

Art Therapy at Home Base: A Survey of the Current Practice of
Art Therapy as an In-Home Service

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ABSTRACT

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Cindy Newton

This paper explores how the practice of working with clients in their homes influences the conditions of therapy, and how this pertains to art therapy in particular. A questionnaire survey was designed based on pertinent literature as well as the researcher's own experience with home visits, and distributed to art therapists who have counseled clients in-home. Questions focused on: the art therapists' backgrounds, the populations they have worked with in-home, the logistics of providing such a service, how in-home therapy compares to their clinical experience, issues specific to working in the home environment, and the merits and drawbacks of this approach to therapeutic practice. Responses were analyzed, summarized, and interpreted according to themes. The results of the survey indicate that the art therapist participants find working in the home environment compares positively with their experiences of therapy in more conventional settings, and enhances the therapeutic relationship. A discussion of specific findings is integrated with relevant theory. Suggestions are made regarding possibilities for the continued practice of in-home art therapy.

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Chapter One

Introduction

Home is where we start from. (D.W. Winnicott)

The impetus for this study came from my personal experience as a student asked to provide in-home art therapy for clients as a part of my internship. I responded to this request with enthusiasm, because I could appreciate the value of in-home service for the older adult population I would be working with. However, not wanting to go into the client's home environment completely green as to what challenges the setting might present, I decided to prepare by doing some research of the literature on this subject.

When I began my search in the summer of 2000, I found little in the art therapy literature about the dynamics of providing therapy in the client's home. I had slightly more luck when I turned to the fields of family therapy, psychiatry, and social work. At that point I began to collect what published material I could find, but also turned to on-line resources to extend my search for information.

An initial posting to professional art therapy e-groups ("e" for email), in which I asked some general questions about art therapy in the home milieu, received half a dozen responses from art therapists who were willing to lend advice and share with me some of their experiences. This was very helpful in my preparation for working with clients in-home. Many of the art therapists who responded to my posting commented on the paucity of research in art therapy literature about this means of service provision, and their feelings of being pioneers in an uncharted aspect of the field. This was the seed that developed

into the topic of my research. I felt if I could somehow collect the experiences of these art therapists in a study about the practice of in-home therapy, it would serve as a valuable reference for the profession, and as a guide for those who are, as I was, venturing into home visits for the first time.

Based on my review of the literature and my early experiences with the challenges of providing in-home art therapy through my internship, I designed a questionnaire focusing on the nature of in-home art therapy as it compares to clinical work, and how working in the client's home environment affects the therapeutic frame. My intent in designing the questionnaire was to gather information toward providing an overview of the current practice of in-home art therapy, and to set up a comparison between the literature review and responses to the survey. It was also important to me that the art therapists participating in the study have ample opportunity to describe their experiences in their own words. For this reason many of the survey questions were deliberately open-ended, and answers were analyzed according to emergent themes.

Due to the quality and quantity of responses I received to my initial query on the e-groups, I felt confident the internet was the most efficient way of recruiting participants for a formal survey, particularly from this small and specific population, and that such a study would be feasible to conduct and the results relevant to the field. An invitation to participate in the study was posted to three professional art therapy communication groups on the internet. I also sent the same invitation by email to several professional art therapy associations in Canada and the United States, as well as to the directors of training programs for

art therapists in both countries, welcoming participation from association members, students, and alumni. These email addresses were obtained from the American Art Therapy Association website. Following these postings, recruitment proceeded in a snowball sampling method, whereby art therapists contacted me to participate in the study and/or to recommend others with in-home experience. Approximately 15 people showed interest in taking part in the study. A total of 13 were able to complete the questionnaire.

