2007) states it is the responsibility of the researcher to identify the level of risks involved and how they will be managed, and to justify the benefits. This research project respects the values of 'respect, research merit and integrity, justice and beneficence' and obtained organisation and participant consent (p. 13). Both the approval of the CQUniversity Human Research Ethics Committee and the participating organisations was sought to ensure compliance of high ethical standards. These ethical issues were closely monitored, which included no discrimination against participants, consent, confidentiality, permission to photograph and reproduce works, respect of cultural differences and diversity, and the rights of participants to decline or withdraw (ANZATA 2013). Due to the complexity of the research project and the four-phase design, approval of ethics was sought for each phase as the research progressed to ensure that all aspects of the evolving research study were included. Any modifications to the

research design were also submitted to the Ethics Committee for approval.

The outline and purpose of this research was explained to all participants verbally and via a written statement detailing the project, its aims and participants' requirements during each phase of the project (See Appendix A, C & H). Participants' real names are not used in any of the documents or the dissertation, or any other publications. An informed consent that described the risks and benefits of participating, with details on feedback and complaints procedures, was provided to all participating organisations and the program participants (See Appendix B, F & I). Those who agreed to participate completed a consent form stating clearly that participants retain the right to withdraw from the research at any time in accordance with the Approval of Ethics requirements. The nature of interviews or questionnaires had the potential of being confronting to certain participants and much understanding and discretion was used during these forms of inquiry. Collaboration with the centre managers and group facilitators at the participating organisations to provide assistance was discussed prior to involving participants, to ensure emotional support was available with respect to distressing thoughts or feelings that may have arisen during the intervention or interviews.

Throughout the process, I was mindful of individual bias towards a positive evaluation of the project, and am committed to publishing the data collected irrespective of the outcomes. If and when the data is published, participants will remain anonymous. All data collected will be treated with respect, and an understanding of the ethics related to 'documentation, exhibition, storage and interpretation' will be adhered to (Kalmonowitz & Potash 2010, p.25). Data collected was stored according to University and ethics requirements and de-identified to protect the privacy of individual participants.

3.4 A MIXED-METHODS RESEARCH DESIGN

After studying the various frameworks and methods used in research, considering the criticisms and suggestions made by researchers in the field, there is no one singular method nor one theoretical framework that is suitable to all art-based research. Every intervention is unique in its research question and requires a methodological design that

caters to answer it. Because of the complexity of arts-based research and the uniqueness of individual experiences, the decision to undertake this research using a mixed methods approach was informed by my understanding of various methods and their suitability to my research question. The rationale for using mixed methods was that the purpose of the research required a combination of qualitative and quantitative methods: the research question refers to 'if' there are beneficial outcomes from participating in the art-making process, and 'how' these outcomes may be achieved, and using either qualitative or quantitative methods individually would not address the 'if' and 'how' (Kroll & Neri 2009).

The preference to use mixed methods in this research was to have the quantitative and qualitative data inform and supplement each other (Feilzer 2010) with the aim that the qualitative and quantitative perspectives would contribute towards an expanded understanding of the phenomena of participants' experiences (Hall & Howard 2008). The mixed methods philosophy guided the method of enquiry focusing on collecting and analysing both qualitative and quantitative data, with the advantage that a combination of both approaches provided rich data to answer the research question (Hall & Howard 2008; Creswell & Clark 2007). I agree with Bazeley (2012) that both quantitative and qualitative approaches are necessary to understand human behaviour, where both outcomes and their engagement in the art-making process need to be understood. I support the opinions of Glasgow (2013) and Wood (1999) and choose not to completely abandon the rigour of scientific measures, but to broaden the focus to include the diversity of human experiences. Having explored the discussion of the various methods used in *arts in health* research and arriving at the rational of using mixed methods in this research study, I outline below the research design in further detail.

3.4.1 MIXED METHODS SEQUENTIAL EXPLANATORY DESIGN

To fully exploit the potential of the mixed methods research, I refer to some of the rationale of mixing quantitative and qualitative research by Onwuegbuzie, Bustamante and Nelson (2010) that includes participant enrichment, optimising sample size and instrument fidelity (using an instrument that is relevant to the

respondent). In keeping with the pragmatic framework, the research design consisted of four phases of data collection that informed and enhanced each other, to maximise the investigation of community-based art programs. Creswell and Clark (2007) describe this design as the Mixed Methods Sequential Explanatory (MMSE) design that is conducted in two phases. However, this research is conducted in four phases, (Table 2). The rationale for this approach is that the quantitative data provided avenues for further explorative research and the qualitative data refined and explained fixed data by exploring participants' experiences in depth. Ivankova, Creswell and Stick (2006) state that the MMSE design is especially useful when unexpected results are derived from the quantitative phase, but also stress the importance of integrating the data collected and connecting the sequential phases at various points of collection and analysis. This design of using quantitative and qualitative methods in a sequential design allowed the first qualitative phase to be informed by quantitative data, and the interviews to be guided by the data collected from the preceding phases.

PHASE	**Phase One**	**Phase Two**	**Phase Three**	**Phase Four**
METHOD	Quantitative	Qualitative	Quantitative	Qualitative
AIM	To identify programs to be involved in study and broad demographics and structures of programs	To develop an in-depth profile of each program, Develop categories and refine	To identify changes resulting from attending programs	To explore individual experiences of programs
DATA COLLECTION	Email. Questionnaire (Q1) (n=30)	Interviews with facilitators and program managers of community centres. (n=13)	Questionnaires (Q2) that encompassed open-ended questions and pre-test/post-test scales. (n=101)	In-depth semi-structured interviews with participants of the art programs. (n=13)
	← Self-Reflective journal/Field Notes →			
DATA ANALYSIS	Descriptive statistics (primarily frequencies)	Informed by Narrative Inquiry	Paired T-tests. Mean. ANOVA	Thematic analysis. Informed by narrative Inquiry

Table 2: MMSE four phase research design

Tashakkori (2009) states that a strict dichotomy of quan-qual methods is not necessary, but rather the importance of identifying a sequence and the type of data needed for each phase. Assigning greater weight to either component may not be possible in the beginning. Priority and dominance of the qualitative phase was determined during the course of the research and during the process of integration (Tashakkori 2009). Being flexible and pragmatic about the research design and open to the data emerging in a mixed method study proved invaluable assets (Bazeley 2012), as it was found that while the quantitative data specifically answered the research question, the qualitative data explored in-depth how the outcomes were reached. During the course of the research, weight was given to the qualitative data as it proved the most suitable method for recording human experiences and insight, and the quantitative data provided information of diverse art program structures and served as statistical evidence of positive outcomes from engaging in creative activity.

The detailed design and tools of the research project entailed further exploration of data collection methods used and their suitability to answering the research question. The most common data collection tools used in art-based projects in primary health care is interviews and questionnaires as they provide deeper understanding in the research of arts-based interventions (Tesch & Hansen 2013; Clift 2012). The four phase design had different aims that guided the selection of tools for data collection and analysis (Table 2). Semi-structured interviews were used in the qualitative phases, providing tools that matched the exploratory nature of this research, which included facilitators' experiences and participants' individual experience. Structured questionnaires and standard scales were used in the quantitative phases to guide and inform the qualitative phases as well as answer secondary questions. The first phase of the study was a quantitative study of availability of programs in community organisations followed by questionnaires to determine meeting of selection criteria to be included in the study. This was followed by semi-structured interviews with facilitators of these programs to explore the preceding quantitative phase and inform the subsequent

phase. The third phase of the study involved pre-test post-test scales to measure participants' experiences, which were further explored by more qualitative methods of interviews. Interviews were conducted with selected participants who participated in the program in order to obtain a deeper understanding of the process of change involved.

Triangulation occurs when several methods are used to study the phenomena and consistency of data is sought with the view that similarities will complete the data (Houghton et al. 2013). The mixed methods design supported triangulation and the data collected underwent comparison of qualitative and quantitative results to further strengthen its reliability. Integrating results from separate data components can enhance validity through triangulation, uncover contradictions between results and expand initial findings (Bazeley 2012). The findings are accurately reported and participants' meanings portrayed accordingly, supported by triangulation, field notes, and the audit trail (Tashakkori & 2003). While analysis was conducted separately, consolidating data at specific connecting points further informed the next phase of data collection, as characteristic of the sequential model (Tashakkori & Teddlie 2003). When data is obtained from diverse quantitative and qualitative sources, this needs to be well integrated to build a blended set of results and written in a narrative that links the interpreted data (Bazeley 2012; Bryman 2007). In this research design, the data was connected when the input from interviews in Phase 2 determined the questionnaires (Q2) being used, and at the second point when participants were interviewed based on the data from the previous phases. I will further explain this sequential design in detail.

3.5 PARTICIPATING ORGANISATIONS AND GROUP PARTICIPANTS

Deciding on a sample in any research is an important process and this can become more complicated in mixed methods. Thus, Onwuegbuzie and Collins (2007) advise considering how the quantitative and qualitative components occur sequentially or simultaneously and the relationship between the two. For the purpose of this research a

multi-stage purposeful sampling was used to identify desired characteristics of groups and individuals representing a sample in two or more stages (Onwuegbuzie and Collins 2007; Hesse-Biber 2010). Sample size is another important factor in order to make statistical and analytical generalisations and should be informed by the research question, the aim as well as the research design (Onwuegbuzie and Collins 2007). Onwuegbuzie and Collins 2007 recommend 64 participants for a one-tailed hypothesis and at least 12 participants for interviews. The decision to have at least n=80 in the quantitative phase and n=12 for both sets of interviews was determined to be an adequate number for this research.

A Victoria-wide search was undertaken to find as many community centres that delivered art programs and were willing to participate in the study. The art program would have to be delivered during the period of the research to be able to participate in the pre-/post-test questionnaires. A total of 13 organisations – some delivering more than one art program - finally committed to the first phase and represented a wide variety of programs delivered across Victoria in similar settings. Facilitators that delivered these programs were interviewed in the second phase. Participants[2] from twenty programs delivered at thirteen organisations that participated in the first two phases of the research completed the questionnaires for the third phase. Participants varied in age group, gender, socio-economic background, general healthy individuals and some had various health or psychosocial conditions, as the research investigated specific outcomes that were relevant to all target groups. Participants did not need to have a diagnosis of a medical condition, social problem, disorder or disability as the outcomes pertained to their overall wellbeing. In fact, participants were mostly from the general public who belonged to the local communities. The main criterion for inclusion in the study was that these individuals had an attendance rate in the program of at least seventy percent. Participants that participated in both the pre- and post-test questionnaires were invited to be interviewed in the fourth phase. The goal was to

[2] While in the research literature individuals who participated in arts-based interventions were referred to as 'clients', 'service-users', 'patients' and 'artists', in the current study those that engaged in the art programs are called 'participants'. Additionally, while in the literature and current research, those who facilitated arts- based interventions are referred to by various titles such as 'artists' and 'art therapists', in this chapter and further I refer to all as facilitators, unless it is important to distinguish the discipline to stress a point.

obtain further insight into individual experiences and maximize the understanding of those experiences (Onwuegbuzie & Colins 2007). Thirteen participants consented to being interviewed and as the desired amount was reached, no further recruitment was undertaken.

3.6 THE MMSE RESEARCH DESIGN IN THE CURRENT STUDY

In keeping with the pragmatic approach that reduces the complexity of reality to a manageable scale (Kroll & Neri 2009), this four phase design provided a systematic approach to investigating the research question. The current research used several data collection methods that suited each phase of the research. Explaining the process undertaken for each phase, the purpose of the data collected, the research tools used and the method employed to analyse the data, provides a clearer understanding of the MMSE design undertaken (Table 2).

3.6.1 PHASE 1 – QUANTITATIVE

Aim

The purpose of this quantitative phase was to establish a number of community-based art groups that were being delivered throughout Victoria that were interested in participating in the current research. When the desired number of programs was reached, the aim was to collect quantitative data on diverse program types and structures and how it was resourced differently, in order to obtain categorical information, demographics and frequencies in the sample. Additionally, the data gathered provided categorical information for statistical analysis in phase 3 and informed interview guidelines with facilitators in phase 2.

Data Collection

A comprehensive list of all community organisations, centres, health initiatives and neighbourhood houses within Victoria was obtained from the Department of Human Services (DHS) website, councils, word-of-mouth and networking. Each

organisation was contacted by email to determine if arts-based interventions were offered to their service users. An introduction letter with research information was sent out to those organisations that ran art programs and had indicated interest in the research, inviting them to be involved initially in the first phase of data collection and the possibility of remaining involved in the subsequent phases. There was no limit as to how many organisations would respond at this stage and optional participation in all phases provided the researcher the ability to ensure that the desired number of participants was reached at each phase.

The extant literature informed the development of questionnaires for this phase, specifically in regards to the contributing factors identified in the literature. Questionnaires were sent out to all community organisations found to offer art programs to their service users and had indicated interest to participate in the current study. In this phase preliminary questionnaires (See appendix D - Q1) were mailed out to these organisations to collect initial quantitative data in regards to target group, participant numbers, program structure, facilitators' roles and disciplines, outcome goals, funding and evaluation procedures of any creative groups that were delivered at their centres. Some questions allowed for fixed responses to specific enquiries and other questions with free responses to allow the flexibility for additional relevant data that were specific to the program delivered with the view that this additional information would further inform the subsequent phase.

Analysis

Quantitative responses from the first phase were entered onto a Microsoft Excel database to obtain demographic details of participants and frequency of structures of the art programs. Descriptive statistics are numerical procedures used to organise characteristics of the given sample (Fisher & Marshall 2009) and this was used to organise and sort categories. Statistical analysis was useful in reducing the data collected in this phase into frequencies that provided

information on the sample, which in this phase were the participating art programs. The data collected informed the discussions held with facilitators in the following phase to determine the importance placed on these very same contributing factors. The categorical information also provided information on variables that were used in analysis in phase 3.

3.6.2 PHASE 2 – QUALITATIVE

Aim

The research had initially planned to use focus groups in the second phase as it could be a valuable method of collecting qualitative data that could explore a range of issues. However, it was unachievable to bring together facilitators and program managers from all regions in Victoria together on the same day to participate in a focus group. The intention of the focus groups was to explore the quantitative data obtained from phase 1, specifically in terms of group structure, space, art materials and facilitator and the importance placed on these factors, and to facilitate the discussion around suitability of the questionnaire (Q2) that was used in the third phase. Barbour (2008, p. 18) suggests the use of focus groups in the exploratory phases to inform the development of the structured tools that will be used with participants. It was determined that the same objectives could be achieved by the researcher having face-to-face interviews with facilitators and program managers on an individual basis. The aim of this phase was to expand on data collected from phase 1 through facilitator knowledge and experience, refine questionnaires used in phase 3, as well as contribute—in conjunction with phase 1—to developing the categories for exploration in phase 4. The meeting with facilitators individually helped to build trust and encourage continued engagement in the following phases.

Data Collection

Semi-structured interviews were carried out by the researcher with facilitators and/or program managers of each participating organisation around specific

details about the art programs run in their settings. The concepts explored were based on the importance they placed in several factors, previously identified in the literature and data collected in phase 1, when planning and delivering art programs. Contributing factors such as the role of the facilitator, art materials, final projects, creative space and creative process were all incorporated into the interviews. The semi-structured nature of these interviews allowed for valuable insight on facilitators' observations of contributing factors on participants' experiences of the art-making process, and their views on the delivery of the art programs, with the flexibility of allowing other emerging themes to surface. Field notes were taken throughout these interviews and generated into reports incorporating data from phase 1 for each organisation.

Input was also sought from facilitators on the suitability of the measurements that were to be used in the following quantitative phase on participants of their art programs, to ensure content-related validity (Onwuegbuzie, Bustamante & Nelson 2010). These interviews provided insight as facilitators were knowledgeable of their own target population and their responsiveness to participation in the research, which included valuing participants' time. Slight modifications were made to the measurements, with ethics approval, resulting from these discussions, which were shortening the length of time for completing them and discarding a section that was not relevant to the population. Reducing the time to complete was important in lessening the burden for respondents as suggested by Glasgow and Riley (2013, p.239) that 'pragmatic measures must require minimal time and effort to complete'.

Analysis

This research endorses that facilitators and program managers contribute to the overall knowledge of *arts in health* through practical experience and skills, and was guided by Narrative Inquiry to understand how this might be studied and represented (Clandinin & Connelly 2000). Similar to their explanation of Narrative Inquiry in the educational context—where the teacher is initially a part of

establishing goals—the delivery of art programs and the aims and goals are shaped by facilitators' and program managers' experience and become a part of the achieved outcomes (p. 29). Through these interactions, the researcher becomes a part of the experience, and taking field notes enriches the intimacy of narrated experiences (Clandinin & Connelly 2000, p.80). Analysis of the qualitative data was guided by Narrative Inquiry and thematic analysis. Clift (2012) states that analytical tools such as narrative and thematic analysis, are important tools for evaluating arts-based interventions in depth.

The analysis required initial sorting of field notes, moving back and forth to develop important points from facilitators' narratives. This process allowed for a broad understanding of factors involved in the delivery of arts-based interventions and more in-depth exploration and interpretation of how these factors may influence participants' experiences. An interpretative approach considers the researcher's ontological and epistemological standpoint that is brought into the inquiry, assumes that reality is socially constructed and seeks to understand the meaning of this reality from individual perspectives – which in the current study is that of the facilitators (Hesse-Biber 2010). This qualitative phase involved the drawing together of differences and commonalities of facilitators' knowledge and experience, to develop a narrative that guided the identification of categories within the data. These categories would guide the interview process in phase 4 and also contribute to a synthesised discussion.

3.6.3 PHASE 3 – QUANTITATIVE

Aim

The aim of phase 3 was to use quantitative measures to demonstrate the change in levels of self-esteem and social interaction of participants attending art programs for a fixed period of time. While the questionnaires used were guided by the literature and research method and informed by facilitators, this phase was undertaken specifically to provide statistical evidence of positive outcomes from participation in art programs for a fixed period of time, which was to

measure changes in levels of self- esteem and social interaction. The inclusion of standardised scales – The Rosenberg Self-Esteem scale and the Social Functioning Schedule – was to provide clear evidence of outcomes that would be followed by more exploration of individual experiences. Glasgow and Riley (2013) state that pragmatic measures can be used in real-world settings, and some of the criteria proposed are that they should be important to stakeholders, a low burden on cost and time, easy to score and reliable over time. Standardised assessment scales have been used in social research for many years, administered at different stages of the intervention with the aim to measure change and evaluate results.

The incorporation of standardised assessment scales in the questionnaire further provided stability as both scales have been used in previous research in the health field and have been tested for validity and reliability (Greaves et al. 2012; Secker et al. 2011). Because of the broad demographic data of the various groups, the research used the same questionnaire (Q2) that is suited to various populations. The questionnaires (Q2) allowed stability, as it was repeated on the same subject at a future date and compared with the initial data. The same questionnaire (Q2) was used to access the same outcomes in all populations. In choosing and modifying the questionnaires and measurement scales in the quantitative phases, I was mindful that the content of the items in the questionnaires or scales were relevant to the respondent, which Onwuegbuzie, Bustamante and Nelson (2010) called content- related validity. As previously reported this was done in collaboration with the facilitators of the participating programs during the interviews in Phase 2.

Data Collection

Organisations that participated in the first two phases of the research further agreed to have one or more of their creative groups participate in Phase 3 of the research within a fixed period of time to investigate change after a period of attendance. I worked collaboratively with the participating organisations to implement the third phase of the research through the use of questionnaires (Q2)

for all group participants. The questionnaires in the third phase of the study incorporated open-ended questions that explored participants' experiences of their interaction in the group, limited demographic data of participants and included two standardised assessment scales. The two formal assessment scales that were slightly modified and incorporated into a single questionnaire (See Appendix F - Q2) were the Rosenberg Self-Esteem Scale and the Social Functioning Scale.

The Rosenberg (1989) Self-Esteem Scale is a self-reporting instrument used for evaluating self-esteem of individuals by measuring positive and negative feelings. The scale consists of a 10 item scale using a 4 point Likert scale and is answered by individuals from strongly agree (1 point) to strongly disagree (4 points). The scale demonstrated internal validity and good test–retest reliability when used in a study with people with mental illness (Greaves et al. 2012). Although in the above study it is used specifically to mental illness, the scale is a suitable measure for a general population, that records participants' levels of self-esteem at two intervals and records the difference in levels to identify improvement and a widely used measure for assessing people's beliefs about themselves (Zeigler-Hill 2013, p. 100).

Social functioning has often been measured by the Social Functioning Schedule (SFS) and recently Secker et al. (2009) developed a more thorough measure for the Social Exclusion unit in the UK for studies accessing outcomes of arts participation. This was constructed to measure social withdrawal and interaction, interpersonal functioning, social relations and pro-social activities (Secker et al. 2009) using a twenty-two item questionnaire that took longer to administer, but was designed to look at many aspects of social interaction, including community participation and engaging in recreational activities. This made it well suited to the current research project. The scale was also used effectively in the evaluation of an Open Arts program tested with eighty-eight people with mental health issues in the UK, and it was indicated to have good internal consistency (Secker et al. 2011). The research design was appropriate to the use of measures that could

be broadly accepted in a number of settings which was relevant to the various target groups recruited in this research study. In this research it was decided to not include the subsection that measured daily independent functioning as it was irrelevant to the targeted clientele and the study. The questionnaires (Q2) were administered at the start of the program and subsequently at the end of the program. The time frame between the two was determined by the structure and frequency of programs in each of the participating organisations but covered a term of sessions or a block of sessions typically lasting about twelve weeks.

Many studies have incorporated the use of formal assessment scales to measure outcomes of programs and participants' experiences. The assessment of health-related behaviours generated by emotional experiences is difficult to measure using scales and can be captured better by verbal responses within that context itself which will give more insight into these emotions as determinants of health and wellbeing (Castro et al. 2010). However, the use of scales when working with large groups helped narrow results that informed follow-up research of more in-depth exploration in the subsequent phase of this research project. The social functioning scale and self-esteem scale were determined to be suitable scales that could address the research question that investigated changes in levels of self-esteem and social interaction.

The questionnaire was divided into four sections: demographic data (P1); self-esteem (P2); social functioning (P3); and experience of the program (P4). The social functioning section was further divided into four sub-sections measuring social isolation (P3s1), social relations (P3s2), pro-social activity (P3s3) and recreational activities (P3s4). The formal assessment scale on social functioning was slightly modified and incorporated into a single questionnaire (See Appendix G - Q2). Modifications involved reducing the number of questions, excluding the section on physical functioning that was not relevant to the population, and updating social and recreational activities to reflect more current trends. Berkman, Kawaichi and Glymour (2014, p.252) state that there is not one single measure that is appropriate for an assessment of social support, social

interaction and socialisation and suggests modifying an instrument to suit the hypothesis.

Analysis

The scale used in phase 3 was a self-reporting instrument used for evaluating self-esteem of individuals by measuring positive and negative feelings. Negative items 2, 5, 6, 8 and 9 on the questionnaire were reverse scored to pair towards positive outcomes. After inverting the scores, values indicated on each item were added together to obtain a total score. Prior to analysing this, data preparation that included data cleaning was carried out to create a standard working dataset suitable for analysis. Quantitative data was analysed using paired t-tests using the SPSS software program for comparison of the mean differences at pre-test and post-test scores in the questionnaires (Q2) that provided indication of outcomes of self-esteem and social inclusion. Paired t-test is a powerful tool for analysing the difference in scores between the pre-test and post-test scores where the same individuals participated in a questionnaire. This provided the results of change in self-esteem and social interaction.

The second aspect of the quantitative data that was subject to analysis was two sets of variables to measure if they had an influence on the reported outcomes of the art programs delivered. The variables data was obtained from the first two phases of the study in terms of program structure and discipline of facilitator as these were the two most distinct variables identified in the data collected. An analysis of program variables using the ANOVA two way factorial design gave a comparison of the effect these variables had on outcomes of groups that possessed those variables. Other variables such as the art space and art materials used were not considered for comparison as the data collected resulted in intangible categories that will be further explained in the qualitative results.

3.6.4 PHASE 4 – QUALITATIVE

Aim

The aim of this qualitative phase was to explore in-depth knowledge of participants' experiences of the art-making process that was informed by data collected from the previous phases. The research was not only interested in what the contributing factors of art programs were, but if and how they affected participants' experiences and influenced outcomes. In the questionnaires in phase 3, participants were invited to be interviewed and gave consent to being contacted by the researcher. Giddings and Grant (2009) state that interviews that follow from validated scales provide further exploration of individual participant's experience, thus expanding the quantitative data. Thirteen participants from eight different organisations consented to being interviewed and represented the experience in that group.

Data Collection

In a study evaluating art therapy research that employed qualitative designs, the most common method of collecting data was through structured interviews (Moss, Donnellan & O'Neill 2012). Personal testimonies from those who participate in arts- based interventions need to be taken seriously (Clift 2012) because the voice of the participant must not be lost as it has the greatest impact (Dose 2006), and interviews are the most efficient method to ensure this. Semi-structured interviews were conducted with selected participants in order to obtain a deeper understanding of the process of change involved. The flexibility of interviews empowered the service user to illuminate what was significant to them rather than researcher's bias of outcome. The interviews allowed the researcher to obtain rich data on how the outcomes were reached, or what hindered them, the factors that contributed to positive results, and the opportunity to evaluate these art programs with the goal of improving their quality for the service user. While categories developed from the previous phase were used to prompt and guide the interview process, it did not constrain

participants' narratives to explore personal meanings and stories, guided by the principles of Narrative Inquiry. The interviews developed from participants' experience of the art space and materials, their views of the group facilitation and their level of socialisation within the group as these were identified as contributing factors to their experience of engaging in the art-making process.

Analysis

While NVivo was used to store all qualitative data, Dierckx de Casterle et al. (2012) caution against over reliance on software packages by focusing too quickly on coding data. Qualitative data from transcriptions of interviews were read and re-read and reflected upon, which allowed the researcher to be open to multiple meanings and perspectives of the participants' experiences and to exploit the full potential of the data (Dierckx de Casterle et al. 2012). When a thorough preparation of the coding process was done and the interviews were comprehended within their context, data from all phases was entered into the qualitative software, NVivo. The software facilitated the raw data into more manageable concepts that were further developed and refined (Dierckx de Casterle et al. 2012).