Initially, for purposes of delimiting the study, it was intended that participants would only be recruited from Canada and the United States. I am most familiar with training programs and professional associations in these two countries, and I felt limiting the scope of recruitment would help me to ascertain the qualifications of art therapist participants. However, responses received from two art therapists outside of this scope (Australia and the Netherlands) were rich in experience, and I felt it was of greater benefit to the study to include them, rather than exclude the information based on a geographic criterion. Also, as the study progressed the relationship between cross-cultural therapy and in-home therapy emerged as an area of interest, and it seemed particularly relevant to include the full variety of responses. In order to develop a clear picture of current practice, when recruiting I asked for art therapist participants who had worked with clients in-home within in the last three years.

The questionnaire was designed in late fall 2000, and submitted, along with the design of the study, for review by the Departmental Ethics Committee. A colleague of mine, currently in doctoral studies in psychology, also agreed to

review the questionnaire design, and offered suggestions. After receiving approval from the ethics committee, recruitment took place during February. Copies of the questionnaires were distributed starting in March to those art therapists who agreed to participate. The deadline for returning completed questionnaires was set for the beginning of May.

The internet proved to be a great aid and tool both for recruitment of participants and distribution of the survey questionnaire. While all participants were given their choice of receiving and returning the questionnaire form by email or regular mail (postage paid), most opted for email. This made it possible to conduct the survey within a time frame of 2-3 months. The expediency of this method was ideal for the time limitations of this study; however, using the internet for the exchange of information in such a study does raise concerns about privacy and confidentiality. This will be discussed at a later point in the paper.

Limitations and Delimitations

This is a qualitative study, and the questionnaire was designed with the intent that it would act as a brief written interview. As such, responses to the questionnaire have been analyzed using ad hoc techniques, in much the same way as a qualitative study of lengthier oral interviews might be. These techniques were used in interaction with each other, and can include: noting patterns, themes, seeing plausibility, clustering, making metaphors, counting, making contrasts/comparisons, subsuming particulars under the general, noting relationships between variables, finding intervening variables, building a logical chain of evidence, making conceptual/theoretical congruity (Huberman & Miles,

1994; Kvale, 1986). While the questionnaire format does not allow for the same degree of depth as would be possible had oral interviews been conducted, it was appropriate given the time and resources allotted for this study, the geographic distance of the researcher from most participants, and for the convenience of participants, who were taking time from their own busy schedules to respond. Despite its brevity, I feel the responses to the questionnaire provide for an interesting overview of several facets of the experience of in-home therapy from the art therapists' point of view.

In Chapter 6 a second component of the study, designed to examine in-home art therapy from the clients' perspective, will be discussed, along with reasons why completing this component proved difficult to do. A response received from a parent whose adult son is a long-term recipient of in-home art therapy will be described to illustrate one case of a client and family's experience of participating in art therapy at home. When citing the advantages of offering art therapy to clients at home as opposed to in a clinical setting, both the authors of the literature on this subject and the art therapists who participated in this study frequently refer to increased comfort and convenience for clients. Asking clients about their experience, and their preference, would seem to be an important component for any research project examining the merits and effectiveness of in-home therapy. While it was not possible to obtain a balance of between therapists' and clients' perspectives for comparison in this particular study, such comparison would be a valuable area for further inquiry.

It should also be noted here that the impact of in-home therapy on the art therapists' theoretical perspective and consequent way of working will receive only limited mention in this paper. For the most part I have chosen a practical rather than theoretical focus for the study. While I feel it is important to address the interaction between a therapist's theoretical orientation and experience of working in the home setting, it is unfortunately not possible in this format for me to address the topic with the depth that it deserves. I would, however, like to acknowledge this as an area that warrants further study and elaboration. It will be proposed as a topic for further research.

The qualitative nature of this project, and a small sample size, do not allow for generalizability of results. Rather, the aim of this study is to look at a specific context – working in the clients' home environment – and discuss how it influences art therapy practice. Through collecting and synopsizing reports from several professionals who have experience providing in-home art therapy services, this study can give some insight into the conditions of working with clients in their homes, the approaches therapists bring to aspects of this field, and their feelings towards its merits and drawbacks.