As qualitative research is used to understand personal experiences and meanings, thematic analysis is a method that organises and interprets the data (Crowe, Inder & Porter 2015). Thematic analysis, informed by Narrative Inquiry, was used to analyse the data collected in this phase. Thematic analysis involved reading and re-reading the transcripts to familiarise with the data in order to generate codes within the data that were further developed into sub-themes and illustrated by quotations (Crowe, Inder & Porter 2015). The inductive approach was suitable for observing patterns and themes that emerged within each category, while being mindful to be careful and reflective in the decision-making process when representing the stories of participants (Holley & Colyar 2012). Drawing on components of Narrative Inquiry that understand individual experiences within a social context, I developed 'narrative fragments enacted in

storied moments of time and space' into manageable themes (Clandinin & Connelly 2000, p. 17). Initially the coding process meant using participants' words to describe categories before becoming more analytical and developing this into more focused themes (Hesse-Biber 2010, p.191). The themes generated in this phase were further synthesised with data from all the preceding phases to address the research question.

3.6.5 SELF-REFLECTIVE JOURNAL AND FIELD NOTES

The importance of a fieldwork diary or journal has been stressed by researchers, as it not only records observations from discussions and interviews, but also records any change of focus, preliminary speculations and emerging codes (Barbour 2008, p.192). A self-reflective journal was kept throughout the research process that allowed me to keep an audit trail and track decisions made throughout the process of the research. As Houghton et al. (2013) state, a journal provides the rationale for judgement on the methods used and the interpretations. Considering that analytical thinking should begin in the very early stages of the research study, thoughts and decisions were recorded on all field visits to participating organisations.

Observations at art programs, discussions with program managers, correspondence and feedback from organisations, and reflections after each interview were recorded. This method of journaling was used throughout the research process to record emerging themes, memos and reflections that were integrated into the analysis. The recording of ideas and thoughts as the research progressed led to improvements in further discussions with facilitators and improvement in every subsequent interview. Self-reflection of the research process and the emerging data generated ideas that warranted further investigations and identification of themes. These were documented as field notes from each phase and dated. As much as I am personally convinced in the healing power of the art-making process from my own experience, every theory is merely an hypothesis until verified by facts and I used this reflective journal

mindfully and without bias, as it is in the process of verifying facts that the truth is found (McDermott 1973, p.49).

3.7 SUMMARY OF DATA COLLECTION AND PROCESS OF INTEGRATION

Qualitative data collected from discussions with facilitators and program managers in the second phase, interviews conducted in the fourth phase and notes from self-reflective journaling were fed into the qualitative data software, NVivo. This software package was used for data storage, coding and development of themes from the different data sources. The program provided a single location for storage that made large amounts of data easily accessible and was found to be a valuable means for robust qualitative records. The NVivo has 'query tools' that guard against researcher bias to emphasise preferred findings and is also able to locate opinions by a number of participants and a variety of sources (Houghton et al. 2013). Onwuegbuzie, Bustamante and Nelson (2010) explain that in the MMSE design, qualitative and quantitative data are analysed separately and consolidated when all sets are complete, then integrating data into a coherent whole. All data was stored, documented, and numbered to facilitate referencing in the analysis and discussions. Data collected from the first two phases on aspects of program structure and discussions with facilitators was consolidated into single individual reports for each of the thirteen participating organisation referenced in this dissertation as Report #1–#13. Interviews were transcribed and numbered as Interviews #1–#13. After all results are reported in the next chapter, data will be synthesised into a coherent whole. A synthesis of findings involves exploring themes that emerge in the results pertaining to the art-making process, situating it within the existing literature, and making an argument that supports my research question (Crowe et al. 2015).

3.8 STRENGTHS AND LIMITATIONS

While the four-phase sequential mixed methods design was a tedious process, the design took into consideration the two most important aspects of the research question: the change in levels of self-esteem and social interaction for participants of art

programs; and to explore individual experiences of the art-making process. However, this research acknowledges there are limitations. Participants had to participate for a considerable period of time in order to analyse change, improvement, increase in social functioning and overall benefits of the intervention. As this is not a longitudinal study, this research doesnot show longer term benefits from the intervention. The short period of the block art group sessions—approximately ten to twelve weeks—may not have been sufficient to produce noticeable changes in score or how long these outcomes were experienced. Some of the participants may have accessed other therapeutic interventions that included counselling, medication, and other wellbeing activities, which presents the difficulty of attributing significant changes to wellbeing specifically to the art intervention.

This was not a comparative study between the different participating groups and apart from the two distinct variables of structure of program and facilitator discipline, other factors such as art space and art materials were not compared. Although the focus was on the art-making process, it would have been beneficial to conduct further in-depth comparisons of outcomes in the different groups.

Ethical considerations allowed for participants to withdraw at any stage and resulted in some data not being utilised. In the interview phase, those who were willing to be interviewed were more likely to have had positive experiences and more negative aspects may not have been represented.

KEY POINTS – RESEARCH METHODOLOGY

- Discussion on the difficulty of suitable research methods to effectively research the arts in the health realm;
- Chosen research method – mixed methods research in Mixed methods sequential explanatory (MMSE) design conducted in 4 phases;
- Research tools used for data collection:

  1) Quan – questionnaires on demographic data of art programs

  2) Qual – discussions with facilitators

  3) Quan – standardised assessment scales

  4) Qual – interviews with art program participants

  5) Self-reflective journal, field notes and observations
- Data Analysis – Descriptive analysis, narrative Inquiry and thematic analysis.

4. RESULTS

Conducting this research using a mixed method design, I was mindful of the reported concerns of integrating data from multiple sources. Data from this current mixed methodology design included statistical data on outcomes of art programs and participants, and qualitative data from discussions and interviews. While data for each phase was collected and entered into the software separately, an integrative approach to the data analysis was undertaken to synthesise data from all components into an overall detailed conclusion to the research question.

This chapter summarises the data that was collected and reported over the four phases. The results are presented separately in each phase, with an emphasis on how each phase informed the next, as is consistent with the Mixed Methods Sequential Explanatory design (Refer to Table 2, Chapter 3). Data was converted into tables and charts that summarised the numerical data to better communicate results that are easily interpreted. Charts and tables present a visual picture of the variables involved and the impact these had on outcomes. Significant quotes from participants were added to illuminate the essence of the key concepts (Dierckx de Casterle et al. 2012).

4.1 PHASE 1 – ART PROGRAMS IN VICTORIA

The purpose of the first phase of this research was to collate information of art programs that were being delivered in organisations around all of Victoria and to identify appropriate programs to be involved in the remainder of the research. A search was conducted Victoria-wide to locate community centres and organisations that delivered diverse art programs to their service usersor the local community. The aim of this phase was to obtain demographic data on creative activities offered at all community centres, neighbourhood houses, councils and community learning and activity centres. Introductory emails were sent out to 276 organisations in the state of Victoria, identified through government websites, social services and networking. Fifty-five responses were received of which 46 of these were actively delivering creative

programs. Thirty-six agreed to initially be involved, although ten opted not to be involved in the research for a variety of reasons. Some of the reasons included the lack of resources to coordinate the research and inability to ensure continuity of program at time of research. Furthermore, due to a lack of resources or funding, some organisations subsequently withdrew and a total of thirteen organisations committed to involvement in all phases of the research. Some of these organisations delivered more than one creative program in their centres, resulting in data from a total of twenty programs for this phase which was within the sample required (Table 3).

GRP	PROGRAM	FACILITATOR	ART SPACE
1	Art Therapy	Art Therapist	Multi-purpose
2	Informal	Peer-led Volunteer	Art room/studio
3	Informal	Peer-led Volunteer	Art room/studio
4	Skilled-base	Artist	Art room/studio
5	Informal	Artist	Art room/studio
6	Informal	Artist	Art room/studio
7	Skilled-base	Peer-led Volunteer	Art room/studio
8	Informal	Peer-led Volunteer	Art room/studio
9	Informal	Artist	Multi-purpose
10	Art Therapy	Art Therapist	Multi-purpose
11	Skilled-base	Artist	Multi-purpose
12	Skilled-base	Artist	Art room/studio
13	Skilled-base	Artist	Art room/studio
14	Informal	Artist	Multi-purpose
15	Informal	Peer-led Volunteer	Multi-purpose
16	Informal	Art Therapist	Art room/studio
17	Informal	Artist	Art room/studio
18	Informal	Peer-led Volunteer	Art room/studio
19	Art Therapy	Artist	Multi-purpose
20	Art Therapy	Art Therapist	Art room/studio

Table 3: Categorical data from 20 art programs

In phase 1 of the research, questionnaires (See appendix D – Q1) were sent out to participating organisations to collect initial data on structure of programs, facilitators'

discipline and training, target groups, art space, aims and goals of the program, funding and evaluation. Questionnaires were answered by program managers and/or facilitators of the various art programs. Individual reports on the data collected were written for each of the twenty participating art programs. Analysis was minimal, consisting of amalgamating common characteristics through descriptive statistics, primarily frequencies. As questionnaires allowed for some flexibility for additional comments, significant comments made by program managers are included in these results. The table (Table 3) above shows categorical data from twenty participating programs, in terms of structure, facilitator and art space. The balance of the data is summarised and discussed under the categories below. The organisations that participated consisted of community centres, neighbourhood houses and not-for profit initiatives.

4.1.1 STRUCTURE OF PROGRAMS

Seventeen of the art programs were run weekly for a fixed term period of eight to twelve weeks and followed the Victorian school term. The three other groups ran a fixed block of sessions but starting at random times. Sessions were between 1.5 to 2.5 hours and only three groups went over three hours. While a third of the groups spent the entire duration on art, other groups occasionally incorporated discussions, games, reflection, social interaction, time for snacks and meditation in the sessions. The desired number for participants in each group was between four and eight or nine and twelve, although two groups had over fifteen participants. However, attendance was not always one hundred percent of those registered. Two of the organisations noted that not meeting the required number of participants meant the program was run at a cost to the organisation. As attendance was not compulsory in all of the groups, numbers attending varied significantly.

Eleven of these programs were informal in nature with flexible attendance and individuals working on their own projects with minimum guidance; others were closed groups with more structure and more intense skill-based support from facilitators. Four groups were delivered by art-therapists with therapeutic intent

with psychosocial education incorporated and using art as a medium for expressing and making sense of experiences. The five remaining groups were skill-based and taught a specific medium. A variety of creative activities were delivered in all the groups which included spontaneous art, mosaics, clay, Chinese Brush painting, painting, drawing, textile crafts, life drawing, nature in watercolours, and a variety of crafts.

4.1.2 TARGET GROUP

Participants of the groups varied in nature including mental health service users, women affected by domestic violence or sexual assault, women with breast cancer, participants with a disability, asylum seekers, refugees and general members of the public. Programs that were delivered to children were excluded from the study and all programs targeted adults above eighteen, with some having a wider age range than others. While most programs catered to both genders, with the exception of three groups, participants who attended were predominantly female.

Group participants were recruited through brochures, advertising, flyers, by word of mouth and on organisations' websites. Only three of the groups went through a referral process and members had to be eligible and assessed to be suitable to participate. In half of the programs facilitators planned and implemented the sessions with participants having little or no input in content and structure. The rest of the groups offered the flexibility of giving participants the opportunity to contribute to the program through discussions with facilitators, feedback forms and allowing more self-direction in the art activity. In some groups authority was shared between facilitators and participants. Some participants were more focused on learning skills and aesthetic quality, while others attended for the enjoyable activity or social or therapeutic element of the art-making process.

4.1.3 FACILITATOR

The art programs were run by one or two facilitators per group, and came from a variety of disciplines such as art therapists, artists, and volunteers that were crafters, art teachers, social workers and community workers. Only four of the twenty programs employed trained art therapists. Facilitators were mostly contracted to conduct the art programs but some were also run by employees of the organisations or volunteers. A few of the programs contracted professional artists who were extremely skilled in their particular art medium and charged higher fees for their teaching. In one of the programs the facilitator was a very well-known artist in the field and these classes were always over-subscribed.

There was a general consensus that facilitators were skilled in their roles and in their handling of the art activity and the group members. A few program managers believed that facilitators could benefit with more specific work in therapy or improve their artistic and teaching skills. One centre manager reflected that facilitators would benefit with knowledge of more specific clientele, such as asylum seekers or those with challenging behaviours (Report #5 & #11). The expectations of volunteer-led classes were for the facilitators to only organise the sessions and guide members of the group.

4.1.4 FUNDING

Two thirds of the art programs charged a token fee to participants to attend which ranged from $5–10 per session with the more skill-based classes charging above $15. Fees charged went towards the cost of paying facilitators and providing art materials and only a few contributed to venue hire. While half of the programs were funded by the fees collected, only three were directly funded by the Department of Human Services (DHS). The more skilled-based programs received funding from the Association of Neighbourhood Houses and Learning Centres (ANHLC) to provide opportunities for upskilling. The rest of the programs were run under the general budget of the organisations. Those programs funded

by DHS were required to undertake evaluations of their programs in order to receive continued funding. Some programs reported a struggle to meet minimum numbers to make it cost-effective and one program held an annual sale of the products created to generate revenue for continuity of the program. One community centre generated their own funds by initiating a regular trading table at the centre.

Groups that offered therapeutic art to a specific clientele received funding from philanthropic bodies, and one reported that it was difficult to get continuous external funding as many funding bodies were interested in funding new programs. Some groups were affiliated with external guilds and societies and ran workshops for their members in the centres.

4.1.5 AIMS AND GOALS

Some programs listed very clear and specific goals for delivering the art programs, while others provided more general goals. Gaining skills was the most recurring goal listed, with some programs placing very high importance on imparting good techniques and skills. The goal to improve social interaction and building of social networks was the second most common to all programs. Social connections were encouraged not only within the group, but extended to providing connections to the wider community by increasing knowledge of resources and services in the local community. Other goals reported were: developing self-awareness; providing opportunities for creative activity; building community; and having fun. More specific goals were 'recognising that people are time poor but desperate to do something creative' and 'to support and witness change'. Programs that were more therapeutic in nature targeted a specific clientele with similar health issues such as cancer, or social problems such as domestic violence. These groups aimed at exploring difficult problems through the creative process and for participants to make sense of their experiences, supporting healing through art. One such group noted a very specific skill as 'rebuilding their identity and developing a positive sense of self' (Report #7).

Program Managers were asked to list one to five goals for the delivery oftheir programs. The top recurring main goals of the program are outlined in Table 4.

GOAL	EXPLANATION	FREQUENCY
GAIN SKILLS	Learning, enhancing and developing skills in creative activity,	15
SOCIAL INTERACTION	Create social connections, make friends and build social supports	14
OPPORTUNITY TO BE CREATIVE	Provide opportunities for creative engagement	5
CONNECTION TO COMMUNITY	Encourage community participation and build community feeling	5
REDUCE ISOLATION	Break the isolation of individuals	3
SAFE AND FRIENDLY SPACE	Provide a safe and calm place to feel relaxed	3
FUN AND ENJOYMENT	Have fun and enjoyment	2

Table 4: The main goals of art programs and the frequency it was listed.

4.1.6 ART SPACE

While thirteen of the centres had designated art rooms or studios in which art sessions were held, the remainder ran their art programs in meeting rooms, common areas and classrooms. Some provided storage facilities for participants' unfinished work and materials. The majority, except for one, reported having disability access and facilities for participants. Many stressed the importance of creating a safe, warm and welcoming place by providing facilities for tea and coffee.

Organisations also considered that providing a calm space was important and one program manager stressed that it was so participants 'can focus on being in the moment of gestural painting' (Report #1).

4.1.7 EVALUATION

Most programs conducted informal evaluations of their programs by calling up their participants for feedback, or filling in feedback forms at the end of the term of the program, resulting in written evaluations and reports. These were conducted by staff, facilitators, program managers and coordinators. One felt that telephone calls gave a personal touch to the evaluation and one reported not having the funds to conduct an external evaluation. Four did not conduct any kind of evaluation. One of the programs had previously participated in a research project.

This is a summary of the data collected in the first phase. The data was used in phase 2 to initiate discussions with organisations' managers and facilitators on the importance placed on the different factors reported in phase 1.

KEY POINTS – PHASE 1

Organisations provided information on art programs:

- Structure of programs varied widely;
- Run in fixed term blocks of 8–12 weeks in art rooms and makeshift spaces;
- Participants were mostly older adults and female;
- Facilitators' disciplines varied from art therapists, artists, and volunteers that were retired teachers, crafters,
- Funding of programs came from Department of Human Services (DHS), local councils, grants, state government;
- Top two goals were: 1) Gain skills
  2) Social inclusion
- Most organisations conducted informal evaluations.

4.2 PHASE 2 – QUALITATIVE FINDINGS

In phase 2 of the research project, I met with facilitators and program managers of participating organisations to expand on data collected from phase 1 from facilitator knowledge, to build trust, to refine questionnaires used in phase 3, and, in conjunction with phase 1, to develop the categories for exploration in phase 4. Initial discussions were around participation in the following phases of the research, consultation around the questionnaires to be used in phase 3, and management of the process of data collection. I felt it was important to build trust with the participating organisations and the facilitators, as their assistance in administering the questionnaires and ensuring respect and confidentiality of the process was essential to the research. In keeping to strict ethical guidelines, participation and consent were explained.

The aim of this phase was also to further explore data from phase 1, particularly around the importance they placed in several factors when planning and delivering art programs. The following is a summary of discussions with thirteen organisations, broken into broad categories for ease of discussion.

4.2.1 ROLE OF THE FACILITATOR

Interviews held with the various facilitators that came from a variety of disciplines revealed different roles that were played by the facilitator. Facilitators ranged from art therapists, artists (professional and amateurs), crafters and art teachers. Facilitators were either paid contractors or volunteers with a creative background or simply enjoyed doing art. Paid facilitators felt it was important to teach skills to others so that participants could achieve confidence in creating, and they did not engage in their own art during the session. Other facilitators felt it was important to show some skills, but mostly their role was to encourage and assist those engaging in the creative activity, allowing for participants' own directions. Volunteers who facilitated were artists/crafters themselves engaged in their own projects during the sessions, and were there to guide participants and share ideas only with the hope of inspiring others through their love for art.

Some facilitators were contractors paid by the centre to deliver skill-based programs and were highly skilled in their own particular art medium or craft. These facilitators planned and implemented the program and focused heavily on the teaching of skills. Facilitators who were art therapists strongly believed they played a significant role in planning and delivering a program that was influenced by the needs of the participants, and stressed the importance of good group rules and boundaries. This therapeutic role focused on observing participants and 'holding the space' for healing outcomes to occur.

4.2.2 ART MATERIALS AND THE FINAL PRODUCT

Informed by the data collected from phase 1 on the variety of art materials used in the art programs, the exploration with facilitators was on the provision, type, availability and quality of art materials used, and their importance to the creative experience, as well as the value of the final product. While most organisations had participants bring in their own materials, some did provide them at a very low cost, used recycled materials or obtained materials through grants and donations. In those programs that did not provide materials, facilitators had no control over what was brought to class.

Facilitators expressed the importance of art materials for various reasons and some felt that people would not attend if these were not provided, especially if bulky items were needed such as papers, easels and sewing machines. A few facilitators reported that a variety of materials stimulated creativity and the correct materials for the project were imperative. Others felt that selecting the type of material to suit the theme of the day was important, as well as having tactile material that had a way of connecting with the user. While some felt that quality material was not necessary as simple material can be more challenging to thinking creatively, others believed that it was important to provide the best quality that was still affordable for participants to achieve good results and continue this activity on their own.

In regards to the final product, facilitators were divided in the value placed on the finished product as some felt it was not the object but the engagement in the art-making process that was important. Discussions on this topic related to the final product being kept or destroyed, shared or exhibited, or used as a tool for communication. Depending on goals participants hoped to achieve in the group, most took their finished products home for personal use or gifts. Facilitators who were art therapists related that the final product gave participants something to reflect on and re-visit at the end of the block of sessions. As such, they encouraged the art to be displayed in order to allow the reflective process to continue. It also provided a point of conversation with those they lived with, or used as a point of reference for communication with their counsellors.

Some facilitators felt the image created was private and participants took home completed works. However, some facilitators expressed the importance of the final product being shared with the local community. It was felt it was important to display the art produced and share achievements. A number of the centres held annual exhibitions or craft fairs and provided opportunities for participants to exhibit or sell their work with a percentage of the profits going to the centre. Some groups were provided assistance to get their work out into the local community or exhibited in local cafes. In one of the groups, participants' works were made into a calendar and in another group the facilitator assisted in the display of the completed work at the local community health centre (Report #7 & #12).

4.2.1 ART SPACE

Noting that phase 1 reported at least a third of the centres did not have designated art rooms or studies, the importance of the art space where art programs were delivered was further discussed. Some centres had designated art rooms—some fully equipped with easels, sewing machines and storage—while others had to utilise meeting rooms or makeshift spaces in multi-purpose rooms. The majority agreed that practical aspects such as good lighting, ample table

space, sinks for messy activities, comfort, tea and coffee facilities, and disability access were very important. It was also stressed that it had to be a private 'safe' space so that the group was not interrupted and participants could feel relaxed. It was suggested that ambience could be created in makeshift spaces with music and pictures. Paintings on the walls and participants' art displayed on noticeboards were encouraged and validated and an opportunity for those to show off their achievements. In one of the centres, volunteers made the effort to decorate the space, and made a banner that was hung up yearly to depict the theme of the year (Report #11).

In creating spaces for art groups to be run, organisations ensured access to tea and coffee facilities to encourage socialisation during break times. One organisation intentionally made the tea/coffee area central and accessible to the other activity groups taking place at the centre to encourage further social interaction among groups (Report #2). Consideration of the structure of the art space, arrangement of tables and aesthetic settings was undertaken by facilitators and program managers to encourage socialisation. Facilitators placed importance on creating a space that participants felt safe, and most agreed it was their role to establish rules and 'hold' the space.

4.2.4 THE SOCIAL ELEMENT

In phase 1, the most common goal for the delivery of art programs was social participation in meaningful activities. Facilitators were asked if they encouraged socialisation within the group or facilitated verbal discussions between participants around the art produced in the sessions. Most reported that the casual environment made it comfortable for like-minded people with a shared interest to converse naturally about the art. Facilitators also indicated some participants had been attending the group for a long time and knew each other well, and observed that some participants reportedly socialised before and after the group with friends they met in the group.

In one of the informal craft groups, participants brought their finished work to class and talked about it as the feedback and support was beneficial. One facilitator observed that the group was very relaxed and that there would be a great deal of talk and laughter during the class (Report #11). When participants attended to learn a skill, socialising would be within the sessions around shared interests, practical aspects about the art, and resources in the community in terms of creative activities. One facilitator felt that it was very important to discuss the project and levels of difficulty among participants. In groups that were therapeutic in nature, facilitators encouraged discussions as they felt that participants were sharing a part of themselves, and that such discussions were validating and grounding. However, one facilitator noted that coming into a group can be daunting to those who attended for the first time, as the art-making was a very emotional experience that was unexpected (Report #1). Facilitators in these groups set up participants' works within the group and talked about the process, allowing for feedback and shared experiences.

All art programs were delivered in groups and no individual sessions were part of this research. Facilitators reported groups to be more structured and provided opportunities for sharing and interacting during the art process. Working in a group showed that different results could be achieved, and were very individual, even when it was the same project. One facilitator stated that while the group may start on similar individual projects initially, when the group became more cohesive, she would initiate a group project (Report #12).

4.2.5 ART AS COMMUNICATION

To explore the aspect of communication as part of the research question, facilitators were asked to discuss their views on art as a means of communication, and it was reported that art started conversations within the group. In the multicultural groups, when English was a second language facilitators reported delivering art programs meant anyone could participate and observed that participants who did not speak English fluently used the groups to

practice their conversation skills. Art therapists stated that there were different types of communication happening, and different qualities as well, and it was important to have the ability to grasp the depth of the process and get under the surface rather than just talking. In programs that were art therapy focused, facilitators stressed that there was communication within participants themselves, and during these times the group was silent while each person focused on their own art. The finished piece also becomes a point of conversation when taken back to family and friends or counsellors to explore.

4.2.6 WHY ART?

Program Managers were asked why creative programs were offered as part of their service in preference or alongside other recreational or social groups. A few of the centres offered art because it had been a tradition for a long time. For example, one Neighbourhood House had an art and craft focus for over thirty years and over thirty-five percent of the programs offered currently were creative activities (Report #5). It was also reported that art was popular and programs were offered according to community interest and need. Some spaces were very much suited for art programs.

Facilitators shared that art had the ability to start conversations, had social benefits, and encouraged skills that supported confidence and perseverance which lead to employability or income-generation (Report #2). Therapy alone may not benefit everyone and people are more reflective and emotions are deeper through art—'it is a part of what they do' (Report #.12). Art gives them the power to show their feelings and share experiences. One facilitator reflected that women get a lot out of making art as it is reflective. Another facilitator related that art had the ability to get oneself out of cognitive processing and to feel with a mind, body and heart connection, and that art relates to the deepest part of self (Report #7). Facilitators also reported that art is about fun and pleasure as well and participants actually enjoyed it and it gave them 'time out'—a positive experience.

I present the results here in broad categories from phase 2 as they were collected. In conjunction with data from phase 1, these categories were used to inform the interviews conducted in phase 4.

KEY POINTS – Phase 2

Interviews held with facilitators on the importance of all elements in art programs.

- Facilitators viewed their roles as teaching skills, guiding participants and inspiring others;
- Some felt the type of materials provided were important while others did not have control over what was used;
- Facilitators reported observing social interaction and encouraged it;
- Facilitators encouraged final products to be exhibited, reflected upon and discussed or emphasised process over product;
- Art-making was viewed as a means of communication in multilingual groups, aided conversations between group members, family and friends;
- Art programs were offered due to demand, popularity and benefits associated with art-making.

4.3 PHASE 3 – QUANTITATIVE FINDINGS FROM PARTICIPANT QUESTIONNAIRES (Q2)

In phase 3 of the research project, questionnaires were administered at different stages of the intervention to measure change and outcomes of participants' experiences after attending the art program for a period of time. The questionnaires (See Appendix G - Q2) were administered at the start of the program and subsequently at the end of the program. Participants who attended at least seventy percent of the program being researched were invited to take part in the post-intervention survey. The timeframe

between the two was determined by the structure and frequency of programs in each of the participating organisations but covered a term of sessions or a block of sessions typically lasting about twelve weeks.

The aim of this quantitative phase was to specifically determine if there was a change in levels of self-esteem and social interaction from attending art programs after a period of time. The following sections describe the analysis performed on the data collected in this phase and the results obtained and will be discussed in conjunction with the qualitative data in the discussion chapter.

4.3.1 DATA COLLECTED

A total of 131 participants completed the first round of questionnaires, but only 101 completed questionnaires in the second round, resulting in 101 acceptable questionnaires. The reduced number was because some people withdrew from programs or did not attend at least seventy percent of the sessions. Additional data on certain sections was also reduced due to missing data and analysis was only performed on the cleaned datasets (i.e. after discarding the data that participants had neglected to answer). Missing data reduced the data on some measures making the data available for analysis less in certain sections. While reasons for non-completion were not collected, some reflection on this is provided in the final chapter. Data was analysed with the assistance of a mixture of software including *Excel, SPSS* and *R*.

	Number of Questionnaires	Number completed	Percentage completed
Part 2 -Self-esteem	101	98	97%
Part 3 s1 – Social Isolation	101	100	99%
Part 3 s2 – Social relations	101	96	95%
Part 3 s3 – Pro-social activity	101	86	85%
Part3 s4 – Recreational activity	101	87	86%

Table 5 - Percentage of completed answers for each section of Q2

Data on gender, age and familiarity of the program was collected at pre-test time. The mean age of the participants was fifty-seven, the youngest was twenty and the oldest was eighty years old. While most of the programs were open to all genders, the majority of the participants were female (ninety-one). There were four males and six participants did not state their gender.

4.3.2 SELF-ESTEEM

A major objective of this phase was to measure if participation in creative activity within a fixed period of time would increase participants' self-esteem. The Rosenberg (1989) Self-Esteem Scale was incorporated into the participants' questionnaires to measure change in self-esteem after a period of time of attending the art group. Table 6 illustrates data obtained from part 2 of the questionnaire, of ninety-nine responses related to mean scores at pre- and post-test. A paired-samples t-test was conducted to compare self-esteem at pre-test and post-test scores to achieve the results stated.

	Test	Mean	SD	t	p-value (one tail)
Part 2 - Self-	Pre	2.038	0.486	2.820	0.003*
	Post	1.920	0.500		
NOTE: Rosenberg Self-Esteem Scale (decrease in value = Increase in self-esteem)					

TABLE 6: t-Test: Paired Two Sample performed on self-esteem scores at pre-test and post-test.

In this calculation (Table 7) H0 is the null hypothesis which assumes that the mean of two paired samples are equal (i.e. pre- and post-test scores are equal). Ha is the alternative hypothesis which assumes that the means of two paired samples are not equal and that the difference is greater than 0. For Part 2 of the questionnaire (scores of self-esteem), this means if pre-test scores minus post-test scores is greater than 0, results show an improvement in self-esteem (H0:µd=0; Ha:µd>0 and 'd' is the difference of pre- and post-test scores). The significance level was set at 5%, expressed as the critical value of 1.66055 for a one tail test. The test statistics must exceed this value in order to accept that there is a significant difference between the Pre- and Post-test scores.

ITEM	HYPOTHEIS AND DECISION CRITERIA	CALCULATIONS – TEST STATISTIC	CONCLUSION
SELF ESTEE M	The null hypothesis (H0) is rejected when the T-statistic is greater than the critical value α=0.05, *df* = 98 $t_{0.05}$= 1.660551217 (critical value) rejection region: t> 1.660551217 (one-tail)	$t^* = \frac{\bar{d}}{s_d/\sqrt{n}}$ $= \frac{0.117686869}{0.415258873/\sqrt{99}}$ $= 2.819854396$ t*= 2.819854396 *t** > 1.660551217 therefore reject H0	At *α*=0.05, I reject the null hypothesis and accept the alternate hypothesis (i.e. pre and post test results show improvement in self-esteem).

Table 7 – Paired t-tests analyses shows a significant improvement in self-esteem

As the results show a significant difference in the scores for pre-test ((M=2.03, SD=0.49) and post-test (M=1.92, SD=0.50); p =0.004), I can sufficiently conclude there was an improvement in participants' self-esteem after attending the art

program for a fixed period of time.

4.3.3 SOCIAL FUNCTIONING

The research study also aimed to investigate if participation in creative activity in groups increased participants' social networks and socialisation. The Social Functioning Schedule formed the third part of the questionnaire that was grouped into four subscales measuring social isolation, social relations, pro-social activity and recreational activities. Social isolation and relations incorporated questions that explored participants' ability to socialise and interact with others. Social and recreational activity was a measure that considered participation in social activities that involved interaction with other people, such as movies, sports and playing games.

Table 8 illustrates data obtained from questionnaires of mean scores at pre- and post-test. A paired-samples t-test was conducted to compare each subscale of social functioning at pre-test and post-test scores to achieve the results stated.

	Test	Mean	SD	t	p-value (one tail)
Part 3 s1 – Social Isolation	Pre	2.360	0.447	0.570	0.2852
	Post	2.382	0.465		
Part 3 s2 – Social relations	Pre	1.936	0.487	2.707	0.0041*
	Post	2.051	0.486		
Part 3 s3 – Pro-social activity	Pre	2.210	0.484	0.730	0.2337
	Post	2.243	0.497		
Part3 s4 – Recreational activity	Pre	2.865	0.486	-0.478	0.3170
	Post	2.847	0.440		
NOTE: (S1-S4 is the Social Functioning Schedule(Increase in value = Increase in Social Functioning)					

TABLE 8: t-Test: Paired Two Sample performed on social functioning scores at pre-test and post-test.

In this calculation (Table 9) H0 is the null hypothesis which assumes that the mean of two paired samples are equal (i.e. pre- and post-test scores are equal). Ha is the alternative hypothesis which assumes that the means of two paired samples are not equal and that the difference is greater than 0. For Part 3 of the questionnaire (scores of social functioning), this means if pre-test scores minus post-test scores is greater than 0, results show an improvement in social functioning (H0:μd=0; Ha:μd>0 and 'd' is the difference of pre and post-test scores). The significance level was set at 5%, expressed as the critical value of 1.66055 for a one tail test. The test statistics must exceed this value in order to accept that there is a significant difference between the Pre- and Post-test scores.

The results show that there was a non-significant difference in the overall scores for pre-test in social functioning as whole, and only a significant difference in social relations (part 3 S2) from pre-test to post-test ((M=1.94, SD=0.49) and post-test (M=2.1, SD=0.49); p = 0.004). The methodology used to measure social functioning was through four separate social factors. The statistical analysis has shown that three of the factors had insufficient evidence to conclude that attending the art program had an effect on social functioning. Although one of the factors, Social Relations, has made an effect, given the majority of factors were not significant, I was unable to conclude from the quantitative data any significant impact on participants' social functioning from attending the art program within that period of time.

ITEM	HYPOTHESIS AND DECISION CRITERIA	CALCULATIONS – TEST STATISTIC	CONCLUSION
SOCIAL ISOLATION	The null hypothesis (H0) is rejected when the T-statistic is greater than the critical value α=0.05, *df* = 100 $t_{0.05}$= 1.660234326 (critical value) rejection region: t> 1.660234326 (one-tail)	$t^* = \frac{\bar{d}}{s_d/\sqrt{n}}$ $= \frac{0.022585149}{0.398716983/\sqrt{101}}$ $= 0.569270794$ *t**= 0.569270794 *t** < 1.660234326 therefore accept H0	At *α*=0.05, I accept the null hypothesis (i.e. that there is no difference in the pre and post test results).
SOCIAL RELATIONS	The null hypothesis (H0) is rejected when the T-statistic is greater than the critical value α=0.05, *df* = 96 $t_{0.05}$= 1.662354029 (critical value) rejection region: t> 1.662354029 (one-tail)	$t^* = \frac{\bar{d}}{s_d/\sqrt{n}}$ $= \frac{0.107178351}{0.393275185/\sqrt{97}}$ $= 2.684085787$ *t**= 2.707103364 *t** > 1.662354029 therefore reject Ho	At *α*=0.05, I reject the null hypothesis and accept the alternative hypothesis (i.e. pre and post test results shows improvement).
SOCIA L ACTIVITY	The null hypothesis (H0) is rejected when the T-statistic is greater than the critical value α=0.05, *df* = 86 $t_{0.05}$= 1.662765449 (critical value) rejection region: t> 1.662765449 (one-tail)	$t^* = \frac{\bar{d}}{s_d/\sqrt{n}}$ $= \frac{0.032457471}{0.41466179/\sqrt{87}}$ $= 0.730096539$ t*= 0.730096539 *t** < 1.662765449 therefore accept Ho	At *α*=0.05, I accept the null hypothesis (i.e. that there is no difference in the pre and post test results).
RECREATIONAL ACTIVITY	The null hypothesis (H0) is rejected when the T-statistic is greater than the critical value α=0.05, *df* = 87 $t_{0.05}$= 1.662557349 (critical value) rejection region: t> 1.662557349 (one-tail)	$t^* = \frac{\bar{d}}{s_d/\sqrt{n}}$ $= \frac{0.017688636}{0.34729254/\sqrt{88}}$ $= -0.477793498$ *t**= -0.477793498 *t** < 1.662557349 therefore accept H0	At *α*=0.05, I accept the null hypothesis (i.e. that there is no difference in the pre and post test results).

Table 9: Analysis of t-test on pre- and post-test scores on social functioning

I will discuss these results more in depth in the discussion section, especially in conjunction with the qualitative data from interviews that offer potential reasons and alternative results, especially in regards to social functioning.

4.3.4 VARIABLES OF ART PROGRAMS

In addition to measuring change in self-esteem and social functioning, the current research study also investigated if the structure or type of program and the discipline of the facilitator impacted on reported outcomes. Prior to analysing the variables of the twenty participating groups, one was removed due to small observation values (i.e. fewer than three participants in the group) resulting in performing an analysis of variables in nineteen programs.

The two variables selected on which to perform this analysis were derived from data collected in the first phase of the study. Through sorting the data on the differences in the art programs, the most identifiable differences in the programs delivered were type of program and discipline of facilitator. These two categorical variables were further categorised as follows:

Type of program

1) Skilled Base
2) Art Therapy
3) Informal

Facilitator discipline

1) Art Therapist
2) Artist
3) Peer-Led Volunteer

A Two-Way Mixed Factorial Design statistical analysis was performed on these categorical variables to test the hypotheses that the different variables did not have a significant effect on reported outcomes.

Variable 1 – Type of Program

Art programs in the participating organisations were structured differently as per data collected in phase 1 and categorised as art therapy, informal groups and

skill- based programs.

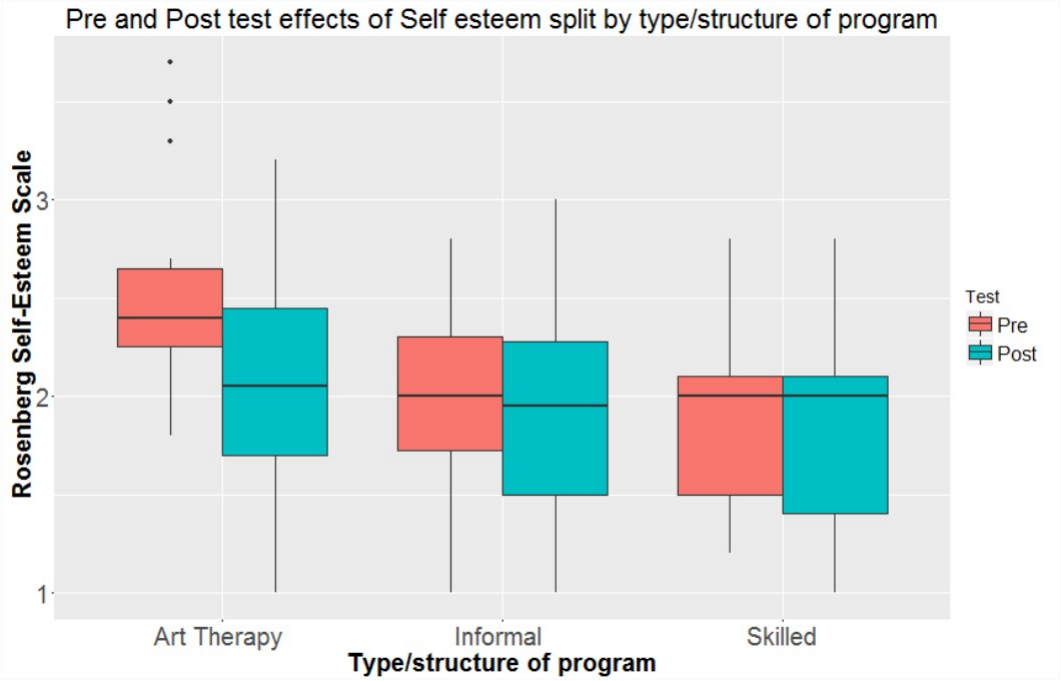


Figure 1 - Box plot on self-esteem scores in type of programs

A Two Way Mixed Factorial Design ANOVA statistical analysis was conducted to test if different levels within each variable had different effects on self-esteem (Table 10). In regards to type/structure of program there is significant difference at 95% confidence only. So at 95% confidence, I conclude that the various type/structure of programs produce different levels. While the aim of this research is not to compare one structure over another, it is noted here that the art therapy groups resulted in the most change, followed by skilled groups and then informal groups. The importance of the result is that together the programs showed a significant increase in self-esteem.

Variables	Test	Mean	SD	DF	Sum Sq	F	p-value (one tail)
Type of program:	Pre			2	0.8628	4.979	**0.0209 ***
Art Therapy		2.55	0.56029				
Informal		2.0086	0.41658				
Skilled		1.8707	0.39404				
Type of program:	Post						
Art Therapy		2.1147	0.56139				
Informal		1.9717	0.51183				
Skilled		1.8310	0.47517				
NOTE: Rosenberg Self-Esteem Scale (decrease in value = Increase in self-esteem)							

Table 10 - A visualisation of the type/structure of the art program.

Variable 2 – Facilitator

Facilitators of the art programs came from a variety of disciplines as per data collected in previous phases. These were categorised into three disciplines: art therapist, artist and peer-led volunteer.

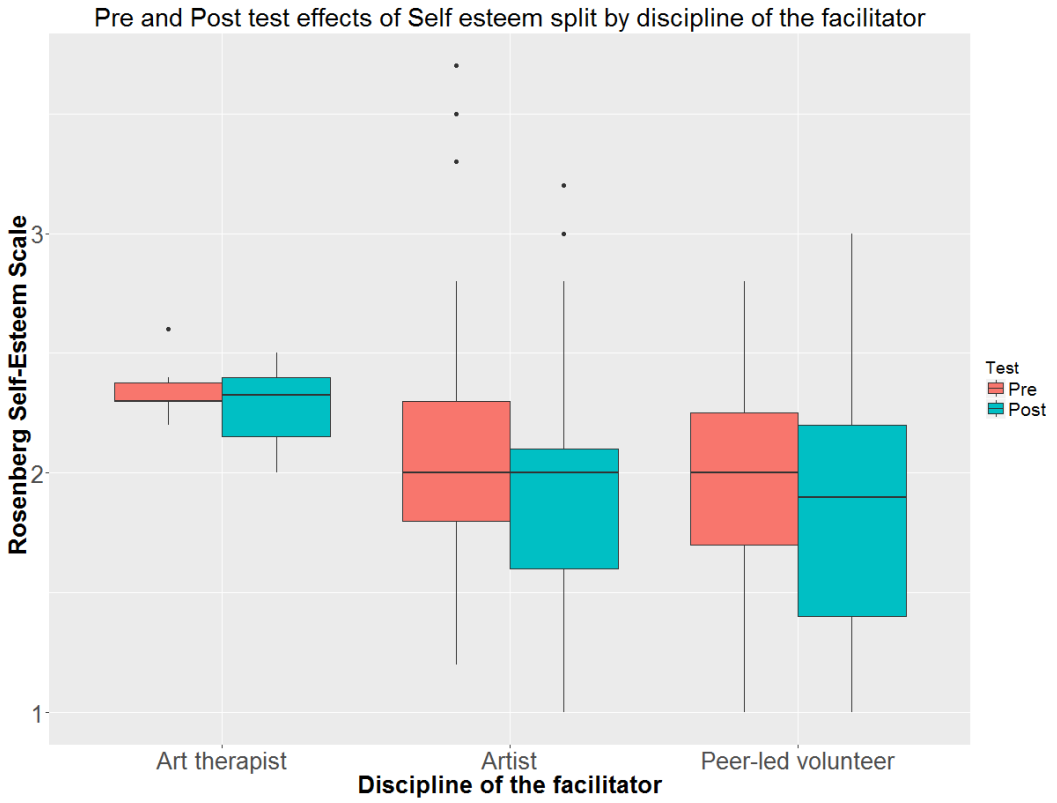


Figure 2 - Box plot on self-esteem scores in discipline of facilitator

Variables	Test	Mean	SD	DF	Sum Sq	F	p-value (one tail)
Discipline of the facilitator:	Pre			2	0.0119	0.042	0.9585
Art therapist		2.35	0.13784				
Artist		2.0544	0.52400				
Peer-led volunteer		1.9913	0.44327				
Discipline of the facilitator:	Post						
Art therapist		2.2783	0.19083				
Artist		1.9268	0.49508				
Peer-led volunteer		1.8510	0.56391				
NOTE: Test is Rosenberg Self-Esteem Scale (decrease in value = increase in self-esteem)							

Table 11:- A visualisation of the discipline of facilitator of the art program.

A Two Way Mixed Factorial Design ANOVA statistical analysis was conducted to test if different levels within each variable had different effects on self-esteem (Table 11). In regards to the discipline of the facilitator, there is significant difference at 90% confidence only. So at traditional 95% confidence level, I conclude that the various facilitator disciplines did not have an impact in the self-esteem scores.

In summary, the results show that there is limited significant difference observed in the variables present in art programs at different organisations improving self-esteem However, it is only significant at the 95% significance level and not significant at the 99% level. Only variable 1 contributed towards the improvement in self-esteem. At 95% confidence level, variable 2 does not have a significant impact. This indicates that the differences in structure of the program had some impact on participants' experience of improved self-esteem, and the variety of facilitator roles did not affect the outcomes of self-esteem.

4.3.5 PARTICIPANTS' EXPERIENCES OF THE GROUP

In the last section of the questionnaire (P4), participants were asked to answer five questions from 'Yes to No' or 'No to Yes' indicating their experience of the art program in relation to communicating and interacting with others in the program. The purpose of this was to investigate if engagement in art activity in a group setting would initiate communication between group members. The results did not show a significant positive change in participants' experiences of group interaction. However, the concept of art as a method of communication and a catalyst for group interaction was explored further in interviews and discussions with facilitators which will be discussed in the following chapter.

Data was collected and tabled and missing values and values marked '?' were excluded resulting in a total of eighty-four valid records (Table 12). In order to determine the significance of the post-test effects, the McNemar's test is an appropriate test used in paired observations with a dichotomous trait and

applicable to 'before' and 'after' designs to test the significance of changes (Lu 2010). In this test, I was interested at the 'discordant' pairs of pre- and post-test observations. The non-discordant pairs are essentially status quo to investigate if there are significant changes in post-test observations. In order to ensure stability of the test, the discord pair samples in total must be greater than 25 (m>25). Since all the discord pairs for Part 4 was 25 or less, a one-tailed binomial test was performed to test the significances of the proportions of the discord pairs, within the McNemar's test framework.

	Discord pairs	n	m	p-value
P4 s1 - Do you find it easy to talk to other participants in the group in the	No to Yes	4	8	0.6368
	Yes to No	4		
P4s2 - Would you confidently strike up a conversation with the person	No to Yes	3	11	0.1133
	Yes to No	8		
P4s3 - Would you find it helpful to talk to someone with the same	Yes to No	5	10	0.6230
	No to Yes	5		
P4s4 - Do you feel awkward/self-conscious in a group setting?*	No to Yes	8	11	0.1133
	Yes to No	3		
P4s5 - Are you often hesitant to talk about your feelings or emotions?*	No to Yes	16	25	0.1148
	Yes to No	9		
***negative scoring**				
Signif. codes: 0 = *** ; 0.001 = ** ; 0.01 = * ; 0.05 =.				

Table 12: Data results of Part 4 of participants' questionnaires in regards to group interaction

The Null hypothesis is that the program does not have a positive effect on the measures. The null hypothesis is rejected if the p-value is less than 0.05. Since all part 4 measures are greater than 0.05, I cannot reject the null hypothesis. The conclusion is that the art program had neither a positive nor negative effect on the measures, indicating that the before and after respondents had no change in

their responses.

It was not part of this research study to determine or investigate preference over any type of program or facilitator discipline but only to find if there was significant difference on the effect of these variables on the outcomes of change in self-esteem and social functioning, thus no further analyses was performed on the available data. The research study was undertaken to highlight the benefits of engaging in creative activity irrespective of type of program or facilitator, and not to compare one with the other. Identifiable categories in the other significant factors of art space, art materials, final product and the social element were not clearly defined and these variables were not analysed in the quantitative phase.

As stated, this is a summary of the analysed quantitative results and I will discuss all these results in conjunction with the qualitative data from the other phases which provide a better understanding and will illuminate both the significant and non-significant outcomes of the study. The aspects of self-esteem, social functioning and art as communication will be explained and synthesised with data from all phases.

KEY POINTS – PHASE 3

- Scales used – Rosenberg Self-Esteem Scale\Social Functioning Schedule;
- Analysis shows a significant increase in self-esteem;
- Significant increase in social relations only but not significant in overall social functioning;
- Variable of type/structure of program had an impact on levels of self-esteem;
- Variable of facilitator did not have an impact on levels of self-esteem.

4.4 PHASE 4 – QUALITATIVE FINDINGS THROUGH INTERVIEWS

In phase 4 of the research project, I interviewed thirteen participants from eight of the programs in relation to their experiences in the art programs they had attended. The interviews were semi-structured and included questions relating to contributing factors of the intervention which were investigated in the previous phases, with flexibility that allowed for spontaneous reflection of individual experiences, and for participants' voices to be heard. The interviews were transcribed and each interview was dated and numbered as Int. #1 to Int. #13, and referenced accordingly in this dissertation. Names of interviewees were removed as per the ethics approval and participants' consent. The data that emerged was subjected to thematic analysis in order to sort data according to contributing factors, and to draw out experiences under each category.

It was proposed that there are many contributing factors that are present in the delivery of arts-based interventions—all of which have great impact on benefits—but that irrespective of the diversity of these factors, the art-making process in itself plays an important role on the outcomes of improved wellbeing. These contributing factors guided the inquiry in all the phases and provided categories for exploration in this phase, that is: facilitator; art materials; final product; art space; social element; and the art-making process. The development of the categories from phase 1–2 has been confirmed through the inductive analysis in phase 4 and converted into themes in this phase. Through further inductive reasoning, patterns and commonalities that emerged within each theme were developed into sub-themes. The data is presented here under the themes explored and sub-themes that were derived from the data analysis, considering participants' experiences that related to that theme (Table 13). I considered the art-making process separately, as during the analysis it was identified that contributing factors were embedded in the art-making process, and there was a crossover of themes in the category of the art-making process. This supports the claim of the art-making process being central to all arts-based interventions.

THEMES	SUB-THEMES	EXPLANATION OF SUB-THEMES
ART SPACE	PHYSICAL SPACE	Practical aspects – good lighting; comfortable chairs; ample table space; storage; tea & coffee facilities. Aesthetics – posters and pictures on the wall; music playing; window views
	THERAPEUTIC SPACE	Private space – safe for participants to talk Rules and boundaries were established in terms of privacy and confidentiality
ART MATERIALS	PROVIDED/ NOT PROVIDED	Costs - expensive if had to purchase on their own Recycled/Donated materials Skill-based classes required purchasing materials
	VARIETY OF MATERIALS	Having a variety and choice of materials Quality, quantity and suitability Challenged creativity
FACILITATOR	NURTURING/ CARING ROLE	Being attentive to the needs of each participant Patient and willing to help
	TEACHER OF SKILLS	The creative skills and knowledge imparted by the facilitator
	GROUPWORK SKILLS	The ability to encourage and motivate the group as a whole and contain confidentiality 'Holding' the space
SOCIALISATION	LOCAL COMMUNITY	Socialising beyond the group Familiar faces in the neighbourhood
	MAKING FRIENDS	Developed long-term friendships that continued beyond the group Feeling socially isolated and actively seeking social connections
	CONNECTING THROUGH ART	Learning a skill to socialise The coming together and participating in a common activity Sharing limited within the therapeutic groups
	MUTUAL SUPPORT	The friends they made provided a support network during difficult times
FINAL PRODUCT	GIFTS & MEMORIES	Sharing and being valued gave confidence A memory of an experience
	EMBODIMENT OF EXPRESSION	Giving thoughts/feelings a tangible form Communicating through the product Being witnessed by others
	EXHIBITED/ SOLD	Pride in the value others paced on the work To be identified as an artist
	PRODUCT NOT IMPORTANT	Process over product

Table 13: Themes and sub-themes identified under these categories.

The observations and the narratives, that, as the researcher I was privileged to witness, of the human experience of belonging and participating in these art groups, were unique to every individual met. I present a number of short case vignettes (pages 120, 131, 135) that provide a snapshot of the experiences of a few of the participants that were interviewed in the relevant categories. The results will be discussed in conjunction with all the preceding data and the literature and its impact on the investigated outcomes in the next chapter.

4.4.1 THE ART SPACE

Participants interviewed talked about the art room firstly in terms of the practicality of the space—such as lighting and comfort, aesthetic features like posters on the wall, and windows with a view—and secondly as a 'safe' space that was private. The sub-themes derived from the analysis were: physical space and therapeutic space. Each will be explored separately before a brief overview of the theme as a whole.

Practical aspects of the physical space that were important to participants were having a room large enough to do their projects, comfortable chairs, good lighting, easy accessibility, and storage facilities to leave unfinished work behind. An interesting aspect disclosed by two participants was the setting of the tables in the room. When participants were new to the group, they were made to sit together, and this encouraged social interaction, whereas others preferred having their own table and more space, and this gave them the option to socialise when they chose to, or focus on their own art individually. Sometimes music was played during the sessions and this fostered more concentration, but in some groups it encouraged conversation about the music being played. If the space used was large enough, other activities like warm-up games or meditation were incorporated. Most participants did not mind that it was a make-shift room and not a dedicated art room. Although they appreciated that one facilitator made an effort to create the aesthetics of the room for each session by decorating the walls and sometimes music was played during the session (Int. #2).

A couple of the participants mentioned that having a window with a view was helpful to distract from what was going on internally and mirrors on the wall were 'thought-provoking in itself' (Int. #2).

The view is just amazing. To have that….especially if you are tired, you could just ponder on your thoughts. You have got that window, and that was really helpful…They have an effect on how you feel. They most certainly do, its new, its fresh, its bright, its warm. It is interesting (Int. #2).

However, ultimately participants felt that it was not about the physical aspects of the room that made the art space appealing, but the people within it and the feelings it generated. All agreed that it needed to be a 'safe' space, which is the second sub- theme in this category, the therapeutic space.

It didn't matter much as long as we were left to ourselves (Int. #12).

It's not just about the room, it's about the people and the feeling (Int. #11).

Participants talked about a 'safe' space in regards to it being a place in which they felt comfortable to talk about their experiences, and said that facilitators played an important role in ensuring that discussions were confidential and privacy was respected.

I can't describe that…and because it is a safe place, it doesn't get overwhelming and then I would just go to the table and ….I would use whatever we need to express what is in our mind (Int. #3).

And it was a very safe space – safe enough to talk (Int. #2).