Assumptions and Stance of Researcher

My own experience with in-home art therapy has certainly influenced my choice of this topic as a research interest, and inevitably informs my approach to the subject. In order that my personal perspective does not unduly affect the design of this study, and in particular the design of questions for the survey, most questions were based upon my findings in a multi-disciplinary literature review

concerning providing therapy for clients in their home environment. For questions pertaining specifically to art therapy, I also drew from the available literature but supplemented this with questions concerning areas I experienced as relevant in my own practice, namely the selection and transport of materials, and the treatment of the art product. Aside from those regarding demographic information, most questions were open-ended to allow participants to respond in their own words as much as possible.

This design is not only in accordance with my theoretical preference for a phenomenological and humanistic approach, which values subjective experience and self-report, but was again intended to limit any biases I might have regarding the practice of in-home art therapy from influencing the data collection process. Having several readers (the ethics committee, my research advisor, and colleagues in art therapy and other disciplines) review and help to refine the questionnaire contributed toward having a design that was clearly written and objective. As mentioned above, it was important to me that the survey questions allow participants to express themselves as much as possible in their own words, while providing me with some structure for comparing and analyzing the self-reports. For this reason an ad hoc method of analysis was chosen, focusing on themes that emerged from participant responses.

Necessarily, within my hypothesis for the study, I had assumptions regarding the home environment and the conditions of providing art therapy. I assumed the art therapists would report that the home environment altered or had an effect on the therapeutic frame, that it placed different demands on their

professional role than work in a clinical setting, and that the home setting influences the therapeutic relationship. While I do discuss my own experience as an art therapist regarding these three expectations, this is kept to a separate chapter. The results of the study come strictly from participant responses to the questionnaire, and are discussed in relation to what was found in the literature.

Definition of Terms

The following terms have been given operational definitions, to clarify the context with which they are used in the study:

1. In-home art therapy/Home-based therapy/Therapy in the home environment:
When an art therapist visits a client in the client's home for the purpose of conducting therapy sessions in situ, rather than meeting the client in a clinical setting.
2. Therapeutic frame:
The boundaries and structure the therapist establishes and maintains with the client in order to provide a secure environment in which therapy can happen. This can include, but is not limited to, ensuring privacy, confidentiality, minimal distractions and interruptions, and safe environmental conditions.
3. Art therapist:
[For the purposes of this study] a graduate, or second year student, of a university degree or diploma program in art therapy or a private art therapy institute affiliated with a recognized art therapy association. It was originally intended that the scope of this study would only include art therapists practicing in North America; however, two art therapists from other geographic regions, who otherwise met all criteria for participation, have also been included.

Following a review of literature relevant to the practice of in-home therapy, I will proceed to discuss briefly my personal experience offering art therapy to clients in their homes. Next, I will outline the investigative procedures for the survey study, and the results of study will be presented. A separate chapter will

focus on the second component of the survey study, in-home art therapy from the client's perspective, and explore the difficulties encountered in attempting to elicit and incorporate self-reports from recipients of therapy in such a study. This paper will conclude with a discussion of, and reflection on, the results of the study, and particular themes or areas of interest that emerged from the data analysis. Suggestions for the continued practice of in-home art therapy and further research in this area will be offered.

Chapter Two

Literature Review

To date, little exists in the art therapy literature about working with a client in the client's home. An extensive literature review located only two articles (Bloomgarden & Sezaki, 2000; Gibson, 1994) and two chapters in broader texts (Bell, 1998; Horovitz, 1999) that pertain directly to the practice of art therapy in this milieu. The bulk of comprehensive information and discussion about the nature of in-home therapy is to be found mainly in the *family therapy* literature (Christensen, 1995; Falloon, 1995; Fisch, 1964; Friedman, 1962; Haapala & Kinney, 1978; Hansen, 1968; Korittko, 1994; McCollum & Synder, 1999; Ryan, 1978; Speck, 1964; Stephens, 1978; Wellisch, 1995; Yager, 1995), although relevant studies have also been published in the fields of *social work and social services* (Booth, Delewski, Haapala, Kinney, & Peccora, 1985; Dore, Lindblad-Goldberg, & Stern, 1998; Heying, 1985; Levitan & Reynolds-Mejia, 1990; Woods, 1988), and *psychology* (Baglio, Barton, & Braverman, 1994).