The overall experience of the art space for participants was the idea of a space in

which they found themselves for a period of time each week, engaging in creative activity, and while the practical aspects of space gave them comfort, it was the 'safe' therapeutic space that allowed for conversations, meaningful experiences and creative learning.

Case Vignette 1:-

A 59 year old woman retired because of ill-health and had the desire to find something different she could do for herself. She had no art background but enrolled in a painting class at the local neighbourhood house. She related that the kindness of the facilitator and the friendly support shown by other participants provided her the space to create and improve without judgement or fear. The art session provided her the time and space to forget everything else and be calm. It gave her something to look forward to each week (Int. #4).

4.4.2 ART MATERIALS

Participants interviewed were asked about the art materials used in the program and the two sub-themes that emerged were the provision of materials and the variety of materials available, and how that related to the engagement of the activity. Each theme will be explored separately before a brief overview of the theme as a whole.

The providing of materials is the first sub-theme and this depended on the type of class and the fees participants paid to attend the art programs. Many of the participants were retired and expressed gratitude that materials were provided as they could not afford expensive classes.

> *I don't get a lot of money so I prefer to use the stuff that was there. Which I think is important too for recycling. So there are two things that I agree with that (Int.#1).*

Those who attended programs to learn a new skill felt the cost of materials was justified and were willing to purchase the materials they needed, as it was an investment in something they would potentially engage in for a period of time. In some of the programs, participants brought in whatever materials they needed to do their own projects in the company of others and for these participants it was the social element that brought them to the groups (Int.#10).

The second sub-theme is the variety of materials that were available. In the programs that provided materials for a variety of projects, participants stated that there was always a lot of choice and reported on how they reacted to the different materials. It was reported that facilitators brought in play dough, objects, cards, crayons, felt markers, fabrics, metal strings, clay, mosaic chips, drawing materials, bits of plastics and recycled materials. Participants were free to make choices and expressed surprise that they were drawn to different materials according to how they were feeling during the process of creating.

> *It might have been the journey about something…and so we might have had a big display of many different bits and pieces that represented that journey (Int.#3).*

The variety of materials provided participants with choice and challenged them to explore, and one participant who used mosaic tiles for the first time said *'it was a good challenge'* (Int. #1). She had also never before used the necessary tools but had learned to in the program, and was happy with the first piece she created, which was a small tile; she then went on to do more challenging projects. Another participant related how the different mediums got her mind thinking and '*it challenged something in you*' (Int. #2). When clay was provided as the medium in one of the groups, a participant vividly described how easily the clay moulded in her hands as if it could capture the memory that was held in her hands, and stated that this had helped her open up, and gave her confidence. When she finally completed the piece, she felt very connected to the finished product and did not care if it was beautiful or not, and that was the best experience for her.

…but the clay…That's when you get your hands dirty you are actually moulding on just a piece of clay and learning….. You can just …And that was the best experience for me (Int. #13).

The provision of art materials differed in all the programs, but ultimately the variety of materials challenged participants' creativity and catered to different experiences within the art-making process.

4.4.3 FACILITATOR

All participants had only positive things to say about the facilitators of the art program. Many viewed the facilitators' role as caring and nurturing, being sensitive to new members and always keeping the group 'safe'. Facilitators were described as being patient, understanding and helpful, encouraging, professional and very creative. Participants reported being encouraged by facilitators' motivation and their love for art. While some reflected that facilitators were highly skilled, with the ability to cater to all levels of skills, they also possessed group work skills and managed rules and boundaries within the group. These characteristics of facilitators as described by the participants were categorised into three sub-themes that viewed the facilitator as: the carer/nurturer; a teacher of skills; and the group coordinator. Each sub-theme will be explored separately before a brief overview of the theme as a whole. The first theme is the facilitator seen in a caring and nurturing role, who guided and encouraged participants through the art-making process.

I enjoy her style. She has got a lot to say about the process. And she is there for you if you need to talk to her. She is very motivated by what she does. She is very caring, creating a nice atmosphere (Int. #11).

Very patient, very friendly. I feel she is very – you know what I mean – like a mother when she have a lot of kids at home at the same time (Int. #9).

The idea of the facilitator being very attentive to individual needs when undertaking that caring role was expressed by participants.

> *She is always willing to help…help you make it look kind of perfect. But at the same time she will say 'you know don't worry, don't stress about it. Just do your thing and take your time' (Int. # 13).*

> *She was really good. She really had to basically hold my hand. She was always positive (Int. #4).*

The teaching of skills was the second sub-theme in this category. Participants appreciated the skills their facilitators possessed and how generously they passed them on. One participant observed how difficult it was for the facilitator to cater to so many different levels of skills in the class but that she had managed it very well (Int. #4). The aspect of sharing ideas and teaching each other was a contributing factor in some of the groups.

Participants reported facilitators having unique skills and treating them as equals. Although they provided them with suggestions and ideas, participants were still left to make their own choices and create their own pieces, allowing participants to enjoy the art-making process.

> *It's nice to have a highly experienced teacher who can see things that you have not even thought of (Int. #7).*

> *And she always shows you. She doesn't tell you how to do it. She doesn't correct anything. She shows you how to do it and…… She shows you the way and talks about and explains why (Int. #4).*

The ability to manage the group with patience and create a 'safe' space for participants highlighted facilitators' group work skills, which is the third sub-theme. One participant reported that being a new member to the group, the

facilitator made the extra effort to make her feel welcome (Int. #9). Participants reported feeling 'stiff', 'uncomfortable' or intimidated by others' skills, initially butthat facilitators and members were always welcoming, supportive and encouraging.

> *Very good. Very professional. Handled the groups very well and was very helpful with one on one when needed (Int. #3).*

The setting of group rules and boundaries were appreciated by participants as it also contributed to the creating of a 'safe' space.

> *…there were boundaries right from the start. So it was very sort of organizedand very respectful (Int. #2).*

The attributes of the facilitator, while categorised into sub-themes as described by participants, were interwoven with each other, such as teaching skills with patience and attentiveness, and being caring and mindful of individual needs and reactions to the group by 'holding' the dynamics of the space. The notion of the facilitator journeying with participants throughout the art-making process was strongly emphasised.

4.4.4 THE SOCIAL ELEMENT

It was evident that most of the participants who attended the programs did so for the social element of belonging to the group. More than half of theparticipants interviewed had gone into the group not knowing anyone, but developed strong friendships with other members after attending for a period of time. Members interacted socially in class over tea and coffee or conversed while engaging in creative activity. Initially they talked about art or relevant creative activities that were happening in the local community, but then it developed into more personal stories about family, children, health and issues they were facing. In terms of socialisation, three sub-themes emerged: socialising in the local

community; making long-term friendships; the role art played in socialisation; and mutual support between group members.

The 'local flavour' was the first sub-theme in this category. The fact that most participants attended art programs within the local community meant that many conveniently progressed to socialising outside of the group, such as meeting for lunch before class or meeting at the local café. Members stated that they lived in the same community and found it pleasant to encounter a friendly face in the supermarkets. A few reported that it was easy to make friends in the group and that living in the same local community made it easy for them to meet for a coffee or go shopping together often.

> *There are two of us that I have become friends with outside of the group. One in particular I see every couple of months and the other one we just bump into each other everywhere we go (Int. #4).*

> *Because we are local we meet each other for lunch before class (Int. #7).*

The local and personal aspect of the small art groups made it inviting to participants. One participant admitted that she would be too scared to enroll in *'those big programs'* and felt that the local programs were better because the members were local and more personal (Int. #4). She felt that she would not like the more structured programs where everyone did the same thing and at a certain time and preferred the friendly atmosphere without the pressure to complete masterpieces, especially when she was doing it for the enjoyment and not to be a fabulous artist.

> *You know the best thing I really appreciate – that the community give us and allow us to do this in the community (Int. #9).*

Making and establishing long-term friendships was a strong sub-theme of socialisation. Some members kept attending the program every term and have

been doing so for two to four years and have become very close friends, supporting each other through difficult times and sharing the good things that happened. Long-term friendships were developed from attending the art program together over a period of time.

> *Sometimes we do more chatting then we do art, but most of the time, often we will just chat. If it someone's birthday, someone will bring something. And the end of every term we start half an hour earlier and we all bring some food. Christmas time we do that. It's social as well which is really important (Int. #4).*

A group participant who had retired commented that it provided her and other members of the group with a social network that they missed from not being in the workforce. It was also that she was exposed to a wider background of people in the groups, as members came from different countries, worked in diverse occupations, and she listened to many worldviews (Int. #7). For one participant who had newly arrived in Australia, the group had become her family, with friends who supported her when her daughter was sick, or called her when she missed a class. They had become such close friends that they went on to organise day trips together. She was extremely grateful for the friends she made in the group.

> *You know these are the only friends that I have in Australia (Int. #9).*

The group experience was also described as being a time to get together for a chat, make something together and have coffee. One participant from the informal craft groups even compared attending the art groups to sitting down at a café with friends for a chat and noted that it cost the same as a cup of coffee as well (Int. #9). Most participants reported finding it easier to make friends in the group.

> *You always make friends in the group. Like you just speak to somebody*

and you get along with them (Int. #4).

When one participant was asked what she felt was the best part of the group, she answered 'Making friends' (Int. #2).

The third sub-theme was socialisation with art being the common thread that connected them. Local community centres offer an array of programs ranging from leisure activities to skill-based classes, but the participants spoke about art being a catalyst for socialisation. One participant said that attending a group that was just talking would be different, as having something like art creates a more light-hearted atmosphere for socialising (Int. #11). Especially for one participant who felt that coming into a new group was daunting, she found it easier to make friends when art was the common factor:

Art helped us relax and it was also kind of that thread that connected us. I wouldn't find ….I don't think so that if I was put in a bunch of other people in a room to just talk I wouldn't be able to open up but we knew…….We are letting go of our stress in that way. And it took us time we didn't just open up the first few days. So the art did help a lot. It helped a lot (Int. #12).

Another participant observed that it was not of any use for her to learn a language if she was not going to travel, and that learning computer skills did not allow for socialising in the class because you had to focus on the computer skills, and that art- making was more suitable as it allowed her to socialise (Int. #7). This is another example of art being the common thread.

Another participant related how the art was the factor that connected them in the group and beyond. In the interviews it was discovered that many participants had been attending classes for a few years and a couple of them for over ten years.

However, even when participants reached a certain level of skills and were hardly learning anything new, they still attended classes for the company or just to paint together and helped each other when necessary. One participant related how she just got together with other artists in a group and painted together, even though they all used different mediums and were at various levels and skills (Int. #6), art being the common thread that brought them together.

The connections made in the art groups created support networks for participants, which brings us to the final sub-theme in this category, that of 'mutual support'. The majority of the groups reported sharing about relevant art projects and creative activities, or discussed ideas and provided feedback or encouragement on projects they were working on. However, members also shared about health, their children or grandchildren, recipes, celebrity gossip and other light conversations. Support and encouragement among group members was common, whether it was support for their creative projects or support in their personal lives. One participant felt that she needed that encouragement and validation, and would consistently bring the items she made to the group sessions or take a photo of her latest creations to send to her friends for their feedback (Int. #9).

Another participant revealed how sometimes when she was satisfied with something she painted, others would say *'Oh you have done really well'* and she felt they were being genuinely supportive (Int. #4). She added that this happened often in the class when they gave each other encouragement or suggested something without being negative.

> *And of course you get feedback from everyone there and that gave me confidence (Int. #2).*

One participant related how she initially found it very difficult coming into a new group and had found that at times she did not feel like attending, but somehow the support of the facilitator and her fellow members encouraged her to keep

coming.

> *Coming together. Sometimes in the morning I don't even feel like getting out of bed but I was looking forward to coming here. So it was everything. It was the company, it was the people, talking, making something and eating together (Int.#12).*

This support in class sometimes went beyond the sessions and group members even offered each other practical support when someone was ill by visiting and assisting with the grocery shopping.

> *And you get to know the people and you sort of…and everyone has times – go through rough times or something and you are able to support them…it's not the same as family but you still listen. And when good things happen, everyone is there to support you again and encourage that too (Int. #4).*

> *It's the support that people give other - that they will go and visit, they will do the shopping, they will pick up things. In other words there is a real care for each other (Int.#7).*

One of the groups had a group member who loved cooking and the members would meet at her place weekly and she would cook them all dinner. Another participant observed how her group members supported each other.

> *They have become very close friends and see one another after class and all the rest of it. They have connected through the class. And other people – they come and they are very supportive with one another and it's really nice to see all that. Like one of them just gone through a health scare and all that kind of thing and they talk about all their issues, it's a very friendly group (Int. #6).*

Participants also reported that at times there was no socialising and the class was silent, concentrating on their projects. Another reported that even if some members did not socialise much, they still felt supported by them.

> *But even though some people didn't talk a lot, they would just come in and support (Int. #11).*

For two of the groups, the block of sessions ended without the opportunity to continue on to the next term due to a lack of funding. As a consequence, one group started a closed Facebook page so that members could keep in touch and another group initiated hiring a community space to continue to meet up weekly as an informal art group.

> *Coming together and also about being creative and using that as a therapy. And also to support each other. If anyone wants to talk about anything, we are open (Int. #2).*

The four sub-themes in this category collectively portray the social support networks that are built around group members. To further strengthen the social element of participating in these art groups the following case vignette (2) describes the experience of one participant.

Case Vignette 2:-

A participant in her 50s arrived in Australia as a migrant and found herself quite isolated. She discovered a craft group run at the local community centre and although apprehensive about being discriminated against or not creative enough, she plucked up the courage to join the group. When interviewed she expressed how she was overwhelmed by the welcome she received by the centre and other group and that it felt like a very 'safe' space. After attending several terms of the program she stated that the group is now her community and her family. She even went on to join other groups in the centre and gained enough confidence to teach one of the sessions (Int.#9).

4.4.5 THE FINAL PRODUCT

Participants reported producing a lot of artwork and creative pieces in the programs and some of them proudly brought the items they made to the interview. Under this theme the identified sub-themes were: gifts and memories; the product as an embodiment for expression; works that were exhibited or sold; and the product not being as important as the process.

It was evident in the interviews that participants were both satisfied and surprised at what they could create. One participant stated that the mosaic piece she made into a kitchen grocery reminder blackboard made her proud saying *'it's sitting there and it looks good. I also feel proud of myself that I have done it*' (Int. #12). She also made another thing and kept it as a reminder of how she felt making it: '*so I keep it there and I remember the class and think it was a good time' a*nd *'makes me feel like I can do something good and makes me feel worthwhile*' (Int. #12). For one participant having the final product was very important to her because she was pleasantly surprised at her own creation.

> *It's just like once you have finished it, you think….wow I didn't think that I could do this. Like M (referring to another participant) she has done clay work and I haven't. And I was like – over the moon. I didn't think I was capable of doing something like that. I was really happy (Int. #13).*

Participants discovered their ability to create things. This realisation, the compliments they received from others and having their skills validated gave them confidence. One of the participants reported that she had built enough confidence in her creative ability from attending classes that she ventured into teaching one of the classes on her own. She was surprised at her own achievement and reported wanting to create another project that she could teach to the class.

> *I feel 'Oh my God' I do something I am proud of myself because I am not*

shy now. I push myself to do it. And if somebody ask me something I can tell him or tell her the answer - I try to help her. And we all finish the class it's beautiful (Int. #9).

I think it's feeling better about myself, feeling a bit more confident about who I am, confidence to be by myself, confidence to be myself (Int. #2).

In the groups that were more craft focused, participants were more likely to keep the items they made for themselves or give them away as gifts. Participants created household items for friends and birthday cards they sent away. The responses they would get from recipients were always surprising and the participants reported feeling valued when friends gave positive comments. One participant had brought a whole bag of items she had completed in the groups to her interview, and very excitedly showed them to me, explaining how each was made and what she did with the final product (Int. #9). She presented an accordion card that she had made for her English teacher, a bracelet she had made for her daughter, a table mat for herself, an origami box in which to put chocolates for a friend, a journal, and a host of other jewelry and cards she will gift to friends. Another participant related how she made cushions for her father, some household ornaments for her mother, and a large hand-stitched quilt for herself (Int. #5).

Receiving validation and praise from others within and outside the group further nurtured participants' confidence.

Well, I feel that it's just getting me going and making me feel really good and I can do something. That I can do something that I enjoy doing and other people when they see it, they really enjoy it and they say to you 'I couldn't do that myself' (Int. #5).

Another sub-theme that emerged was the final product being an embodiment of an experience or expression. One of the participants related how the art material

took the form of what she was thinking in her mind and communicated it to others.

> *Out of my mind and onto the paper or onto the creation or whatever else we were making ….which helped me to release it from my mind from that moment on (Int. #3).*

> *And the other thing I found was sort of being able to put it out…..And not have to carry that burden so much by yourself…It was out there for others to see and hear and accept and so it lessened the burden (Int. #3).*

One participant related how she felt that she needed to take one of the pieces she created back with her to be able to recollect the experience and share that with her counsellor. She felt it aided their therapeutic conversations and communication, as it represented her experiences.

> *Yes, I was able to talk about what happened through those pieces…when…it was sort of like my memory bank to have that there (Int. #3).*

The third sub-theme was that when participants' final products were exhibited or sold in public spaces, it gave them a sense of pride. In the more skilled-based programs, participants were encouraged to either exhibit their work in the centres' annual events or assisted to have their works up for sale in local community cafes and galleries. Some had even proceeded on to selling their work independently, with one participant reporting one of her pieces was acquired for the Botanical Gardens Collection (Int. #7). When participants were asked how they felt about selling or exhibiting their work, one participant reflected: '*well someone likes my work enough to put it on their wall at home'* (Int. #7).

> *Now I get my satisfaction from the painting that's finished or particularly when it sells. I've got to have a sense of achievement as far as I am*

concerned (Int.#7).

In programs where the medium was painting, participants worked on their projects over time and produced less work. Some took commissions to paint for family and friends and one particular person accepted a formal commission. Being identified as an artist was a big deal for one member and this was when the facilitator commended her for her ability to paint. When she realised she could paint it turned her from feeling inadequate to learning how to express herself creatively.

> *…turned me around from thinking I was inadequate. That I could paint, that I knew how to mix colours and that I knew my colours and tones and that (Int.#6).*

The final sub-theme was the importance of the process over the product. When one participant who sold a number of her paintings in a year was asked if she painted with the intention to sell, she replied '*No I paint because I want to do it and I enjoyit'* (Int. #7). This was re-iterated by some of the other participants who felt thatthe process was more important than the final product. In fact, when facilitators focused on the therapeutic process of creating art, the final product was at times discarded. For example, pieces created out of play dough would be destroyed after they were used for discussion and feedback in thegroup.

One participant reflected that although some of the craft projects taught in the group were simple enough for kids, ultimately it was the art-making processand coming together with others that was important to her, and the product created had less importance (Int. #9). Case vignette (3) further strengthens the notion of coming together to learn a skill within a socialenvironment.

Case Vignette 3:-

A 72 year old woman had to retire early to care for an ailing family member and needed an activity that was mentally stimulating in a different way. She found a skilled-based class at the local centre and developed her skills in painting and drawing. When she gained enough skills to sell and exhibit her work that gave a sense of satisfaction and pride that others valued her work. She continued to attend the classes, even when she gained enough skills for the friendships and the company. She said she painted because she enjoyed it (Int.#7).

4.4.6 THE ART-MAKING PROCESS

Participants were asked how they felt during the process of engaging in the creative activity and the experience of the art-making process. Some of the responses were that they felt relaxed, focused, absorbed in the activity, calm, like a child-like experience, emotional, proud and it felt good. Responses were categorised into four sub-themes: the ability to play and be creative again; communicating their experiences and emotions in a tangible form; a time for relaxation; and the satisfaction of being able to achieve something (Table 14). While some of the sub- themes overlapped with others, each will be explored separately in reference to the art-making process.

THEME	SUB-THEME	EXPLANATION OF SUB-THEME
THE ART-MAKING PROCESS	PLAY & RE-IGNITING CREATIVITY	- Permission to play as an adult - Being creative in their younger years and having the opportunity to be creative again
	EMOTIONAL COMMUNICATION	- Time to think and reflect - Communicating through the artwork
	RELAXATION AND 'TIME-OUT'	- Relaxing - A meditation - A distraction from the stresses of daily life.
	SATISFACTION/ ACHIEVEMENT	- The challenge and satisfaction of learning something new

Table 14: Themes and sub-themes identified under the art-making process

The ability to play and be creative again was the first sub-theme. After attending for a period of time, participants felt that it had allowed creativity back into their lives again. Participants related how they had been creative in their younger years but were made to feel uncreative, or commitments did not give them the time, and they had found they wanted to re-connect with their creativity.

> *Like Oh I am creative. Cause I had been, but I believe I was born creative. And I have been made to think that I wasn't creative at all. I was you know, I was not worth anything. So it was a really big thing to even just to consider being creative again. It was huge (Int. #2).*

Many participants spoke about being creative earlier in life and wanting to get back into being creative, or found that attending the art groups had re-kindled their creativity. These participants stated that it felt good to be creative again. Participants also reported the engagement in creative activity as being something they loved doing, an activity to enjoy and a time to play.

> *I feel fantastic! I feel like I am spend time with something I love it (Int.#9).*

> *The reason to do it is for the enjoyment. And yes I get a lot from It as well. And I am doing things I never would have done. But I am basically here because I enjoy it in lots of different ways and that's the whole purpose of it (Int.#4).*

Two participants described how the creative process made them feel like a child again and compared art-making to play.

> *Sometimes you need to feel you are a child and experience that in a free way (Int.#11).*

> *It brought out the child in me and things I would have done in my*

childhood (Int.#13).

The participant described her relationship with clay as a medium for expression and stated that playing with the clay would take her back to being a child again and she could imagine herself in a very peaceful place which made her very calm.

> *For me I find that doing things with the clay and making this also it sort of…..It brought out the child in me and things I would not have done in my childhood and also doing things that I like because my clay was about beach because that is where I go to find my peace (Int.#13).*

Art as a means of communication was the second sub-theme. This aspect of the process that was brought up by participants was the emotional outpouring of feelings and experiences onto paper, into a tangible form that was a way of communicating with themselves and others. These participants described their experience very vividly as a time to rationalise and think.

> *I think it can be quite emotional, and often sometimes that people were in tears. But you can be almost……..for me it was quite relieving….like a physical relieve...it was time to work through it and leave it behind you…that's was how I sort of saw it…… a sort of reflection time and also bound in with time to…..time to ponder, don't know if that's the right word, time to sort of dissect something....you are allowing the look at it from sort a bird's eye view and then go….ok do this is what it was……Ok I allowed it….okay I have seen it and that was what happened and I can put it all behind me now (Int. #2).*

One participant felt that it was important for her to keep her hands busy and not just to be talking at all times, but still felt she was communicating. She added that being able to express herself through the art was the most important aspect of the group:

…expressing yourself through art. It's just wonderful. And it does bring healing and confidence. It's also a sense of peace as well (Int. #11).

Participants stated that sometimes having the art materials in the room distracted from the awkwardness of a new group setting. One participant said that just sitting and playing with the play dough gave her something to do with her hands while they were talking or thinking.

There were these mediums for you to use, to express yourself, I guess or to…. If that helped you to sit…..like we played with play dough a lot… that just something to…just that play or just something to do with your hands while you sitting thinking about or talking about by yourself…kind of therapeutic in itself (Int.#2).

Some participants had reported the art-making process was communicating their personalities to others and that every piece was different but beautiful. One participant recalled the art-making process as a dialogue with herself and another participant said it was a time to think about things and come to terms with it.

Yeah, just thinking about particular things….for me it was trying to come to terms with things. Just finding a way of being comfortable with it and moving on, rather than having it affect me emotional all the time, psychologically, so it was time for me…like me time…..like ok that happens, sometimes like self-talk and everything…time to get back to myself…Like these bad situations might draw you away from who you are, yourself, it sort of takes away all your time (Int. #2).

It enables that thought process, to be able to change your mind, to think around (Int. #2).

One participant compared making art to being in a counselling session where participants just talked continuously without having time to reflect

but with the art-making process, there was time for 'lots of reflection, lots of delving into your own thoughts and being able to let go of it' (Int. #2).

Having time away from stressors and to relax was the third sub-theme in the art-making process. Some of the participants reported that engaging in the creative process provided them with relaxation, calmness and distractions from the worries they were experiencing at that time. Participants also related how this 'time-out' gave them the opportunity to reflect and think through the art they produced.

For me, it was very relaxing. And like when you stay focused on what you are doing and when you are trying to do it…you forget everything else and you are just in your own little world at that time and that was a really good feeling for me (Int.#13).

It feels really good. I feel very satisfied afterwards. And I feel quite calm too. I don't have to think about everything else that is going on. I don't have to think about all the medical problems. I don't have to think about the doctors. I don't have to think about everything else. I can tune out that is my time. I don't have to think about all the rest of the rubbish (Int. #4).

Time away from all the stresses of life was re-iterated by other participants and a time to tune out.

It's just to me like meditation. It just sort of clears your head. It fills it with something really nice. It's problem solving too. And it sort of keeps your thoughts (Int. #6).

One person recommended attending art classes to another friend, who was going through the loss of a loved one, as an activity '*to take your mind off things*' (Int. #1) because she said she knew how much it benefited her and wanted to bring others who needed it. For others who were more socially isolated for different

reasons, it gave them something to participate in as well as be with others.

> *…and it's a lot better for me to do things outside and that so then I am not all just sitting at home doing nothing….. and I love coming here, because you are doing a lot of things and there are a lot of lovely people here (Int. #5).*

Participants also felt that making a commitment to attend a class each week forced them to make time for themselves to be creative, because as much as they wanted to do art at home, they would get distracted with home and work commitments. Another participant related how she would be so busy with commitments and would find excuses not to attend, but when she did, she found it relaxing.

> *And it does make me draw and paint and do things I otherwise wouldn't do (Int. #6).*

Other participants re-iterated that the art-making process was a distraction from their busy and stressful lives, or a healing process.

> *But you are so focused on your painting that you lose yourself in that painting. I can …I find that incredibly at the end exhilarating because you have cleared your mind of all the stuff that clutters up your normal daily living (Int. #6).*

> *I feel it's good for me to do artwork. It's cathartic. I feel it's healing me when I am doing it. Hmmm…I feel alive (Int. #11).*

> *I think like I can create and I can just not think of the bad things. No, no…. I left all the bad things behind my back and do art (Int. #9).*

A few participants recalled that they were going through a difficult stage in their lives

and needed something creative. For example, one woman was forced to retire from work to care for an ailing family member, and felt she needed to engage in something that was mentally different, and found an art program that allowed her to develop skills in painting and drawing as well as provided a distraction from her caring role (Int. #7). One woman who was suffering from depression and anxiety as a result of separating from her husband, as well as dealing with chronic back pain, found that engaging in an art group made her feel better and connected her with people again. Another participant who retired due to ill-health found she needed '*something for me'* and '*something I had never done before and something I really wanted to do'* (Int. #4).

> *Because it let my feelings out when I am doing sewing and everything (Int. #5)*

One participant described the first twenty minutes of the class being busy with chatter while everyone was setting up, until everyone gets lost in their work, and then for the next two hours *'they have left everything behind and given themselves time to paint'* (Int. #10).

The fourth sub-theme is the recognition of participants' own achievements. A growing sense of achievement while participants were engaged in the activity was quite apparent, especially for those who doubted they could be creative in any way, as articulated by a few of the participants. This recognition of their creativity and skills that was brought into awareness during the art-making process was ongoing.

> *I feel like I am achieving something….just like remodelling yourself I suppose. Especially for me, having chronic pain and depression, I feel like that shift from being worthless to being worthwhile again is there and for me is really important. And it doesn't matter what it is and how it is. It's yours and you have made it (Int. #1).*

> *It's just like you have finished, you think….wow, I didn't think that I could do this....And I was like over the moon. I didn't think I was capable of doing*

something like that (Int. #13).

There were participants who specifically attended the art program to learn a skill and were more focused on the aesthetic aspects of the process and producing the best results. Two participants felt that even if they were not always making amazing pieces they were learning through engaging in the process. For some the process of learning itself was described to be enjoyable.

> *Yeah each one is getting better. Every time you do something, you learn something different. And you learn as much by doing something wrong as you do by doing something right…and you don't learn if you don't do it (Int. #4).*

> *Because I quite enjoyed doing it and there is something else. But each thing I have done in whatever it was, I have learned something ……. I learned I can actually do things (Int. #4).*

However for a few of them, even if only learning a skill was the intention at the start, the art-making process took over and led them in a different direction.

> *You just become so flexible you let it go. The end product is very different from what you have started. …And you are still happy because it is your own creation (Int. #12).*

The data showed that some of the earlier categories that represented the contributing factors were also embedded in the art-making process and influenced participants' experiences. This very important aspect will be discussed in the following chapters. To sum up the data I would like to include a response from a participant. When asked to give three words to describe her art-making experience, her answer was proud, happy and learning (Int. #8). This chapter provided results from all four phases of the research, which will be synthesised in the last three chapters.

KEY POINTS - PHASE 4 RESULTS

- Participants attended the art programs to connect with others, to re-kindle their creativity and as time-out from stressful lives;
- The art space needed good practical aspects of comfort and aesthetics but also a 'safe' space for expression;
- Participants expressed gratitude for art materials provided because of expense and appreciated having choice as it challenged them;
- Completed products were kept by participants, given away as gifts, exhibited or sold and communicated messages to others;
- Facilitators of the art programs took on the roles of nurturers, a teacher of skills and holding the group safe;
- The social element of attending groups was apparent and long-term friendships were formed with mutual support between members;
- The art-making process was described as providing satisfaction, a time to relax, a time to play and to communicate within oneself.

5. SYNTHESIS

In this study, while data was collected separately, each phase informed and improved subsequent phases. The results from the four phases of data collection outlined in the previous chapter have provided evidence to support the contention that engaging in creative activity in community-based art programs can result in increased self-esteem and social inclusion, with some qualifications. In this chapter, the results are integrated and the findings are discussed in relevance to the literature and the research question. I will also examine why all aspects considered did not demonstrate change in phase 3 through further exploration of the qualitative data in phase 4. With the intention to make a comparison of diverse arts-based interventions that exist in the broad field of *arts in health*, I reviewed the literature to discover several contributing factors in the delivery of arts-based interventions being attributed to impacting and producing positive outcomes for those who engaged in the creative activity. Through this lens, and exploring these same factors throughout the research process, I specifically investigated art programs in the community in Victoria to determine if these identified factors were present, and how they contributed to outcomes. The themes and sub-themes derived from phase 4 demonstrate common elements that exist in all programs, mirroring the contributing factors in the literature. Before discussing in depth how the contributing factors and the art-making process contributed to the positive outcomes demonstrated as a result of attending these programs, I will first introduce the unique benefits of community-based art programs that emerged in the data.

5.1 COMMUNITY-BASED ART PROGRAMS

In this research study, I elected to investigate art programs delivered in community settings in Victoria as it is an area of arts in promoting health that has not been subjected to vigorous research. I suggested that these art programs have the potential to achieve the same outcomes reported in the broad field of *arts in health*, because of the presence of the same contributing factors and, more importantly, they provide the opportunity for engagement in the art-making process. Additionally, there were several

unique advantages that emerged in the data, that are highly relevant to the research question, and that seek to highlight the benefits of these art groups delivered at local community centres, neighbourhood houses and other organisations, such as the 'local flavour' of these community-based art programs.

A very strong advantage of art programs being delivered at local neighbourhood centres is that members live in the same community and are more likely to extend their socialising beyond the group because of the practical reason of proximity. While we all belong to many different kinds of communities, the communities in which we live give us a greater sense of belonging and a fuller sense of community (Horsford et al. 2014). In the current study, several participants reported meeting up for coffee with other members or encountering another friendly face at the local supermarket, meeting for a meal before the class or gathering for a drink after. One member even cooked a meal for the rest of the group every week (Phase 2 reports). In the UK, 'Art and Mind' community art projects gave people a greater sense of belonging in community and created new friendships (Stickley & Duncan 2007). Stephenson (2013) discovered that older adults were at risk of being isolated and participation in art programs offered them opportunities to remain connected to peers and community. As one participant brought up, as older adults who have left the workforce, having this social network was necessary to their wellbeing (Int. #7).

Skill-based community art groups provided opportunities for older adults to improve or learn a new skill. Considering that the average age of participants in the current study was fifty-seven, learning a new skill could be intimidating, and not surprisingly, many older adults shy away from enrolling into a college or technical school to learn a new art or craft. These skilled-based community art programs were more accessible when they were offered in the local community centres and neighbourhood houses, where people met members of the local community and the smaller numbers allowed for more personal attention, as well as familiarity with staff and facilitator. One of the participants in the current study who was interested in learning a skill had chosen to attend the local art programs as the space was less formal and there was no pressure to excel, only lots of encouragement (Int. #4). Furthermore, in the current study, participants exhibited or

sold their work in local art galleries or cafes (Phase 2 reports). Given the opportunity to learn a creative skill and showcase it in the local community, participants re-align their self-image to other members, friends, family and the wider community, who recognise their talents (Spandler et al. 2007). Participants view themselves in new light and feel a sense of achievement and satisfaction to have their paintings viewed in public or validated by others (Int.#7; Int.#6).

Art therapy groups or arts-based interventions in health frequently cater to a targeted clientele, especially if it is specifically funded for people affected by a certain illness or social problem, such as cancer or domestic violence (Borgmann 2002; Mills & Kellington 2012) and receive funding for a limited period of time. However, the continuity of the group—no matter how beneficial it may prove to be – may not be funded for subsequent terms (Vick & Sexton 2008; Phase 2 reports). One of the organisations' program manager in the current study reported that after a few terms it was difficult to obtain external funding, as funding bodies preferred to fund new programs (Phase 1 reports). While fixed-term arts-based interventions produce positive results, it is time-limited and does not cater to those living with long-term conditions or having ongoing social issues (Holford 2011). In the literature, participants in short-term interventions have reported that while their self-esteem improved when attending the art groups, those improvements were not maintained after the groups finished (Perry, Thurston & Osborn 2008). Unfortunately, restrictions on funding only allow for short-term interventions (Richardson et al. 2007) while most community-based art programs offer continuity to participants. The informal art groups in the current study were delivered at very low cost to participants and run by volunteers, making it affordable to many, ensuring stability and sustainability. Holford (2011) suggests that longer-term art groups led by volunteers are invaluable to individuals who have to live with long-term conditions and are a cost-efficient way to provide assistance based on mutual support and empowerment. Alternatively, in the current study, two of the fixed-term art therapy groups had great impact on those that attended, but participants interviewed expressed a reluctance to end the experience and disappointment that they could not attend more sessions on an ongoing basis. In fact, participants of these groups felt the need to maintain their new found creative activity and friendships, and independently sought

ways to do this by starting a Facebook group and initiating an independent, informal creative group among themselves (Phase 4 interviews). Art programs in the community did not target a specific group of people and reached a diverse selection of people in the local communities. However, the current study did note that some of those who accessed these art programs did have ailments, long-term illnesses and social problems. I interviewed one participant affected by severe back and chronic pain, another person with a physical disability, socially isolated individuals and people dealing with loss and grief. These individuals found the groups to be very therapeutic indeed, and chose to continue attending because of the reported benefits they were reaping from it, through difficult times in their lives (Phase 4 interviews). Art groups in the community offer long-term interventions to support individuals to cope with their issues, build support networks, and provide an indirect method of seeking support (Perry, Thurston & Osborn 2008). Low-cost programs ensure sustainability for organisations to keep delivering art programs and provide continuity of its benefits to those that attend. Furthermore, as the communities in Victoria and wider Australia become more racially and ethnically diverse, making non-discriminatory social connectedness a high priority, and delivering culturally inclusive programs, have become more relevant.

The community centres, neighbourhood houses and the organisations that participated in the current study received some state funding and various other funds, but were also creative in sourcing funds through community fests and sales, or in-kind donations of materials. Whilst stretched for resources, these organisations found creative ways to offer these programs to the community because they were personally convinced of their benefits. Most community centres received a general budget to provide a range of programs to the local community, but were flexible in the type of programs that they offered. Their reasons for including creative programs in their timetable varied from community demand, centre traditions and program managers' personal experience with art and its benefits. Their intuitive planning of programs offered considered community members' financial status, needs and preferences, and catered to these. Hence, the range of therapeutic art groups: more expensive skill-based paid-facilitator art programs to the informal peer-led volunteer art and craft groups (Phase 1 Reports). Unfortunately, because of limited funding, most community centres did not have the resources to

rigorously evaluate their programs. Evaluation and research were funded by government bodies for large community projects, such as a mental health recovery art program (Wreford 2010) and a three year evaluation of three community-based art projects (Kelaher et al. 2012; Johnson & Stanley 2007). In the current study, informal surveys and evaluation questionnaires were collected by some organisations, and participant feedback was a significant influence in future programs delivered at the centres, but most did not result in any formal publication that could contribute to the overall claim on the benefits of participating in creative activity.

In order to understand the relevance of self-efficacy and social connectivity as part of attending arts programs, it is important to recognise the motivation for attending the programs in the first place. The interviews provided some insights into these various reasons as to why someone chooses to attend an art program—regardless of the aims of those that deliver the program or the organisations that fund it to achieve very specific goals. In the current study, participants attended classes for a variety of reasons—to manage their anxiety, help them cope with stress, to socialise, get them out of the house to do something fun, relaxation and calm, all of which are pre-requisites to good health (VicHealth 2010). I will show in Chapter 6 how some of these aims were achieved by participants while engaging in the art-making process. An unspoken advantage of participation in these art programs was that most of the participants actively sought them out, and so were already committed to fully engaging in the activity and not referred or recommended to participate in therapy because they were diagnosed with an illness or deemed to have a social issue. Participants did not feel compelled to attend weekly and did so because they enjoyed it. Zeigler-Hill (2013, p. 2) states that individuals who desire a high level of self-esteem will actively seek out strategies and activities that enhance these feelings, and making it available in local communities provides that opportunity.

In the wider social arena of social capital, social cohesion, community resilience and social inclusion is encouraged and promoted by the Victorian Government. The 2015 Victorian Government's Strategic framework, that utilised the social cohesion model, focused on connecting communities and working in partnership with community

organisations to build community strength through shared interests and mutual self-help groups. Being able to maintain a sense of community at an older age promotes wellbeing through keeping people connected to peers and community (Stephenson 2013; Noel 2008). Developing artistic interests helps one to participate in community (Reynolds 2012) and community provides rich sources of social support, ideally within the same geographical location (Moody & Phinney 2012). Additionally, when participants' works are displayed and viewed by the public it gives them the sense of belonging to community, which can be an empowering experience for them (Vick & Sexton-Radek 2008).

One of the main goals of providing art programs in many of the organisations in the current was to elicit social interaction and build social supports to foster community participation in the local neighbourhood (Phase 1 reports). Members participated in annual fests or craft shows that involved whole communities. Some groups were involved in charity or fund-raising projects as a group, such as the previously mentioned ANZAC day poppies and mosaic mural at the local health centre (Phase 4 interviews). In one of the groups that catered to vulnerable and isolated newly migrant women in the community, the aim of the program was to connect women and empower them to support one another. Delivering art-programs in the community addresses building social supports at the root of communities by promoting socialisation and mutual support (Ryan 2004).

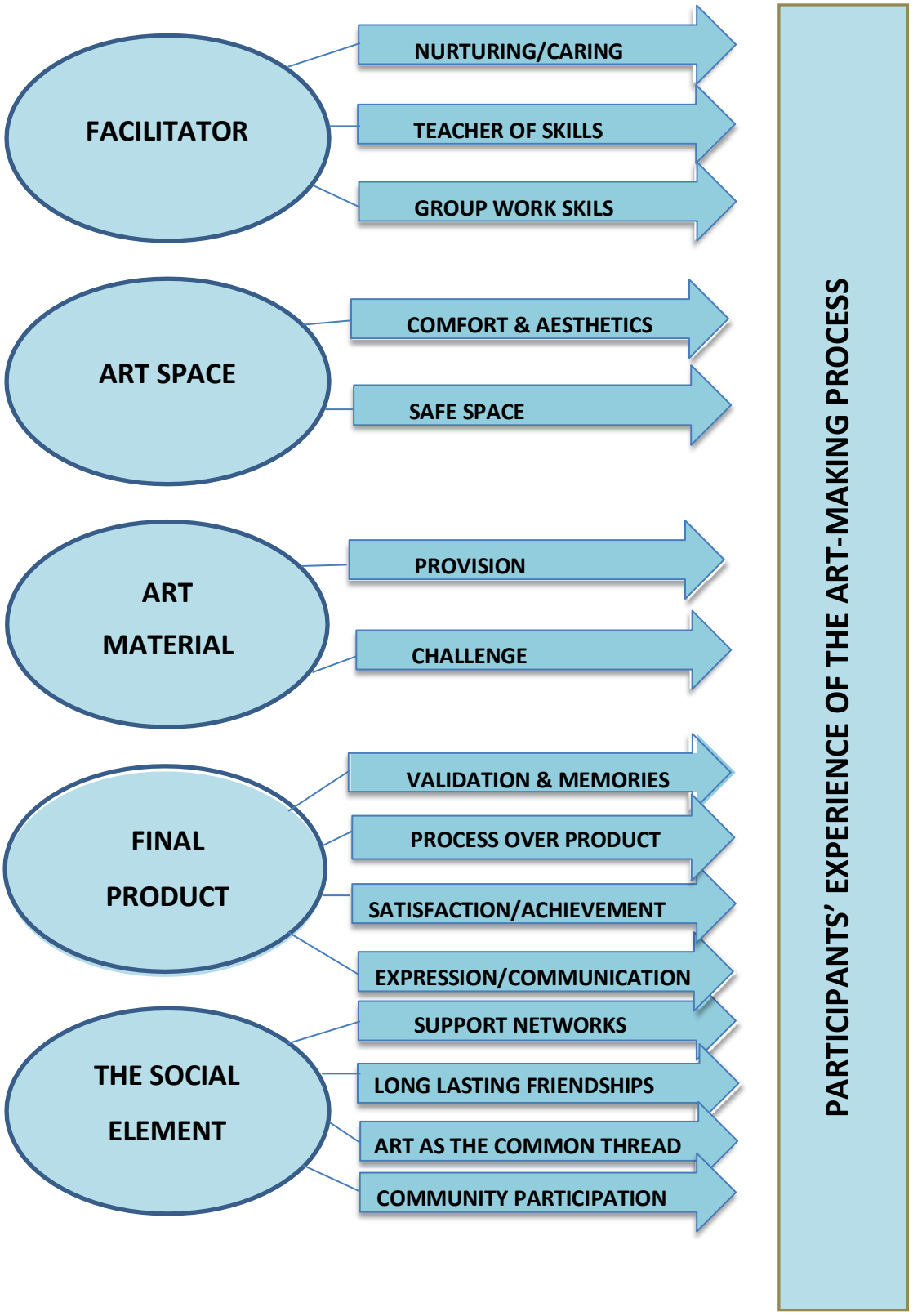
Most arts-based practitioners will agree that the art-making process of creating is inherently therapeutic (Reynolds 2000; Sandmire et al. 2012). Most group work facilitators will agree that participating in an activity within a group that allows for sharing a common interest, witnessing and supporting each other, will naturally elicit social connections (Gitterman 2006; Preston-Shoot 2007; Yalom 2005). These two aspects that are crucial exist in art programs in the community, with the added advantage of passionate creative facilitators, of learning skills and space for recovery. Delivering art programs in local community centres also has the advantage of long-term involvement for participants, building social connections as well as keeping them engaged in community, as recognised by the Australia Council of the Arts (Wreford

2010). The literature reported that good self-esteem and social connections is an antidote for the onset of ill-health and mental health issues (Prescott et al. 2008; Reitzes & Mutran 2006; Stinson et al. 2008). If low self-esteem is a psychological risk factor to ill-health (Stinson et al. 2008), then having opportunities in local communities to increase residents' self-esteem and social support can only improve the wellbeing of whole communities.

5.2 CONTRIBUTING FACTORS

Both in the literature review and data from participating organisations in the current study, it was evident how diverse and differently structured each art-based intervention was and that it would be impossible to generalise, compare or research the programs as being effective without discussing the contributing factors present in the programs individually. Indeed, these provided the basis of the themes that emerged from phase 4 and were further categorised into sub-themes during the analysis. By exploring each theme separately in relation to the literature, I will provide a clearer understanding of how these factors may have affected participants' experiences and influenced positive outcomes. Figure 3 provides a visualisation of how the contributing factors impacted in participants' experiences.

FIGURE 3 - CONTRIBUTING FACTORS AND ASPECTS OF THESE FACTORS THAT IMPACT ON PARTICIPANTS' EXPERIENCES OF THE ART-MAKING PROCESS



5.2.1. FACILITATOR AS CARER, TEACHER AND FELLOW ARTIST

The role of the facilitator is a strongly debated factor in the literature on art therapy in reference to the importance of the therapeutic alliance and the therapeutic use of art materials (Harnden, Rosales & Greenfield 2004; Van Lith, Fenner & Schofield 2011). It is stressed here that the importance of the skills the art therapist brings to the therapeutic alliance, and the knowledge of the use of art materials, is invaluable. However, in the current study I focused on the role facilitators played in each of the programs and how different characteristics and skills of the role contributed to participants' experiences. It is not unusual for professionals of various disciplines to use the healing power of the arts, such as film makers, counsellors, artists, relief workers and even ordinary people (Kapitan 2014). The disciplines of the facilitators of the art groups in the current study varied from artists and art therapists to volunteers who were retired teachers, artists and crafters, which reflected the diversity of disciplines of facilitators found in the literature (Argyle & Bolton 2005; Van Lith, Fenner & Schofield 2011; Allen 2008; Marshall-Tierney 2014). While the literature also revealed facilitators from other disciplines such as occupational therapist (Harris 2008), counsellors (Whisenhunt & Kress 2013), nurses and artists (Thomas et al. 2011), for the purpose of this research project, the focus is on the qualities and skills of the facilitator. It is important to state here that this research is not claiming preference for any one discipline over the other, but discusses the various unique skills and attributes each contributed to the process as drawn from the literature and the data collected.

Establishing a therapeutic alliance is a key role in facilitation, and Van Lith, Fenner and Schofield (2009) reported that facilitators needed to have an understanding and valuable insight into the phenomena of participants' experiences of art-making in order to provide support and guidance through the process (Van Lith, Fenner & Schofield 2011). The importance of the facilitators' ability to build trust and acceptance was also identified as crucial to allowing group participants to be confident in disclosing personal feelings (Harnden, Rosales & Greenfield 2004),

This idea of building trust within thetherapeutic alliance is further emphasised in the literature when working with vulnerable clients—such as suicidal adolescents (Harnden, Rosales & Greenfield 2004) and clients in mental health recovery care (Van Lith, Fenner & Schofield 2011)—to ensure respect and confidentiality through encouragement and imparting hope within a safe relationship.

These essential nurturing features of establishing and maintaining a safe relationship between a facilitator and participants within the groups was evident in the current study. Most of the facilitators, regardless of their background, demonstrated insightfulness in their observations of participants' experiences and the transformations that took place when they were focused on the creative activity (Phase 2 reports). The detailed caring observation of the group made by an artist facilitator showed considerable insight into the therapeutic nature of the creative process, which demonstrated understanding of participants' fears, hesitations and progress (Phase 2 reports). Facilitators were insightful of the significant role they played in the participant's experience, and instilled the basic characteristics of a therapeutic alliance, which is building trust and acceptance (Harnden, Rosales & Greenfield 2004) and providing support and guidance (Van Lith, Fenner & Schofield 2011). This trust allowed group members to be confident about sharing their experiences, and the support and validation they received through this continued to build their self- esteem. Only one of the organisations' program managers expressed concern regarding the limitations of facilitators who did not possess clinical training related to effectively managing challenging behaviours or more complex social issues that presented as part of their clientele (Report #5). Such concerns reflect the other side of the debate in the literature regarding the ability of the facilitator to maximise participation in the therapeutic process (Ball 2002; Banks 2012). In the current study of community based art programs, participants came from all walks of life, and included some who had health and social issues. However, the aim of these programs was to provide opportunities for improved overall wellbeing through creative engagement and not to address more complex issues that can be supported by other professionals in their lives.

Another important characteristic of a facilitator, as noted by Van Lith, Fenner and Schofield (2009), is a deep sense of wanting to assist and the desire to make a difference through creativity (Lamb 2009). While this was not frequently mentioned in the literature, these same characteristics were reported by the art group participants in the current study when they described the dedicated volunteers that led the art groups, who were passionate about their craft and volunteered with the desire to share and inspire others to be creative. The facilitator's caring and nurturing role, as described by participants in the current study, made them comfortable in unfamiliar groups and gave them the confidence to challenge themselves in the activity, gradually building their self-esteem (Phase 4 interviews).

Researchers have used the analogy of facilitators taking on the role of fellow travelers in the creative journey, when they described how peer support workers delivered art programs alongside participants, being aware of the struggles as well as the possibilities of the art-making experience (Allan et al. 2015; Allen 2008). This journeying with participants has also been found to establish equality in the challenging creative process, making it less intimidating for members in the group (Marshall-Tierney 2014). Engaging peer workers as mentor facilitators contributed to beneficial outcomes for a group of mental health patients, as facilitators were seen as fellow companions pursuing and enhancing their artistic skills (Howells & Zelnik 2009), which similarly occurred in the volunteer-led art programs in the current study.

Some of the facilitators who were volunteers leading the participating art groups were amateur crafters and artists, but at the same time were local community members who experienced the same struggles, joys and stresses of everyday life, which were reportedly shared extensively in the groups. Participants described how they encouraged dialogue among group members through sharing, feedback, suggestions and ideas about the art-making (Phase 2 reports; Phase 4 interviews) creating an atmosphere of a collective group journey. Geller and

Greenberg (2012, p.69) state that the building of a therapeutic alliance is created when the therapist or facilitator is a companion in the participant's journey of self-discovery. The volunteers became peers in a collaborative creative journey of art-making and drawing, as opposed to expert-teaching-novice or observer-watching-creator. Because the imparting of skills was not the primary focus of these volunteer-led groups, participating collectively and on an equal basis contributed towards building confidence and pride through creative engagement. Group participants reported being treated as equals and not being corrected or told what to do but instead facilitators generously shared their skills and provided suggestions while always allowing participants own creativity identities to emerge (Int.#4). It is also probable that the absence of authority and the sharing of a collective journey in these volunteer-led groups created an atmosphere of comradery which contributed to the reported social interaction of group members**.** The structure is similar to self-help groups, based on the concept of mutual aid where group members benefit from giving and receiving help and that provide a network for social connections (Horne 1999), which I will explore further when discussing the social element of art-making.

The advantage of engaging professional and amateur artists as facilitators to deliver therapeutic art groups has been established in the literature; for example, in the case of hospitals in the UK that increasingly supported the role of the arts in promoting health by bringing artists into open studios in the hospitals (Graham-Pole 2001; Greaves et al. 2012). Graham-Pole (2001) stated that the most natural caregivers are allies in assisting patients to reclaim their inherent creative geniuses. Argyle and Bolton (2005) state that the acquisition of skills from artists give participants confidence, increased self- esteem and a sense of achievement. In the current study, professional skills complemented the facilitator's caring role which Kramer (2000) describes as being able to balance the act of not interfering with participants' work but offering technical advice and encouragement.

A few of the art groups in the current study employed professional artists to

teach specific skills, such as Chinese Brush Painting or Botanical Art in watercolours. The aim of these groups was to increase self-confidence through developing artistic skills and cater to supporting artistic communities by providing opportunities for serious artists to access programs that enhanced their skills (Phase 1 reports). Participants who enrolled in these skill-based groups reported being able to learn a new skill at their own pace or rekindle an art they had indulged in during their younger years. Participants repeatedly stated that they were proud of their achievements and reported learning skills gave them the confidence to challenge themselves and were appreciative of both the teaching skills and patience of facilitators (Phase 4 interviews). The enhancement of positive attributes by teaching skills and building individual strength builds upon a person's ability to overcome difficulties and learn decision-making processes (Lewis 1990). Contracting professional artists with specific artistic skills had numerous advantages, as some of these facilitators indulged in their own creative upskilling and pursued their interests externally, which in turn were passed on and benefited the participants in the group (Phase 2 reports). Having skillful facilitators with the added advantage of a caring nature gave participants the benefit of learning a new skill without the pressure of performing or being expected to produce exhibition-quality pieces. In the current study, although some of the skill-based groups were about learning and teaching skills, facilitators were mindful that individuals learned at their own pace and allowed for flexibility as long as participants were satisfied with their own work (Phase 2 reports). Many of us would have had our inherent sense of creativity squashed by our teachers in school, but given the opportunity to create and make art in a less threatening environment re- ignites our creative skills (Geller & Greenberg 2012, p. 219). The facilitators' considerable insight into the challenging creative process, coupled with the technical knowledge required to teach skills, contributed markedly to participants' building of confidence in their abilities and individual strengths.

Community organisations in the current study delivered art programs as part of their aim to encourage socialisation, and facilitators additionally played a role in

achieving this goal (Phase 1 reports). It was found that these facilitators encouraged socialisation in all their groups—whether it was lively chatter, getting feedback and advice from other participants about their work, or more serious sharing of emotional experiences the art-making may have evoked (Phase 2 reports; Int.# 2).

While the literature on *arts in health* programs has not highlighted the facilitator's contribution in encouraging social interaction, there is substantive literature on group work that has always placed the responsibility of managing group dynamics— including social interaction—in the hands of the facilitator (Yalom 2005). Participants interviewed in the current study recognised the ability of facilitators to monitor group dynamics and encourage communication, as well as maintain equal participation by all members of the group (Int. #3). Facilitators were also reported to possess skills in making the less confident group members feel comfortable and practiced non-discrimination, creating a safe space for social interaction to take place (Int. #11).

All facilitators bring unique skills into the program, be they artistic skills, group work skills or therapeutic skills. Artistic skills are not solely attributed to the professional artist or the trained art therapist but also to many peer-led volunteers who are retired art teachers or self-taught talented artists. The satisfaction of acquiring skills in the process had the potential to increase their confidence to take further challenges towards building self-esteem. In the analysis of the impact on building self-esteem and encouraging social interaction by the three different types of facilitation of art groups in the current study—that is art therapy, skill-based and peer-led—the variable of facilitator discipline did not have a significant impact on the outcomes reported. In analysing the qualitative data, it revealed that facilitators influenced the outcomes of increased self-esteem through the teaching of skills that increased confidence and the building of trust that supported disclosure and acceptance. While not discounting or minimising the therapeutic role of the therapist, or the highly skilled talents of the professional artist, it is important to acknowledge that the caring insights, the

unselfish sharing of skills and talents, and the ability to manage group interaction were demonstrated by all facilitators. I have highlighted above these various characteristics embodied by the facilitators of the art groups in the current study, who, although from various disciplines, have proven to contribute notably to participants' reported increased self-esteem.

The trained and skilled art therapist is a valuable asset to the art-making process as a whole and reaps the numerous benefits the literature on art therapy has shown, particularly when working with people who have specific emotional and mental health issues (Van Lith 2015). However, the literature has also provided insight into the valuable skills that are imparted by facilitators of other disciplines which was further substantiated in the current study. Perhaps more importantly in the context of community-based art programs, it is not the facilitator's discipline but rather the characteristics of facilitators, such as insightfulness into the creative process, the desire to assist and the imparting of skills, that created an alliance and a space for participants to build confidence and support networks that improved their self- esteem. Facilitators also similarly envisioned their roles from encouraging creative activity, setting group rules and boundaries, inspiring others, observing change to those who focused solely on teaching skills. It was not surprising to find that all the interview participants regarded the facilitator's role as crucial to their creative experience. This supports Lamb's (2009) assertion that an arts intervention can be carried out by any practitioner who has the desire to make a difference through creativity and does not need to be an art therapist or possess an art background. More importantly, the therapeutic alliance is created when a facilitator is committed to being with the participants in their healing process (Geller & Greenberg 2012).

5.2.2 THE ART SPACE AS A TRANSITIONAL SPACE FOR THERAPEUTIC OUTCOMES TO OCCUR

The importance of the art space both in the literature and the current research, relates to two types of space: the physical space and the created atmosphere of

the therapeutic space that is embodied by the group and the facilitator. In terms of physical space, this can be further divided into practical aspects and aesthetics of the space. Allan et al. (2015) stated it was important to have enough physical space so that individuals could choose to work in a private space or interact with others. Creating a space that was suitable for art-making with objects and music (Malchiodi 2007) and one that was charged with artistic energies (McNiff 2004) are also important. Practitioners have been known to convert clinical environments and counselling rooms into spaces that were pleasant and offered physiological comfort as these less stressful environments aided in promoting wellness (Goelitz & Stewart-Kahn 2006). Facilitators expressed that creating the space for an art program was an act of making a significant place for the group to be invited into, making participants feel valued (Leibmann 1990, p. 80).

In regards to practical space, some organisations in the current study advocated for funding to provide dedicated art studios that were fully equipped with easels, sinks and storage for unfinished work and these aspects were greatly appreciated by participants as well as practical aspects of lighting and comfort (Phase 2 reports; Phase 4 interviews). Fenner (2011) and Liebmann (1990) stress the importance of the physical space in which the art-making takes place and that practical aspects should not be overlooked. Alternatively, many community centres did not have the luxury of providing an exclusive art space for creative activities, which meant that multi-functional rooms had to be converted weekly to cater to the delivery of art programs at their centres. This also had the cumbersome disadvantage that materials had to be stored away and taken out for each session, thus time and effort was spent in altering the space for the creative engagement. However, as Malchiodi (2007) suggested, art spaces can be created with objects and music. Art program facilitators in the current study made the effort to create these environments by decorating them with posters or images and some played music during the sessions (Field notes – Phase 2), which can be considered as an act of caring and valuing participants' attendance in groups (Liebmann 1990, p. 80).

While makeshift spaces have been known to be used effectively for arts-based interventions, such as kitchen spaces in wards (Luzzatto 1997) and school counselling rooms (Cook & Malloy 2014), the benefits of having participants engage in creative activity in a dedicated art studio is strongly supported in the literature. Allan et al. (2015) promoted the use of art studios for art therapy rather than clinical spaces and in his practice chose to use community art studios when working with adults with severe mental illness, as it gave them artistic identities that increased their confidence. There is extensive literature that supports the benefits of providing people with artistic identities, rather than stigmatising them with labels of illnesses or social issues in terms of raising their self-esteem (Lamb 2009; Lentz 2008)— providing art programs held in art studios as compared to clinical spaces addresses this preference. This is reflected in a comment made by one of the participants in the current study who stated that it made considerable difference to her confidence to be acknowledged as an 'artist' (Int. #6). Allan et al. (2015) further observed that the art studio was an 'artistic sanctuary' for his patients. Similar to providing a 'sanctuary' to his patients, art studios in the community provided participants in the current study a temporary space or 'sanctuary' away from the daily stressors of life (Phase 4 interviews).

While the importance of the physical space in providing comfort and an aesthetic environment is mentioned in the literature and appreciated by participants in the current study, interviews revealed that participants did not place much importance on the physical space 'as long as they were left on their own' (Int. #12). On the other hand, the idea of the second type of space, that is the created therapeutic space, was more frequently mentioned and appreciated. This aspect of therapeutic space or transitional space has been broadly explored in the literature, indicating that facilitators held the responsibility of creating that space through containment (Luzzatto 1997) and providing a safe space that helped group members relax and express themselves (Lipe et al. 2012; Allan et al. 2015). Providing a 'space and a place' for clients to explore feelings and examine their problems to arrive at a better understanding of their situation, is a part of social work practice (Bogo 2006, p.64). This also suggests an interdependency of the

two contributing factors of facilitator and art space.

This safe and therapeutic transitional space emerged in the data in every phase of the current study. Centre managers of the participating organisations acknowledged the need to provide a welcoming atmosphere and an environment where participants felt confident and relaxed (Phase 1 reports). Facilitators ensured group rules and confidentiality were adhered to (Phase 2 reports). Participants described their space as being a private space and a space that was their own (Int. #12; Int. #2). Facilitators revealed that they consistently endeavoured to create a space that was accepting, friendly and non-threatening and participants recognised that it was the facilitators that created the atmosphere and held the balance of it being structured so that it was 'safe' but flexible to allow for social interaction (Phase 4 Interviews).

In my discussion on the role of facilitators, I indicated that facilitators played a part in encouraging social interaction within the group by placing tables to face each other to facilitate conversations, but were aware it was confronting for new members to the group (Phase 2 reports). Depending on the goals of the art program, I observed that in the informal art groups, members were seated in a circular arrangement that was more conducive to socialising (Field notes – Phase 3), indicating facilitators making conscious efforts in utilising the art space to encourage socialisation within the group. However, while the facilitator plays a role in encouraging interaction and holding a 'safe space' for exploring connections, the full potential of mutual support can only be developed by the group members themselves (Steinberg 2004, p. 3).

While it is not possible to define a direct link between the art space to reported outcomes in the current study, it is evident in the above discussion that the art space created played an important role in participants' ability to fully engage in the art- making process and the group interaction. This transitional therapeutic space allowed for inner healing to occur, the 'safe space' that allowed for personal discussions to take place, and the space that inspired participants to let

go and be creative (Phase 4 interviews). It was also extensively described by participants in the current study as a space to escape from the chaos of daily life; a space that was comfortable for socialising to occur; a space where art and creativity is the common element in the room and where no distinctions of age, gender, race or professional status distract; a space that is different from the therapy room in a wellness centre or the counsellor's office that has expectations for one to contribute to the intervention; and a space where they put aside everything else in their lives and made time for creativity (Phase 4 interviews), again reflecting Allan et al. (2015) idea of the art space as 'sanctuary'. All these revelations of participants' reflections on 'space' were related to their experience of engaging in the art-making process, which I will explore further in Chapter 6.

In the current study, the evidence of the dedication of those who plan and deliver art programs at these centres, in regards to generating a space for their clientele to derive the most from their art-making experiences, was recognised as a contributing factor for positive outcomes to occur. Participants who found themselves in that space for a period of time and surrendered to the art-making process reaped the benefits that art 'space' had to offer. More importantly spaces were created by the conscious decisions of facilitators and the presence of participants that embodied the space.

5.2.3 ART MATERIALS PROVIDED CHOICE AND CHALLENGED PARTICIPANTS

There is sufficient literature that supports the concept of materials used in the delivery of art programs playing a very important role, especially in regards to facilitators' knowledge about the different art mediums and their suitability to specific clientele and purpose of the intervention (Malchiodi 2007; Snir & Regev 2014). Providing a variety of materials challenges participants to create something with their own hands and encourages them to explore boundaries that take them beyond their comfort zone (Stephenson & Orr 2013; Eckhoff, Hallenback & Spearman 2011). This challenge was likened to the experience of changing and developing (Corem, Snir & Regev 2015; Eckhoff, Hallenback &

Spearman 2011). The scope for participants to choose the materials they are inclined to work with, and making their own decisions in the process, are likened to skills of problem-solving and making choices in life (Guttman & Regev 2004; Gussak 2009). Even when participants are initially nervous and apprehensive about doing art with unfamiliar mediums, taking risk and exploring new possibilities is part of the process, and when they begin to feel comfortable with the medium, they develop a sense of ownership and empowerment (Wilson 2002).

The data collected in the current study did not provide much indication that the type of art materials played a very important role in the delivery of the art programs as compared to some of the literature, but the idea of challenge and choice were sub- themes that did emerge. The variety of choice in the provision of art materials motivated participants' thinking and the challenge of using materials that are unfamiliar. This idea of being challenged was re-iterated by participants in the current research, who stated that having a variety of materials challenged their thinking and mind set, and by experimenting with unfamiliar materials, they 'learned as much by doing something wrong as they did by doing something right' (Int. #4). Additionally, the role of art materials was very much entwined in the creative process, as participants experimented and strived to conquer the challenge of using unfamiliar materials, and in that process building confidence in their abilities.

In the current study, apart from the art therapy groups that acquired funding to provide a variety of art materials, most of the other groups had limited materials. In fact, in some groups participants simply brought in the materials they could afford or were more comfortable with using, and joined the class for the social element or to be in a creative space away from the chaos of daily life. Liebmann (1990, p. 76) adds that even the decisions of participants to be involved in these groups have numerous benefits, such as deciding to attend, their level of participation, choice of materials, choosing to share or socialise, or how much effort they put in producing a piece of work—all these encourage autonomous

functioning within the group, but also provide rehearsals and practice for life beyond these groups. In the current study, in the informal groups each participant worked on a different project and participants reported that this gave them the opportunity to share skills and an opportunity to experiment with new ideas and materials (Phase 4 interviews). It also encouraged mingling and interaction among group members, as one participant had described that they were constantly curious about other members' works and circulated around the space to share ideas and experiment with each other's mediums (Int.#12). It is obvious in this exploration of art materials as a contributing factor, that there is an interdependency of the social element, coupled with group dynamics, and that they are all embedded in the art-making process. I will further explore the concept of art being the catalyst of social interaction later in the discussion on the art-making process.

The type of art materials provided in the different art programs that participated in the research was very diverse and could not be clearly categorised to statistically analyse any kind of influence of the different mediums on participants' experiences. More important than the use of sophisticated art materials (Tate & Longo 2002) was the availability of choice and unfamiliarity of the medium that challenged participants, rather than the type of material itself, and confidence increased as challenges were faced. A quantitative analysis on the impact of the different mediums on outcomes was not performed and this may be a consideration for further research.

5.2.4 THE FINAL PRODUCT AS AN EMBODIMENT OF EXPRESSION, VALIDATION AND PRIDE

It is not uncommon for art therapists to give more prominence to the creative process and not place importance on the final image or product created (Penzes et al. 2014; Sandmire et al. 2012). However, Kahn (1999) advised that the importance of the final product should not be under estimated, as it is a contributing factor to the whole intervention and process, and Franklin (1992)

states the completed product is a powerful tool that validates the person's uniqueness. The final product has been described in the literature as a representation of the creator's achievement and validation of their creative skill (Thomas et al. 2011; Allan et al. 2015), the embodiment of thoughts and feelings in a tangible form (Florsheim 1955; Van Lith, Fenner & Schofield 2009; Hyland-Moon 2004), and a means of communicating a message to others (Kelaher et al. 2014). These same themes emerged throughout the current study and were very much entwined in participants' experiences of the art programs.

A sense of achievement and pride was extensively articulated by participants in the current study, as well as portrayed when they proudly presented the items they had created in the art sessions in their interviews, and excitedly explained how each was made and what they intended to do with each item (Field notes – Phase 4). It was evident in their sharing how proud they were of their achievements, and reported being surprised at their own ability to create things that were appreciated by others. Items gifted to friends that were welcomed and displayed in their homes provided validation of their talents (Phase 4 interviews). According to the literature (Franklin 1992; Drapeau & Kronish 2007), self-esteem is the belief in one's own qualities and strengths. When participants' talents in the current study were validated by others and the products they gifted received appreciation, this increased confidence in their own ability, which can boost self-esteem. Through the process of support and validation by others, the individual has the ability to see his or her own value in being able to gift what they create, resulting in increased self-esteem (Brandler & Roman 1999, p. 5).

The importance of the final product as a sense of achievement and an embodiment of an experience is further developed when participants are given the opportunity to exhibit their work in public places (Lamb 2009; Moody & Phinney 2012). There is evidence in the literature that describes the benefits of exhibiting work produced in the art sessions (Kelaher et al. 2012; Thomas et al. 2011; Leichner, Lagarde & Lemaire 2014) when sufficient skills were acquired and participants felt confident in doing so. Allan et al. (2015) demonstrated this with a

group of adults with long-term illness when work exhibited promoted recovery and emphasised their strengths rather than their illnesses. This new identity of 'artist' improved their engagement in the community that validated their talent and skill (Allan et al. 2015) and resulted in increased confidence and motivation. Many community-based art projects often engage participants to create art that addresses relevant community issues that culminate in public exhibitions (Moody & Phinney 2012), and artists involved in community projects gain self-esteem by having the public see the work they produce (Leichner, Lagarde & Lemaire 2014). This can be a potential weapon against stigma (Lamb 2008; Lentz 2008). Just as Dissanayake (1988) and Florsheim (1955) have stated, it is part of our human nature to make our ordinary daily things special, and that we do this by giving emotional experiences, thoughts and feelings a tangible creative form to share with others.

Exhibiting work at their local cafes or exhibitions was highly encouraged and supported by facilitators and centres of the current study. This was also evident when participants had their works sold; as one exclaimed, 'Well someone likes my work enough to put it on their wall at home' (Int. #7). Receiving validation for their creative talents had a positive effect on their sense of identity as artists and at times 'a much needed sense of achievement' (Int. #7). We develop self-respect in terms of how others treat us and evaluate us (Campbell 1995, p.42) and feedback from others helps to form self-identity and feelings of stability (Cohen & Syme 1985). One of the craft groups had participated in a group to create poppies for an ANZAC community event display and another group produced a group mural to be displayed in the community centre. This public recognition of their creative skills gave them a sense of pride and the opportunity to contribute a valued role in charity work and participate in community, both of which has the potential to increase a person's self-esteem (Reynolds 2000). Campbell (1995) states that the identities and fulfilment of every individual is grounded in participation in community as we all social creatures.

Another important aspect of the image created or artwork produced has been

about giving thoughts and emotions a tangible form, which has been reported both in theory and practice (Florsheim 1955; Guttmann & Regev 2004). Participants' creative works embodied difficult emotions externalised during the art-making process (Van Lith, Fenner & Schofield 2009) or discarded ritually onto a tangible form (Hyland Moon 2014). The benefits of giving an emotion a concrete existence was that it helped to define a sense of self (Lamb 2009) and provided an alternative perspective to the experience (Collie, Bottorff & Long 2006). Sometimes the product created can also be a positive experience, and the importance of that final product remains a constant reminder of what it represents, offering continued support and comfort (Perry, Thurston & Orsborn 2008).

Similarly, a participant in the current study vividly recounted her experience of making art as having to carry a burden by herself and then being able to put this into the art form. When others witnessed the created image, 'It was out there for others to see and hear and accept and so it lessened the burden' (Int. #3). In one of the groups, participants created art objects from playdough, reflected upon them in groups and were provided feedback, but the completed pieces were then recycled, which supports Van Lith, Fenner and Schofield's (2009) idea of ritually discarding an experience. One participant vividly described her extensive creation of a mosaic and clay sculpture that embodied her feelings during the process and revealed that for her 'it does bring healing and confidence' (Int. #11).

Whether participants engage in a reflective process within the art session or not, the experience embodied in the art image or product created is preserved and can be revisited at a time of less vulnerability, or shared with someone being 'able to talk about what happened through those pieces' (Int. #3). This quiet revelation can provide deep awareness to the individual about his or her own distressing thoughts, happy memories and intense experiences, or even communicate distressing fears and anxiety to those close to them (Phase 2 reports). In the current study, it was reported how members were able to take home images they created as an aid of communication to initiate difficult

conversations with family members (Phase 2 reports). Participants also took their finished products to counselling sessions, as they found that it aided their discussions or prompted the memory of their experiences (Phase 4 interviews), which borrows from object relations theory in psychotherapy that states the product created is a person's self-representation of his or her traits and abilities (Ahles 2004, p. 42). Sometimes the image created is simply a permanent reminder of a memorable holiday or event that constantly communicates this feeling back to the creator. The final product created allows the viewer, counsellor, family member or the artist themselves to take in what is being communicated through the image or product in all its essence. The concept of the final product being a means of communication is very much embedded in the art-making process and will be further explored.

The importance of the final product created in the art groups of the current study, whether completed or unfinished, discarded, gifted or exhibited, served as a reminder of achievements, a validation of talents and a means of communicating personal experiences to others. While it is produced during the art-making process, the tangible form possesses the potential to be beneficial beyond the process itself.

5.2.5 SOCIAL NETWORKS FOSTERED FRIENDSHIPS, PROVIDED SUPPORT AND ENCOURAGEMENT

The quantitative results showed a significant increase in one aspect of social functioning, that is social relations, but there was not a significant change in the other aspects of social functioning, such as social isolation, pro-social and recreational activity. Upon reflection on the data collected in phase 4, it is likely that most of the participants already had established social support networks and an active social life before attending the art group during the period under investigation and measures did not reflect an increase in scores over the short period of time. As some of the group members had been attending the art program for a number of years, social connections could have developed over

this time, thus the scores did not show a significant change within the period of time researched. If those that had participated in the research period started from a point of limited social supports, it is likely the results may have been different.

Although the increase in social functioning did not meet statistical significance, the qualitative data collected in the interviews with participants strongly highlighted the social aspect of attending art groups. As uncovered in the interviews, it was generally related how the groups gave participants the opportunity to make new friends and foster long-lasting friendships (Phase 4 interviews). The socialising and friendships developed in the groups was consistently apparent in my direct observation of the groups, reported in the discussions with facilitators about group members (Phase 2 reports) and disclosed by participants themselves. I personally witnessed the evident comradery and social interaction that took place among members of the art groups during the art sessions (Field Notes – Phase 3). Most knew each other by name, excitedly shared the projects they were working on with each other, enquired after each other's health and families, and displayed a sense of caring for one another (Field notes – Phase 3). Centre and program managers disclosed that there was always laughter and chatter overheard from the art room during the sessions (Phase 2 reports). Participants reported making new friends in the art groups, spending time together outside the group, organising group events and celebrating special days of members during the art-making sessions (Phase 4 interviews). The social element of art programs in the community was clearly a recurring factor.

Building social support networks has been identified as a pre-requisite to mental wellbeing (VicHealth 2013) and having social resources 'reduces the need for professional intervention' (Horsford et al. 2014, p. 78). The inter-relationship between self-esteem and social bonds has been highlighted by Stinson et al. (2008) in their study of the social model of health that stated low self-esteem greatly affected the quality of one's social bonds and together increased poor

health. With the growing evidence that good social relationships are a major determinant of health, White (2006) stated that art programs should use creativity to enhance social relationships.

In the current study, while all participating organisations identified building social networks as one of their goals for delivering art programs and all participants acknowledged the social aspect of attending these groups, there were several sub- themes in the data that reflected this social element of participating in creative activities. These were support networks, building long-lasting friendships, participating in community and being with like-minded creative people, with art being the common thread. The element of 'support' was frequently articulated when participants described the relationship they had with other members of the group, were overwhelmed by positive responses about the work they created (Int. #9), the encouragement they received when things became challenging, and the care that was demonstrated when one member was struggling through a difficult time (Phase 4 interviews). Kawachi and Berkman (2014) state that social support includes emotional support, socializing or relaxing together , confiding in problems and gestures of affection – all of which were reported by participants in the current study.

There are reports in the literature of arts-based support groups delivered to those dealing with an illness such as cancer (Oster et al. 2006), mental health conditions (Van Lith 2015) or struggling with a social issue such as homelessness (Thomas et al. 2011), in order to address the lack of social support networks that may have collapsed in those difficult times. However, it has also been noted that, while these support groups provide opportunities for engaging with others who share similar issues, participants have noted that these connections do not transfer beyond the short-term period when they were part of that group, and members dispersed, resulting in missed opportunities to nurture long-term friendships (Perry, Thurston & Osborn 2008). Additionally, delivering specific support groups identified a person by their illness or social issue which can be a hindrance to their confidence in interacting socially, as the stigma associated with

this may sometimes fuel discrimination and hinder a person's social integration (Lamb 2009). In the current study, some groups catered to people struggling with a specific issue, and one participant from the group reported that the friendships she made in the group did not transfer beyond the group, as members did not want to share the same issues outside the group or did not feel comfortable sharing outside the 'safe and confidential space' (Phase 4 interviews).

In contrast, long-term friendships were apparent in many of the art groups in the current study. As stated earlier, many group members attended these art programs term after term and some have been attending for years, providing the time for nurturing and establishing long-lasting friendships. The participants themselves described how they had come into the group not knowing anyone, or just one other person who may have introduced them to the group, and that they had made friends relatively easily as members were always welcoming, supportive and encouraging (Phase 4 interviews). As opposed to the group forming on the basis of illness or social issue, for some of the programs art was the common thread that brought a group of people together. It is also interesting to note that among the mix of participants who attended the art groups in the current study, some individuals were dealing with self-disclosed health issues like chronic back pain and depression, and social isolation, and the community-based art groups provided them both practical and emotional support (Phase 4 interviews). Just as participants reported initial conversations were around art and activities then progressed into more personal sharing, Gitterman (2006) explains that group members test other members' genuineness by sharing less threatening and safe issues, but when support is gradually received, they risk more personal sharing.

In addition to the delivery of non-specific support groups, the notion of art as the common thread of bringing a group of people together was described meaningfully by one facilitator in the current study who stated 'because art is related to the deepest part of self' (Report #7). In the literature, art was found to be a language that transcended cultural barriers and a means of communication

(Dancevic 2005; Davis 2010). Communities in the state of Victoria consist of migrants from many different cultures, and assimilating into a culture can initially be quite daunting and difficult, especially if they were not fluent in the dominant language. The art programs in the current study catered to diverse ethnic groups, and in one group a participant described how she had built her social network through joining the art group in her local community centre. She reported that the friends she made have become her 'family in Australia' (Int. #9).

Social connections can potentially be achieved through meaningful engagement in a host of community projects, recreational groups, sports and cultural events, with creative activities that embody aspects unique to the activity. When the common denominator in a group of people is art, the socialisation within the group proves easier to progress further beyond the art session, as it is easier to maintain friendships through shared interests (Reynolds, Nabors & Quinlan 2000). For example, some participants compared their counselling sessions to the artgroups stating that just talking about emotions does not help and makes it more confusing, whereas having the balance of doing art was helpful (Phase 4 interviews). It was stated by some of the organisations that social interaction was the aim of the program, especially as an opportunity to meet like-minded people, or encourage socialisation through a shared activity, and art programs were delivered as part of their social inclusion initiative. Gitterman (2006) states that when members are given the opportunity to participate in collective interests and mutually satisfying activities, it contributes to building mutual support. As an added advantage, engaging in art is a very inclusive activity, unlike sports or physical activity where certain people, such as the elderly or physically disabled, may not be able to participate and as one participant noted, you can still engage in conversation while doing art (Int. #7).

As previously mentioned, most research conducted studies over limited periods of time, covering the intervention but seldom covering what happens to participants after they exit from the program, or if the social connections they established continued to flourish. In the current research, I had a glimpse of

possibilities of how social networks built during a short-term intervention can have long-term effects. When funding only allowed for one block of sessions for some groups, this did not hinder members to become more creative about how they fostered these new friendships, as well as continue to nurture their new found interests for their wellbeing.

There are many reasons why someone chooses to join an activity, whether it is to be with like-minded people or to learn a skill in a group setting, and in the current study many participants disclosed that it was a desire to pursue something creative. In the more skilled-base groups, less socialisation took place as some of the participants enrolled in the art programs specifically to learn a skill and already had existing social networks. They were also focused on reaping the most benefits from learning skills as they were made to pay higher fees for the professional artists that facilitated the classes. Interestingly, while a few initially signed up to learn a skill, still many continued to attend the art group for the company and the friendships even when they stopped learning new techniques, as people are comfortable associating with others who engage in similar activities and develop common ideas and ways of doing things (Davidson 2015)

A good social network is linked to one's self-esteem and confidence (Reitzes & Mutran 2006). As one participant reflected, the group helped her to make a commitment to do something regular outside of the house and was her only point of social contact for a period of time; eventually this built her social confidence with family and others (Int. #1). The idea that engaging in creative activity reduced social isolation was very strongly articulated by one participant who said she attended the art groups to enjoy the company as she had spent a lot of time alone (Int. #5). Social networks have a notable impact on one's wellbeing and the ability to cope with stressors, and these community-based art groups facilitate friendships and social networks that provide members with support and meaningful engagement. Regularised social interaction provide group members with a sense of stability and control and this psychological state aids in response to life stressors (Cohen & Syme 1985, p.6).

In this chapter, I demonstrated how the contributing factors impacted on participants' experience of the art-making process and identified potential explanations as to how these contributed to the positive outcomes and social interaction. In all three types of art programs that participated in the current study— art therapy, skill-base and informal groups—these contributing factors existed, but in a variety of ways, with aspects of that factor influencing the art-making experience. In the next chapter I will discuss the art-making process and how these factors are entwined within to highlight the art-making process as central to the beneficial engagement in creative activity.

KEY POINTS – SYNTHESIS

A synthesis of results from all four phases

- Community-based art programs developed local friendships, provided skill-building and supported community participation;
- Participants viewed the facilitators' role as caring, nurturing, a teacher of skills and the holder of the group;
- Participants paid less importance to the physical space and more on the transitional space as a safe space 'to be' and socialise;
- The variety of art materials challenged participants to explore, invited curiosity thus increasing confidence;
- The final product created became an embodiment of an experience and a sense of pride when validated by others;
- Shared activities in a group setting encouraged socialisation and art was the common thread.

6. DISCUSSION: the art-making process

The majority of the literature claims the art-making process to be the most important factor in creative engagement and is thus the focus of all arts-based interventions (Reynolds 2012; Sandmire et al. 2012; Spaniol 2001). When initially structuring the research question, I identified the art-making process as an important contributing factor that was highlighted in the literature along with the other factors that impacted on outcomes of arts-based interventions. However, as the research progressed and through further investigation of the literature and analysis of the data collected, I have placed the art-making process as central to the arts-based intervention encompassing all other contributing factors that have been discussed in the previous chapter. The five contributing factors of facilitator, art space, art materials, final product and social element, support, influence, complement and remain entwined within the art-making process. While discussing the art-making process, I will sporadically situate when and how some of the other factors complement it and collectively impact on both the experience of the process and the outcomes. Exploring this interdependence between the various factors in more detail will demonstrate this centrality of the art-making process and the importance this has for this thesis.

In the literature review and the current research, emphasis was given to the art-making process to acknowledge the single common factor that is present in every arts-based intervention or creative engagement, irrespective of facilitator disciplines, arts space, materials employed and type of programs. The experience of the art-making process was the focus of enquiry in this research, as it was hypothesised that the therapeutic benefits highlighted in the literature could be achieved from the art-making process, as is present in community-based art programs. These programs provide all the contributing factors necessary for therapeutic outcomes to occur and have the potential to offer participants all the benefits encompassed in the engagement of the art-making process in a multitude of ways as outlined in the previous chapter. Here, I look at different aspects of the art-making process as found in the literature and relate this to the data collected in the current research, while revealing how the process interconnects with the

contributing factors as discussed in the previous chapter. Drawing on broader literature and theory from other fields I provide a deeper the understanding of the art-making process as it is experienced by those who participate.

Tracing the entire process of a participant's engagement in creative activity from the moment they step into the art space, remain engaged in the process through to the completion of the final product, will provide a deeper understanding of how the art-making process is central to the participant's experience. The process is not a linear one but an ongoing process that continues to challenge, build confidence and provide reflection and insight to the participant, all within an environment that is supported by the facilitator and the other members of the group.

6.1 THE ART-MAKING PROCESS

The art-making process begins when participants enter the creative space and give themselves time to be creative. Participants in the current study spoke about 'being creative again' as though it was embedded in their human nature to be so but had inadvertently became suppressed by traumatic events, illnesses that took over their lives or simply the commitments of everyday demands. Winnicott (1971, p. 54) states that ill-health and ongoing environmental and social factors can stifle one's creative process. The art programs provided them a temporary escape from this chaos (Phase 4 interviews). This can also be related back to the contributing factor of the art space where participants focus on themselves for one to two hours within their busy week. They socialise, they play, they create and as one facilitator observed that for the first 15-20 minutes there is chatter and busyness and everyone is setting up until everyone gets lost in their work and for two hours they have left everything behind and given themselves time to paint (Report #9).

In this time and space, various contributing factors and elements of the art-making process connect and intertwine to provide benefits to those who engage in the creative activity. Liebmann (1990, p. 80) refers to this 'transitional space' as having 'a place to be' and the art-making process as an ongoing process of creative functioning that facilitates

motivation and self-respect that is supported by the group.

6.1.1 PERMISSION TO PLAY

Within that time and space, the art materials, tools and equipment—whether provided or brought in by participants themselves—invite exploration and imagination which is likened to play. The element of 'play' exists when a participant enjoys the interaction with the art material to experiment and discover new possibilities while not focused on the end product (Penzes et al. 2014). Eberhart and Atkins (2014) add that it is part of the process of being curious and open to possibilities of the art medium—investigating the textures and changing its form—and exploring what it can do for them. Facilitators in the current study expressed the importance of the art material for the purpose of stimulating and challenging creativity as well as having tactile materials that connected with participants (Phase 2 reports). The importance of play has been promoted by art and play therapists alike as an opportunity to indulge in spontaneous activity and imagination that gives life meaning (Spencer 2012; Argyle & Bolton 2005; Winnicott 1971).

As we move into adulthood and become focused on careers and family responsibilities, we forget to play; to indulge in that one activity that does not have a goal, or an end result or purpose. This is the ability to lose oneself in unconstrained activity without the pressure to be productive but to simply enjoy the participation itself. In the practice of occupational therapy, the experience of feeling intensely involved, being able to concentrate deeply in the process to the point of losing sense of time and to let go of self-consciousness, is known as 'flow' (Jacobs 1994).The current burgeoning popularity for adult colouring books in the market suggests there continues to be a need for adults to indulge in a child's activity. While there is a strong debate against adult colouring-in being promoted as art therapy (Malchiodi 2016), it has been related to reducing stress by and evoking childhood memories (Williams 2015; Ford 2015). Art therapist Claire Edwards in Ford (2015) states it gives adults permission to do something

that in the past belonged only in the childhood domain. Marks-Tarlow (2012) claims that play is not just aimless expenditure but that the freedom of play is important for vitality later in life. Winnicott (1971, pp. 53–54) further adds that in playing, the adult is free to be creative and discovers self through play with the art materials, and individuals searching for self will find themselves in the products they create. This suggests the contributing factors of art materials and the final product to be very much a part of play in the art-making process.

Similar to children playing with the aid of materials to express themselves, the group members in the participating art programs looked forward to their weekly art sessions as a time to let go and play like a child (Int. #11). Children express freely without the fear of being judged or ridiculed for not producing amazing images that are aesthetically pleasing or masterfully executed, but adults sometimes feel threatened by the fear of being criticised by others, or are even self-critical of their own achievements. According to Booth (1997, p.52) the sense of 'wonder' in play is ingrained in us as children which can sometimes be suppressed with grown-up reality and that the making of art can revive this wonder. The experience of play is done for its own sake and when art meets play there is 'imagination, invention, improvisation and innovation' (Booth 1997, p.142).

Participants in the current study described the desire to return to a childhood activity, but were initially hesitant because of the fear of not being good enough, or were hindered by the fear of trying (Phase 4 interviews). However, Leibmann (1990) states that anyone who has used art as a child can be encouraged to be creative again, if not pressured to be artistically correct. The non-discriminating space ensured by facilitators gave participants the confidence to relax and explore creative play without fear of failure, mirroring the top reasons of 'fun' and 'relaxation' given by forty-five individuals diagnosed with schizophrenia and depression living in the community who attended a local creative program (Lipe et al. 2012). The community-based art groups in the current study provided participants the space for spontaneity and the materials for play. The supportive

and social aspect of the group created conditions necessary for play. Play therapy used with children and adults has been identified to increase capacities related to social competence, community membership (Marks-Tarlow 2012), heightened self-esteem and improved social skills for adults in nursing homes (Ledyard 1999). The element of play in the art- making process as a means of self-growth and socialisation is a very important one, as Winnicott (1971) clearly sums up:

> Playing facilitates growth and therefore health; playing leads into group relationships; playing can be a form of communication (p.41).

6.1.2 'TIME-OUT'

In addition to being a recreational and fun activity, Gray (1978) advocates that the art-making process provides participants with 'time-out' and an escape from the daily stressors of life, factors reported in the literature as essential to a person's wellbeing (Macnaughton, White & Stacy 2005). In a study by Reynolds (2000) that examined the promotion of wellbeing through arts-based interventions, women referred to the art-making process as relaxing and calming, as the cognitive task that required focus and attention provided a temporary distraction that alleviated worry. In another study, creative activity was evidenced to have reduced stress and anxiety, encouraged relaxation and provided participants a temporary escape from reality (Sandmire et al. 2012).

The art-making process was described as 'time-out' by one participant in the current study; time for her to forget about everything else—the doctors, the medical appointments—and to just enjoy being there in the group engaging in art (Int. #4). Eberhart and Atkins (2014, p. 47) refer to it as alternate space from ordinary life where the world becomes present and the participant is open to the exploration and discovery of the moment, and Ahles (2004, p. 219) adds that 'creativity is a portal to presence', which can be compared to Mindfulness.

6.1.3 SILENCE AND MINDFULNESS

Mindfulness has been used in conjunction with art because fully engaging in the art-making process allows one to be present in the moment to richly experience what is taking place before them (Coholic 2011; McKenie & Hassed 2012). Mindfulness teaches one to be focused and to concentrate on the present that temporarily transports one away from all the demands of life, providing the participant time to rest, to reflect and to recuperate (McKenzie & Hassed 2012). In the clinical environment, Mindfulness is used to train the mind to regulate emotions by focusing on sensory processes (Cayoun 2011), which in the community-based art programs is provided by the exploration of the variety of art materials.

It was reported by facilitators of the current study that sometimes there was silence when participants were focused on the art-making process (Phase 2 reports). Even in groups that were quiet by nature, members still shared a common creative experience in silence, which Eastwood (2012, p. 106) described accurately as the group art-making process being 'the experience of being with others yet also alone' and Patterson et al. (2011) say that participants don't have to participate in conversation but just be in the room or art space. While the verbalisation of experiences of art-making and conversations between group members are encouraged, there are times during the art-making process when it is silent. The acceptance of silence in the art-making process is also a very important contributing factor to a person engaging in a creative activity and has its own benefits. According to phenomenological theory, silence should be accepted and not interrupted or analysed because the silence can be therapeutic, as it is a space that allows participants to focus on themselves and the creative process and for the artwork emerging to be a therapeutic tool (Guttman & Regev 2004; Luzatto 1997). Art therapy has also been used in conjunction with meditation on the shared importance of being present in the moment and space. Both require a safe and non-judgmental environment and openness for participants to create distance from difficult emotions to gain

awareness (Kalmanowitz 2016), and this time and space was provided in the programs examined in the current study.

This silent participation in the art-making process can be compared to the practice of Mindfulness. Just as mindfulness teaches us to be present in the moment, the arts encourages openness and curiousity in the possibilities of the material and makes us pay attention to the moment to notice ordinary things (Dissayanake 2000, p.197). Mindfulness promotes self-awareness and the ability to understand emotions and how they affect us, and with this self-awareness comes a deeper understanding of self and our reaction to emotions of fear, anger and anxiety (McKenzie & Hassed 2012, p. 244). Similarly, the *arts in health* literature reports that the silent communication that takes place between self and artwork during the art-making process, gives self-awareness of one's feelings and emotions leading to better understanding of self (Argyle & Bolton 2005; Lev-Wesiel 1998; Lark 2005). In the participating art programs of the current study, sharing of the art produced was encouraged, but in some groups the discussions were not facilitated or unpacked therapeutically. However, the act of creating art can be deeply experienced in silence and appreciated personally without being symbolically dissected or interpreted to contain meaning. The act of giving feelings and experiences a tangible art-form can be self--cleansing with or without the need for verbal interpretation or aided insight by another person, which introduces another aspect of the art-making process, the concept of art as communication. I further explore this concept of art as communication between 'self', 'public' and 'artwork'.

6.1.4 COMMUNICATION

Exploring the use of art as a means of communication was part of my research question and in the literature review I discussed communication between the artist and the image created and how this takes place within the art-making process. The idea of projecting feelings onto a tangible form that is manageable is supported by psychoanalytical theory, which states inner experiences are

externalised onto an arts medium then transformed and communicated back to the creator in healthier ways (Johnson 1998). However, it has been debated whether this transformative communication requires a therapist intervention, a specific art medium, a therapeutic space, or verbalization about the image or product created (Johnson 1998). While it has been suggested in the literature that the communication aided through art can only be facilitated by a triadic relationship between therapist-client-artwork (Ball 2002; Banks 2012), it has also promoted the value of the dyadic relationship of the image being able to communicate back to the creator (Greece 2003; Collie, Bottorff & Long 2006). It is this act of putting down on paper or canvas, an image, a drawing or a line that is the externalisation of one's unconscious feeling or emotion which communicates back a message the creator consciously receives (Collie, Bottorff & Long 2006; Argyle & Bolton 2005; Lev-Weisel 1998; Banks 2012). It is explained by Schaverien (2014) as a way to manage chaotic thoughts, distorted memories and inner experiences into a more manageable form or narrative which becomes more meaningful to the person. In the current study, the embodied image provided participants a means of expression without words, when it provided them a 'memory bank', a release of emotions and a visual reminder of a meaningful event (Phase 4 interviews).

Historical theoretical discussions of the art-making process are very much embedded in this concept of self-communication and Mindfulness practice. Both Jungian theory and Freud's psychoanalytical theory claim art to be the tool that brings unconscious thought into the conscious realm (Meissner 2000). More recent theoretical concepts that look at art-making through a scientific lens further support this theory comparing creative engagement to the mental organisation of complex emotions that improves psychological resilience and increased self-awareness (Hass-Cohen & Carr 2008; Belkofer & Kanopka 2008)

I briefly discussed in the previous chapter that the product created is an embodiment of expression that acts as a tool of communication to the creator and those that witness it, which is an important aspect of the art-making process.

In the current study, participants spoke about how the art they produced gave them a bird's eye view and a different perspective of an experience or emotion that allowed them to rationalise and reflect upon (Int. #2). One participant stated she was able to talk about her experiences through the pieces that she created (Int. #3) and another spoke about how her paintings told a story (Int. #13). Collie, Bottorff and Long (2006) describe this as the physical act of making art as a means of expression, the art becoming a mirror that reflected expressions back to the individual, putting the creator in a space to begin to think about things, making them understand and interact with what is being created. When one is fully immersed in the creative process, it allows the person to resolve inner conflicts and challenge their own thinking (Van Lith 2015). This personal communication takes place throughout the art-making process between the image being created and the individual, bringing forth valuable insight, an unburdening of emotions or a release of feelings.

6.1.5 THE SELF-RECOGNITION OF SKILLS AND CREATIVITY

I previously discussed communication between the artist and artwork and at times, the personal communication that takes place is simply about participants recognising their skills and abilities in producing art, the image or product being created providing them validation of their talent. The communication that takes place between the art and the participant during the art-making process brings about self-awareness that gives participants different perspectives of themselves (Argyle & Bolton 2005; Lev-Weisel 1998). Many of the participants in the current study revealed their surprise at their own talents, with one of them saying, 'I didn't think I could do this' (Int. #13), thus contributing to increased self-worth Dewey (1930, p.31) defines self-esteem as a positive or negative attitude towards one's self and a person develops and maintains good self-esteem when they have a good sense of self-worth.

The satisfaction of acquiring a new skill frequently occurred in the skill-based art programs of the current study, where skill learning was a major part of the art-

making process and participants spent that time focused on improving skills. However, even during that process of learning, participants were constantly surprised at their capabilities and talents and, while in that art-making process, had the confidence to continue to experiment and challenge them. Harnessing the power of an individual's creativity through engaging in art can lead to personal growth or sometimes simply enjoyment (Lentz 2008). This meaningful engagement or 'serious leisure,' as termed by Moody and Phinney (2012), is an ongoing process of working closely with the art materials at hand, with the image being created continuously providing challenges for decision-making. When the product or image begins to take shape, it gives the artist the confidence to further challenge themselves and this works continuously to build more confidence. Returning to the concept of flow in occupational therapy, the process encourages a person to develop new skills, take on new challenges and stretch their abilities in order to manage a situation (Jacobs 1994). I compare this experience to an ongoing process of experimenting and enduring the consequences of one's actions, about trial and taking risks (McDermott 1973, p.63). Goldsmith and Matherly (2001) state that the view of one's self as being creative, and the recognition of creative abilities by others, increase one's self-confidence. The skills gained from making art, also makes connections to life experiences and life-long learning (Booth 1997, p.23).

6.1.6 CREATING SOCIAL BONDS

Within the art-making process, learning skills in a group environment also promotes socialisation. In comparing the skill of learning to be creative to that of learning computer skills or a language, one participant pointed out the social benefit of participating in creative activity. She stated that learning a language was of no use to her if she did not travel, and as for learning computer skills, it did not allow for socialising within the group because one had to concentrate, while sharing a creative activity stimulated and supported socialising (Int. #7). Returning back to the element of 'play' in the art-making process as previously discussed, Argyle and Bolton (2005) suggests that the playfulness of the art-

making activity that is spontaneous, self-motivating and relaxing naturally creates social bonds. Just as children establish positive social attitudes—even when it can be frightening— when given the opportunity to play (Winnicott 1971, p. 50), the art-making process achieves the same outcomes.

Hyland-Moon (2014) acknowledges in her work that people come together to knit, sew, paint and create within a supportive community not specific to needing a therapeutic intervention. While individual participation in the art-making process provides the creator the discussed benefits of insight and self-awareness, the added advantage that is unique to group art programs is the benefit of art being witnessed or shared. Both positive and negative experiences of the art-making process can be contained and supported when art is made within a supportive group environment and a 'safe space' (Rankanen 2014). As one participant in the current study articulated that 'by sharing with others, it felt the burden was lessened' (Int. #3), so the group provides a holding environment for the participant involved to take risks, and learn to trust through producing artwork that has personal significance (Liebmann 1990, p. 76). The therapeutic process of art-making combined with group processes, such as the sharing of information and feedback, contributes to the therapeutic process of change (Crawford & Patterson 2007). Art-making within a group setting allows members to share a 'visual language' that enables connection and meaning-making (Mills & Kellington 2012), further encouraging social interaction. There is evidence in the literature that claims group work enables people to be more confident, increase social networks and increase interpersonal skills (Preston-Shoot 2007). Dissayanake (2000) states that humans require mutuality and belonging, and those deprived of this become insecure and lack self-esteem and that group participation in a common activity strengthens affiliation and contributes to the wellbeing of those who engage. The other benefits of engaging in the art-making process within a group environment is combined with the therapeutic effects of group work, such as installing hope and the development of socialisation skills occurring through role play and interpersonal feedback to build self-esteem (Yalom 2005). The group environment and presence of others allows for

emotional risk-taking during the art-making process that challenges thought processes, and reduces the feeling of attempting this in isolation through building shared experiences (Rankanen 2014). 'Support' was a recurring reflection by participants in the current study and the encouragement they received from each other while making art together re-affirmed their status as part of a community, giving them a sense of belonging in that collective group art-making process (Phase 4 interviews). Returning to the notion of being alone while with others is a great aspect of group activities, as stated by Teglbjaerg (2011) about his patients who reported having a sense of connectedness and belonging even when they were painting on their own.

6.1.7 SUMMARY OF THE ART-MAKING PROCESS

While it is extraordinary what goes on during the art-making process, the experience is unique to every individual. This research has discussed aspects of this process beginning from the moment participants set up the space and choose materials, immerse themselves in the creative activity, and begin to produce an image or a product. The art-making process—the choosing of colors and mediums, the act of creating, the playing, the indulgence in something for oneself, the learning of a new skill, the immersing in a relaxing activity, the insight and awareness gained—and everything else that has been described as part of this process, is the central aspect of any engagement in a creative activity, whether experienced individually or shared in a group setting. It is summarised very accurately by a participant in a study by Quail (1994) when she described the process as opening and allowing herself to experiment with colors and textures to express her feelings, then as the product took shape it motivated and encouraged her until she spontaneously surrendered to the experience, trusting and allowing the process to take place.

This current study was based on the premise that the magnitude of the art-making process, and the effect it has on those who participate, is central to the experience of any engagement in creative activity. The art-making process is

defined here as an act of immersing oneself in creative activity in its simplest form, which is an experience of letting go, surrendering to a process of change through what is being created, and allowing what emerges to embody what is felt then communicated back to self with renewed knowledge and confidence. Yet, at other times, art-making does not have to be the representation of our psyche or an emotional ventilation of our frustrations, but simply a recreational activity that values the self, acknowledging that we deserve to have fun, to relax and to be with others. In this chapter I discussed how the contributing factors are embedded in the art-making process and confer with Dissayanake (2000, p.1971) that the goal of art-making is to enjoy the activity and not to arrive at a destination, and with Booth (1997, p.22) that the result does not solely rely on the medium but on the quality of the art-making process.

While there is evidence of increased self-esteem and social interaction in the current study, these outcomes become further substantiated when they are experienced beyond the confines of the group itself. In the literature, there were research studies that demonstrated participants were able to translate their experimental playful activity of painting to everyday life situations such as solving problems (Teglbjaerg 2011; Kelly & Doherty 2016) and that the sense of purpose gained from discovering their creativity gave them the ability to engage in other areas of their lives (Spandler et al. 2007). While the current research study was limited to a fixed period of time under investigation, there were indications reported of wider outcomes from attending the art groups on an ongoing basis. The confidence gained in the group gave them the confidence to stand up to other issues in real life (Int. #3), and for another participant conquering her shyness, being in a group gave her the confidence to join other groups in the community (Int. #9). The art activity provides opportunities to rehearse solutions and to learn interpersonal skills that are transferable to lives beyond the group (Kelly & Doherty 2016).

Spandler et al. (2007) stress that by focusing on something other than their stressors in life participants are relaxed and develop new coping strategies. Those

that re-discovered their creativity as time to relax and unwind realised that engaging in creative activity was an important aspect and endeavoured to commit to 'time out' on a regular basis. Group art programs offer individuals a reason to meet regularly and nurture their creative activity within a context that is non-judgmental (Leibmann 1990, p. 75). In regard to the social networks established in the groups, as Yalom (2005) states, groups are a social microcosm for participants that allow for interpersonal interaction styles to appear with opportunities to identify and reflect, facilitating meaningful socialisation techniques that can be mirrored in the wider social arena. People participate in groups because the development of a person occurs in his or her local environment and the process of becoming ourselves occurs through the process of social living (Campbell 1995, p.39).

KEY POINTS – ART-MAKING PROCESS

- The variety of materials and the relaxed environment allowed participants to engage in explorative play;
- The space held by the facilitator was a safe space that encouraged relaxation and socialisation;
- The creative process was a recognition of skills and validation by others further provided encouragement;
- Participating in the activity in silence provided a space for Mindfulness and internal communication;
- The group provided a supportive and trusting environment;
- The product created became an embodiment of participants' expressions facilitating communication with self and others.

7. CONCLUSION AND RECOMMENDATIONS

The aim of this research was to show that community-based art programs that have rarely been vigorously evaluated for their benefits can achieve the positive outcomes of engagement in creative activity, as outlined in the literature, and should contribute to the overall evidence-base of arts in promoting health. By identifying the various factors that contribute to the experience of the art-making process in the literature, I have shown these factors to exist in the art programs in the study and how they contributed to participants' experiences. I discovered how the contributing factors of facilitator, art space, material, product and the socilisation are embedded within the art-making process and as a whole influences outcomes. I have presented the benefits of engaging in creative activity, the positive outcomes reported in the data, and the role of contributing factors to the art-making process in art programs that impacted on the experiences of those who participated. This research study involving local art programs in community settings distinctively places this form of arts-based intervention in the broader field of *arts in health* and promotes the contribution it makes to the body of evidence on the healing power of the arts.

In the literature, I explored the different disciplines of facilitators and the diverse attributes and skills they brought to the role. I included literature from various professional practices such as art therapy, social work and occupational therapy and highlighted the elements of a good therapeutic relationship. In the current study, I identified similar characteristics of all facilitators, such as nurturing and caring, holding the space, teaching skills and, most importantly, the desire to make a difference through art, and how these characteristics contributed to the participants' experience of the art-making process. The literature claimed various art materials produced variable experiences for participants, and in the current study I reported that all materials provided for choice and variety, stimulated creative senses and provided participants with the potential to play, take risks, challenge themselves and make decisions through play and creativity in the art- making process. The contrast in extremes of the art space in which arts-based interventions were delivered were reported in the literature from

the luxurious studio space used by art therapist Killick (2000, p. 103), described as 'sanctuary-like', to the art cart wagons rolled into patients' rooms in hospitals (Tate & Longo 2002). In the current study, it was found the physical space was of less importance to the art-making process than that of the therapeutic 'safe space' that was supported by facilitators and other members of the group. The literature was inconsistent in the therapeutic value and importance placed on the final product. However, in the current study, the evolving and final product or image played an essential role in the art-making process, providing reflection and insight to participants, as well as validation of their skills and talents. I have discussed the art-making process encompassing all the contributing factors as central to every arts-based intervention and how the community-based art programs in the current study provided that opportunity to its participants to gain the benefits of improved self-esteem and increased social support by participating in the art-making process.

This research focused on supportive social supports that enhance a person's wellbeing, as determined by a number of government and state bodies (VicHealth 2013; US Dept of Health & Human Services 2011, p. 8), as incorporating mental and social wellbeing and meaningful engagement in leisure and artistic activities (Bungay & Clift 2010). The literature review stressed the importance of self-esteem and social networks in contributing to one's health and wellbeing. Self-esteem has been well-evidenced as a pre-requisite to mental wellbeing of self, a precursor to making friendships, and the necessary element for emotional health. People with resilience and self-esteem are less likely to suffer from depression and less prone to ill-health (Stinson et al. 2008). While participants in the current study – who were from the general local community - would possibly already have high self-esteem, Rosenberg (1989) states that a person with positive self-esteem recognizes their limitations and always seeks opportunities to improve. In the current study, the quantitative results showed a significant increase in participants' self-esteem from participating in the art programs for a period of time. The qualitative results identified that participants gained positive self-regard through artistic achievements and validation from peers, which Zeiger-Hill (2013, p. 2) states is a favourable view of self and belief in one's own competence, which is good self-esteem. We know from the literature that an individual's self-esteem improves when they

recognise their own achievements and when they receive positive affirmation on the work they produce (Noel 2008; Reynolds 2000), which repeatedly occurred in the current study.

There is also a high possibility that members of the local community attended art programs for the sheer enjoyment of the activity, or as an avenue to make social connections, but it is evidenced in the literature that building and maintaining friendships and support networks also contribute to improved self-esteem (Reitzes & Mutran 2006). In the current study, the social element of art programs was well reported by all participants. Supportive social networks—as has been clearly reported by participants in the current study—affect health enhancing behaviours, improve personal knowledge and prospects, promote functional coping skills, buffers the damaging influences of stressful life events and re-enforces meaningful social roles in the community (Davidson 2015; Berkman, Kawachi & Glymour 2014). These outcomes benefit anyone irrespective of whether they suffer from ill-health or have a social problem, or are healthy confident individuals of the general population. I have shown the benefits of providing these opportunities to the general public within local communities through community-based art programs.

As we move towards greater emphasis on the social determinants of health, methods of prevention while someone is well should be just as important as providing interventions when someone is ill (Lane 2006; Ryan 2004; VicHealth 2013). With the focus of health care moving towards community responsibility (Dyer & Hunter 2009), people with long-term conditions are more inclined to attend groups in community settings. Thus, it is necessary to provide cost-efficient programs – such as creative activities – to improve wellbeing in local communities specifically for long-term conditions, aimed at outcomes of increased self-esteem, confidence and socialisation which have deep lasting effects and assist adjustment to health-related conditions and outcomes (Holford 2011). The changing focus of mental health care in Australia towards a more holistic model in the community increases the value of providing opportunities for meaningful engagement in local communities as interventions for improving wellbeing.

When we discuss health in general, we include healthy living and prevention of ill health. We take vitamins to ward off viruses, eat well to avoid diseases associated with bad eating habits, and we exercise regularly to keep our hearts healthy. We should also then engage in creative activities to receive healthful benefits of mental wellbeing before we are unfortunate enough to be in a place of needing therapy, with the focus on maintaining wellness and preventing ill-health (Spaniol 2001). As Graham-Pole (2001) boldly suggests, art-making is the antidote to epidemic diseases of modern times, like cancer, diabetes, anxiety, depression and many more. While there is no evidence to support this, there is evidence to show that art-making improves self-esteem and a person's social connections (Reyes 2014; Argyle & Bolton 2005) and these two factors improve a person's wellbeing and increases their capacity to cope with illness (Van Lith 2015).

The field of *arts in health* consistently advocates for more art therapy in hospitals and clinical settings and the obvious benefits this brings to those who suffer a disease or illness is invaluable. However, by providing opportunities for creative engagement in the community, we are offering participation without the stigma of disease or social issues. In this way, the focus of artistic interest is not as much to relieve suffering but to focus on promoting positive emotions by highlighting strengths (Wilkinson & Chilton 2013). Art therapy has succeeded in infiltrating the health realm, which has been invaluable to the profession and the possibilities of delivering art programs in health settings. But healthful art-making belongs everywhere and to everybody, and needs to be made accessible to not only those who are ill or those who need therapy, but anyone who has the desire to improve their wellbeing through engagement in the arts. Art therapy is a highly valued therapeutic intervention that far outweighs the benefit of painting on one's own and indulging in group creative activities, but we also cannot ignore the significant benefits of art programs delivered in the community, and the contribution to the wellbeing of those who participate in the art-making process. Thus, community art programs should be promoted, highlighted, researched, and given the recognition they deserve in the overall body of evidence in the field of *arts in health*.

Arts in health interventions have progressed from the ancient traditions and methods of

creativity healing the body, soul and mind. In the introduction, I traced the proliferation and progress of art therapy in the UK, USA and in Australia and the ambiguity of the term that led to the diverse practice of arts to promote wellbeing. Different historical traditions, political environments, health legislations and cultural contexts will naturally lead to diverse practices of arts-based interventions but based on the common belief that art has the power to heal. While there is no universal definition of art therapy, the use of art to achieve therapeutic healing prevails as the common agent in both art therapy and art as therapy (Stoll 2005). We need to re-visit the early inherent belief in the power of art to heal and recognise community-based art programs as another opportunity to provide art as a means to promote wellbeing.

There were a variety of programs that participated in the current study. Those that taught skills provided a high level of instruction with the aim of empowering members through learning a new skill and gaining confidence in that skill, but incurred higher costs and catered to a more affluent target group. On the other hand, organisations also committed to providing friendly, accessible, low cost social art and craft groups that did not focus on teaching skills. Art therapy groups provided therapeutic discussions of the art produced and therapeutic alliances allowed for inner healing to take place. In each one of the participating programs the art-making process commonly existed offering the benefits of that engagement to members who participated in them. Irrespective of the type of program or the discipline of the facilitator, all programs provided participants the time and space to engage in the art-making process and all the benefits associated with it. Arts-based interventions can encompass 'art programs that produce beneficial outcomes' and 'therapeutic programs that create art' (Vick & Sexton-Radek 2008, p. 10). All the art programs in the current study possessed the contributing factors of facilitator, space, art material, and socialisation in varying degrees but essential to the participant's meaningful experience of the art-making process.

The Art Council of England provides funding for the best art initiatives in community projects and evaluate them for outcomes. VicHealth is the Australian equivalent with its own arts initiatives, such as Creative Connections and Creative Capacity Plus (VicHealth 2003), and conducts research and evaluation on its impact. The importance of

community-based art programs should also be recognised as an important aspect of *arts in health* research. Research that highlights the voice of the participants and their individual experiences of the art-making process in these interventions should be just as important as scientific measures of evidence-based practices. I have great admiration for those who endeavour to continue to deliver art programs with limited resources and advocate for the evaluation of outcomes that will contribute to the evidence base on the benefits of engaging in creative activity to improve wellbeing. It is hoped that everyone engaged in promoting *arts in health* will look at the field as Kapitan (2014) does, as a 'community of practice' that encompasses research from all fields of arts-based interventions and practices, or as McNiff does (2004, p. 266) as 'a community of people committed to art and healing' in order to develop a strong base of shared knowledge. While art programs have been delivered in the community in Victoria for decades, it has been an area of *arts in health* that has been under-researched. In this study, the local art programs have been brought to the forefront of arts in promoting health and have been demonstrated as beneficial to those who attend.

7.1 RECOMMENDATIONS FOR FURTHER RESEARCH

A lot of research and planning was undertaken to arrive at the most suitable research design that would answer the research question, paying due attention to the complexity and ongoing debate around the best methods for arts-based research. While the four-phase sequential mixed methods design was a tedious process with minor changes made as the data collection progressed, it was found that the design took into consideration the two most important aspects of the research question. The two aspects were: to measure if there was an improvement in self-esteem and social interaction for participants of art programs in the community; and to give 'voice' to the participants who experienced engaging in creative activity specifically in relation to the art-making process. Acknowledging there are some limitations to the study, I have expressed these in Chapter 3.

I hope that providing first-hand reflections and comments from facilitators and participants from their experiences provided a deeper understanding of a process that

perhaps cannot be exclusively measured by scales or scientific measurement. There needs to be more research that illuminates individual experiences of the process of art-making. A fixed period of time that was consistent across all programs would be hard to manage and the area covered was extensive. However, it would be useful to encompass many more art groups run in the hundreds of centres around Australia and have a more substantial comparison on the influence of structure, facilitator, art medium and space.

Art therapy has been evidenced to enhance mood, encourage coping strategies, build resilience and more, and large community art projects successfully create public awareness of important social issues, as well as empower communities. However, these other outcomes have not been measured or explored in the current study. The aim of this research was to investigate the positive outcomes of self-esteem, communication and social interaction and it is acknowledged that other therapeutic outcomes are achieved in the practice of art therapy, community art and *arts in health*.

In terms of the method used in the current study, valuable feedback on the process came from the final phase of data collection. Participants felt that the quantitative questionnaire did not capture their full experience of engaging in creative activity, and welcomed the opportunity to be interviewed in the final phase to share their experiences in the art groups. The mixed methods approach incorporated standardised validated scales for accurate measurements of change, as well as qualitative methods that captured participants' voices. This would both satisfy the call for evidenced-based research as well as stay true to social research that illuminates the human experience. The value of further research in this field will not only contribute to the shared knowledge of the benefits of creative activity, but also will advocate for continuous funding and promotion of art programs to be delivered in local communities.

I hypothesised that benefits of self-esteem and social inclusion can occur in community-based art programs even in the absence of conventional art therapy protocols and irrespective of the various facilitators' disciplines, structures of program, art space and other factors because they provided opportunities to participate in the art-making process. The art-making process is present in every engagement in creative activity and

providing more opportunities for engagement should be proliferated. Social workers, nurses, occupational therapists, artists, individuals and many of us in a variety of helping professions have encountered windows of opportunities to deliver an art program, but have perhaps hesitated because of the lack of resources, the lack of confidence in our therapeutic ability to facilitate, or the lack of availability of a suitable physical space. McNiff (2004, p. 263) states that the healing power of the arts should be universally accessible to all and should not be encapsulated by any exclusive discipline. I hope that this research encourages those who believe in the power of art as a healing tool and the intrinsic value of the art-making process to seize every opportunity to provide opportunities for art-making. Art-making has the power to heal and any person who engages in creative activity is provided the opportunity to fulfil what is simply our human desire to express and communicate, thus providing opportunities for creative engagement should be a universal goal.

Finally, by placing the art-making process at the centre of the participant's experience of engaging in creative activity, I have shown that every opportunity created for this process to take place should be valued in itself. I have demonstrated that the factors that exist in every intervention contributed to this experience in a variety of ways, making every individual's experience unique. In regards to the community-based art programs in Victoria, I have provided the evidence that participants' experiences of the art-making process contributed to the building of self-esteem and social support. Ultimately, it is the art-making process that possesses the necessary contributing factors that fuel the power of art to heal.

Key Recommendations for further research include:

1) Art programs are delivered in communities across Australia and this study captured programs in Victoria only. All programs in other communities would benefit from proper evaluation methods and rigorous research.

2) The use of qualitative and participatory methods wherever possible to provide an opportunity for those directly involved in the art-making process to have a say in what they experience first-hand.

3) More in-depth research on each contributing factor of the art intervention to investigate if and how it affects outcomes of the art-making process.

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9. APPENDIX

A. RESEARCH INFORMATION SHEET

ART PROGRAMS RESEARCH PROJECT – Levels of participation

"Does the process of creating art in art group programs run in community care settings in Victoria, enhance communication and deliver the therapeutic outcomes of increased self-esteem and social inclusion?"

This document outlines the various levels of participation the organisation can be involved in the research project. Please tick **x** the levels you will be involved in.

Introductory

- [x] Provide information on availability of programs and basic data on target group and contact details of the organisation and program facilitators.

Phase 1

- [ ] Provide further information on data of the art programs in terms of group structure, goals, evaluations etc. This involves answering a more detailed 3 page questionnaire that will be emailed to you and can be returned electronically.

Phase 2

- [ ] Participate in a 3 hour focus group consisting of program coordinators and facilitators with other organisations to discuss the data collected and an opportunity to have input in the implementation of the third phase of the research.

Phase 3

- [ ] Administering questionnaires consisting of measurement scales to program participants at two intervals. Questionnaires will be provided and the researcher can assist with this.

Phase 4

- [ ] Work collaboratively with the researcher to identify individuals to participate in interviews conducted by the researcher.

Disclaimer

The boxes ticked above indicate your level of participation in this project. Please note that this document is **non-binding**, i.e. that the organisation is in no way bound by this document. It is an indicative expression of support and required for Human Ethics approval. The organisation has the choice on how much they would like to be involved in the research. No research beyond the introductory phase will be undertaken until ethics has been approved.

Name of Organisation: _____

Name of Representative: _____Role: _____

Signature: _____Date:_____

B. PHASE 1 and 2 CONSENT FORM

A RESEARCH PROJECT EVALUATING THE BENEFITS OF PARTICPATING IN ART PROGRAMS IN COMMUNITY SETTINGS IN VICTORIA.

PARTICIPATING ORGANISATION CONSENT FORM

I ……. have read the information sheet provided to me and all questions on the research project have been answered to my satisfaction. I hereby consent to participation in this research and agree to the following:-

1) Participation or non-participation in the different levels of the research is the choice of the organisation.
2) I have the right to withdraw from the project at any time without penalty.
3) The research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles written for journals.
4) Confidentiality of all participants will be maintained to preserve anonymity and if required, fictitious names may be used in publication.
5) A statement of results will be available to participating organisations in which the art program is delivered.
6) That to be included in this research I will have had to participate in Phase 1 at least.

Signature: ……. Date:……..

Name (please print): …….

Role : ……Contact No:……

Organisation:- ……

C. PHASE 1 INFORMATION SHEET

INFORMATION SHEET FOR ORGANISATIONS PARTICIPATING IN PHASE 1

A RESEARCH PROJECT EVALUATING THE BENEFITS OF PARTICPATING IN ART PROGRAMS RUN AT COMMUNITY SETTINGS IN VICTORIA.

This information leaflet explains the research project that will be conducted inyour organization.

PROJECT OVERVIEW

Art Programs are run in community organisations across Victoria that benefits those who participate in these programs. However there is limited research on the benefits of these programs and this research project seeks to examine if creating art in these settings achieve positive outcomes through the use of questionnaires and interviews.

PARTICIPATION IN PHASE 1

All organisations that have expressed interest in participating will be sent a 3 page questionnaire on the demographics of their target group, details on the structure and goals of their art programs, demographics of facilitators, questions on funding and evaluation.
Participants have the right to choose to participate or not participate and the right to withdraw at any stage of the research without penalty.

BENEFITS AND RISKS

This research will contribute to the evidence of the positive benefits of the arts in promoting wellbeing and it is hoped that it will encourage organisations and policymakers to introduceor continue to deliver such programs in community health settings. The collection of data in this first phase will be used to explore points of further discussion in the focus groups in Phase 2, as well as complement and inform the subsequent phases of the research.

CONFIDENTIALITY & ANONYMITY AND PUBLICATION

Participants' real names will not be used in any of the documents or the thesis, or anyother publications.

CONSENT

Participants will be required to provide a signed consent to use the data collected.

FEEDBACK

All participants are entitled to receive a report on the research project when completed. If you wish to receive a report please provide a correspondence address or an email for electronic copies.

QUESTIONS OR FURTHER INFORMATION

If you have any questions about this research project or require any further information please feel free to contact the researcher, Susan Dragon at susan.dragon@cqumail.com

CONCERNS AND COMPLAINTS PROCEDURES

This research has an ethics approval and if you feel that you have been treated unjustly or without respect, please contact CQUniversity's Office of Research (Tel 07 4923 2603) or email to ethics@cqu.edu.au should there be any concerns about the nature and/or conduct of this research project.

THANKS

Your participation in this research project is greatly appreciated. If you consent to participating, please sign the attached consent form.

D. PHASE 1 QUESTIONNAIRE – Q2

ART PROGRAM RESEARCH PROJECT QUESTIONNAIRE (Q1) – PHASE 1

This questionnaire is the first phase of the research project which aims to collect more detailed demographic data in relation to the art program/s that runs in your centre. Please note if there is more than one program run with different structures and cater to different target groups, please fill in a separate form for each group.

Name of organisation/Centre:_____

Name of Program:_____

Address of Program:

Tel no: _____ Contact Person:_____

1) GROUP STRUCTURE

a) What kind of art group? Ie. Craft, painting, drawing, sewing, etc

b) Is it run regularly (weekly, monthly), drop-in, in fixed term blocks or ongoing?

c) Duration of each group session?

Is the entire duration spent on doing art? If not, what else?

d) What is the desired number of participants for each group?

e) Further comments about the structure of the group.

2) TARGET GROUP/PARTICIPANTS

a) Who are the participants of the group?

b) Gender of group

c) Age range of group

d) How are group members recruited?

e) Do group participants have caseworkers in the same organisation/Centre?

f) Do group participants have input in the planning of the structure and content of the art program? If so, how?

Further comments about participants.

3) FACILITATORS

a) How many facilitators are there for this group?

b) Are the facilitators' employees of the organisation, volunteers or paid contracted facilitators?

c) What are the disciplines of the facilitators? (art therapist, artists, social workers,etc)

d) Do facilitators help plan content of the group?

e) Do you feel facilitators could benefit from further training? If yes, in what area?

f) Further comments about facilitators.

4) GOALS

a) What are some of the goals for running this group, if any?

i)

ii)

iii)

iv)

Further comments about goals.

5. COSTS AND FUNDING

a) Are participants charged for this program?

b) How much are participants charged?

c) What are the fees collected used for?

d) How is the art program funded?

e) Does funding depend on evidenced positive outcomes?

Further comments about costs and funding.

6. VENUE AND FACILITIES

a) Where are the art sessions conducted – art room/hall/group room etc?

b) Do you have facilities specific to your target group, ie: disability access, parentsrooms,

c) Further comments on venue and facilities.

7. EVALUATION

a) Do you conduct an evaluation of the program?

b) What method of evaluation is conducted?

c) Who conducts the evaluation?

Further comments on evaluation

FURTHER PARTICIPATION IN THIS RESERACH

This next session outlines the involvement of participating in this research. Please indicate if you would be interested to participate in the next phases of this research.

The researcher would like to come out and meet with you to discuss a little more about your art group and inform you about further involvement.

NOTE

For any enquiries or clarification of this questionnaire, please contact the researcher:- Susan Dragon

Email: susan.dragon@cqumail.com

CONCERNS AND COMPLAINTS PROCEDURES

This research has an ethics approval (Project Number H14/02-018) and if you feel that you have been treated unjustly or without respect, please contact CQUniversity's Office of Research (Tel 07 4923 2603) or email to ethics@cqu.edu.au should there be any concerns about the nature and/or conduct of this research project.

APPRECIATION

Your participation in this research project is greatly appreciated.

E. PHASE 3 CONSENT FORM

A RESEARCH PROJECT EVALUATING THE BENEFITS OF PARTICIPATING IN ART PROGRAMS IN COMMUNITY SETTINGS IN VICTORIA.

RESEARCH PARTICIPANT CONSENT FORM

I ……. have read the information sheet provided to me and all questions on the research project have been answered to my satisfaction. I hereby consent to participation in this research and agree to the following:-

1) Participation or non-participation in the research project will not affect my status as a service user in the organisation or any other services I receive from this organisation.
2) I have the right to withdraw from the project at any time without penalty.
3) The research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles written for journals.
4) Confidentiality of all participants will be maintained to preserve anonymity and if required, fictitious names may be used in publication.
5) A statement of results will be available to participants at the individual organisations in which the art program is delivered.
6) That to be included in this research I will have to attend at least 70% of the program.

Signature: ……. Date:……..

Name (please print): ……..

F. PHASE 3 QUESTIONNAIRE – Q2

Phase 3 – Art Research Project PARTICPANTS' QUESTIONNAIRE (Q2)

Record no:

Organisation:

Group:

Participants' details Gender: Age:

How long have you been attending this program?

PART 1 – Your experience in the Art program

a) Is this the first time you are attending an art program? Yes No
b) Did you do any kind of art/creative work before attending this program? Yes No
c) Would you like to continue accessing art programs such as this? Yes No

PART 2 – Self

Below is a list of statements dealing with your general feelings about yourself. Please indicate by circling how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.

   Strongly Agree Agree Disagree Strongly Disagree

2. At times I think I am no good at all.

   Strongly Agree Agree Disagree Strongly Disagree

3. I feel that I have a number of good qualities.

   Strongly Agree Agree Disagree Strongly Disagree

4. I am able to do things as well as most other people.

Strongly Agree Agree Disagree Strongly Disagree

5. I feel I do not have much to be proud of.

Strongly Agree Agree Disagree Strongly Disagree

6. I certainly feel useless at times.

Strongly Agree Agree Disagree Strongly Disagree

7. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Agree Agree Disagree Strongly Disagree

8. I wish I could have more respect for myself.

Strongly Agree Agree Disagree Strongly Disagree

9. All in all, I am inclined to feel that I am a failure.

Strongly Agree Agree Disagree Strongly Disagree

10. I take a positive attitude toward myself.

Strongly Agree Agree Disagree Strongly Disagree

PART 3 – Questions on Social Interaction

Section 1 – Please circle the number 0-3 that most suitably answers the question eg. ②

1. What time do you get up each day? Average weekday

0	**1**	**2**	**3**
Before 9am	9am – 11am	11am – 1pm	After 1pm

Average weekend

0	**1**	**2**	**3**
Before 9am	9am – 11am	11am – 1pm	After 1pm

2. How many hours of the working day do you spend alone?
   (for eg. In your room alone, walking out alone, listening to radio or watching TV alone, playing computer games alone.)

HOURS Spent alone		Please rate
0-3	Very little time spent alone	**3**
3-6	Some of the time	**2**
6-9	Quite a lot of the time	**1**
9-12 or more	A great deal of the time	**0**

3. How do you react to the presence of strangers?

0	**1**	**2**	**3**
Almost Never (avoids them)	Rarely (feels nervous)	Sometimes (accepts them)	Often (likes them)

Section 2 - **Friends**

1. How many friends do you have at the moment?
   (persons whom you will see regularly in person, do activities with regularlyetc.) Number of friend:

0	**1**	**2**	**3**
0-2 friends	3-5 friends	6-9 friends	10 and over

2. Have you got someone you find it easy to discuss feelings and difficulties with? Yes No
   How often have you confided in them?

0	**1**	**2**	**3**
Almost Never	Rarely	Sometimes	Often

3. Do other people discuss their problems with you?

0	**1**	**2**	**3**

Almost Never	Rarely	Sometimes	Often

4. Do you have a spouse/partner/special boyfriend/girlfriend? Yes No

5. How difficult do you find it talking to people at the moment?

0	**1**	**2**	**3**
Almost Never	Rarely	Sometimes	Often

6. Do you feel uneasy with groups of people?

0	**1**	**2**	**3**
Almost Never	Rarely	Sometimes	Often

Section 3 – **Social Activity**

Put a tick (**√)** in the appropriate column to show how often you have participated in any of the following in the past three months

	NEVER	**RARELY**	**SOMETIMES**	**OFTEN**
Cinema				
Theatre/Concert				
Watching an indoor sport (squash, bowling)				
Watching an outdoor Sport (Footy, etc)				
Visited an Art gallery/Museum				
Visiting places of interest				
Attended a Talk/Meeting/workshop				
Evening class				
Visiting relatives/friends				
Being visited by relatives/friends				
Parties (birthdays; work party)				
Formal occasions				
Nightclub/social club				
Playing an indoor sport				
Playing an outdoor sport				
Eating out/ go out for coffee				

Church/Religious activity				

Section 4 – **Recreational activities**

Please place a tick **(√)** in the appropriate column to indicate how often you have done any of the following activities in the past three months

ACTIVITY	NEVER	RARELY	SOMETIMES	OFTEN
Playing musical instruments				
Sewing/Knitting				
Gardening				
Reading things/books				
Watching TV/DVD				
Listening to radio/music				
Cooking/Baking				
DIY activities/Fixing things				
Walking/strolling				
Driving/cycling (recreationally)				
Swimming				
Hobby (collecting things)				
Shopping				
Creative work (painting/drawing)				
Holiday/camping				

Any other recreation or pastime?

ACTIVITY	RARELY	SOMETIMES	OFTEN
1)			
2)			

PART 4 – **COMMUNICATION**

1) Do you find it easy to talk to other participants in the group in the art program? Yes No

2) Would you confidently strike up a conversation with the person next toyou? Yes No

3) Would you find it helpful to talk to someone with the same interest? Yes No

4) Do you feel awkward/self-conscious in a groupsetting? Yes No

5) Are you often hesitant to talk about your feelings oremotions? Yes No

G. PHASE 4 INFORMATION SHEET

INFORMATION SHEET FOR ART PROGRAMS PARTICIPANTS IN PHASE 4 – INTERVIEWS

A RESEARCH PROJECT EVALUATING THE BENEFITS OF PARTICIPATING IN ART PROGRAMS RUN AT COMMUNITY SETTINGS IN VICTORIA.

This information leaflet explains the research project that will be conducted in the community setting in which you attend the art program.

PROJECT OVERVIEW

Art Programs are run in community health organisations across Victoria that benefit those who participate in these programs. However there is limited research on the benefits of these programs and this research project seeks to examine if creating art in these settings achieve positive outcomes through the use of questionnaires, focus groups and interviews.

Phase 3 of this project has been completed in your centre which consisted of participants answering questionnaires at two intervals and this research will move onto the next phase.

INVOLVEMENT OF PHASE 4

All participants that have participated in Phase 3 are eligible to participate in Phase 4 of this research. Participation will involve attending an interview with the primary researcher at your convenience to provide you an opportunity to share your experience of attending the art programs at the centre.

Participants have the right to choose to participate or not participate and the right to withdraw at any stage of the research without penalty. Interviews will take about 40 mins. Interviews will be recorded and transcribed at a later date.

BENEFITS AND RISKS OF THE RESEARCH

This research will contribute to the evidence of the positive benefits of the arts in promoting wellbeing and it is hoped that it will encourage organisations and policymakers to introduce or

continue to deliver such programs in communitysettings.

CONFIDENTIALITY & ANONYMITY ANDPUBLICATION

Participants' real names will not be used in any of the documents or the thesis, or anyother publications.

CONSENT

Participants will be required to provide a signed consent to participate in Phase 4 ofthis research.

FEEDBACK

All participants are entitled to receive a report on the research project when completed. If you wish to receive a report please provide a correspondence address or an emailfor electronic copies.

QUESTIONS OR FURTHER INFORMATION

If you have any questions about this research project or require any further information please feel free to contact the researcher, Susan Dragon at susan.dragon@cqumail.com

CONCERNS AND COMPLAINTS PROCEDURES

This research has an ethics approval and if you feel that you have been treated unjustly or without respect, please contact CQUniversity's Office of Research (Tel 07 4923 2603) or email to ethics@cqu.edu.au should there be any concerns about the nature and/or conduct of this research project.

THANKS

Your participation in this research project is greatly appreciated. If you consentto participating, please sign the attached consentform.

H. PHASE 4 CONSENT FORM

A RESEARCH PROJECT EVALUATING THE BENEFITS OF PARTICIPATING IN ART PROGRAMS IN COMMUNITY SETTINGS IN VICTORIA – Phase 4.

RESEARCH PARTICIPANT CONSENT FORM TO BE INTERVIEWED

I ……. have read the information sheet provided to me and all questions on the research project have been answered to my satisfaction. I hereby consent to participation in this research and agree to the following:-

1) Participation or non-participation in the research project will not affect my status as a service user in the organisation or any other services I receive from this organisation.
2) I have the right to withdraw from the project at any time without penalty.
3) The research findings will be included in the researcher's publication(s) on the project and this may include conferences and articles written for journals.
4) Confidentiality of all participants will be maintained to preserve anonymity and if required, fictitious names may be used in publication.
5) A statement of results will be provided to participants at the individual organisations in which the art program is delivered. If you would like a copy of this please tick box
6) That to be included in this research I will have to have participated in Phase 3 of the research.

Signature: ……. Date:…….

Name (please print): ……

I also consent to the interview being recorded. YES NO

Signature…….. Date……