Growing from the community mental health movement in the 1960's and 70's, researcher-practitioners have looked at in-home interventions with families in a variety of situations, and in many cases have found it effective in affording the therapist greater information about clients, fostering the therapeutic alliance, and enhancing therapeutic gain by allowing clients to develop new skills in their usual environment (Bloomgarden & Sezaki, 2000; Dittmar & Kinney, 1995; Dore, Lindblad-Goldberg, & Stern, 1998; Falloon, 1995; Fisch, 1964; Friedman, 1962; Woods, 1988). Working with families in their homes is an acknowledged tactic in

crisis intervention, particularly when children are at risk for being placed in foster care (Baglio, Barton, & Braverman, 1994; Barton & Wood, 1988). This is in accordance with a philosophy of normalization via deinstitutionalization and community-based care, and is also promoted as a cost-efficient treatment method, as such programs are purported to cost less than residential placement of children (Barton & Wood, 1988; Booth, Delewski, Haapala, Kinney, & Peccora, 1985; Dittmar & Kinney, 1995; Fraser & Haapala, 1987).

The majority of the literature about in-home therapy discusses these brief crisis intervention programs, most notably Homebuilders™ and others modeled on its design. The original Homebuilders™ service began in Tacoma, Washington, in 1974, and has since influenced the development of a number of similar programs. Through these programs, families at risk for having a child removed from the home receive intensive support services delivered in-home, usually from a case worker who is available to the family on-call 24 hours a day, over a short period of time -- usually one to two months. As well as psychosocial services, families are offered concrete assistance such as help with transportation and finances, advocacy within the community, and respite care (Christensen, 1995; Dittmar & Kinney, 1995). These programs typically seek to work with the family as a whole, and are based on principles drawn from family therapy and multi-systemic therapy.

While this type of intensive program differs greatly from the nature of most of the in-home art therapy services that will be discussed in this study, which tend to be longer in term, shorter per session, and focused on supportive

psychotherapeutic treatment rather than the provision of concrete assistance (e.g. financial aid, skills training, household maintenance), what they share is the choice of the client's home environment as the primary location for the delivery of therapeutic services. From this we can proceed to compare the literature, with an eye toward what researcher-practitioners in various fields have found to be special considerations for, and the merits and drawbacks of, providing psychotherapeutic assistance to clients in the home environment.

In three early articles: Fisch (1964) discusses his experience of home visits in his own private psychiatric practice, Friedman (1962) postulates a rationale for home visits in family therapy, and speculates about the advantages, and Speck (1964) explores new dimensions that open in treatment when family therapy takes place in-home as opposed to a professional setting. These writings, much referred to in later literature, present various reasons why a therapeutic practitioner might choose to conduct therapy in the client's home, and pay particular attention to how the home setting effects change in the role of both therapist and client. All three authors discuss in-home therapy in the context of working with families, and do not mention using this approach with individual clients.

A primary advantage to working with clients at home, cited by each of the authors (Fisch, 1964; Friedman, 1962; Speck, 1964), is that -- in the context of family therapy -- this is often the best setting in which to reach all family members and involve them in the therapy. This is discussed both as it applies to very young or infirm members of the family, who might not be able to attend therapy in

a clinical setting, as well as members who are resistant to participating. Requiring the family to bring unwilling members to a clinical setting for treatment can strain what might already be difficult family relations; providing therapy at home helps alleviate this responsibility on the family (Speck), and can also help the family appreciate that not just one member has problems, but that the family as a whole can benefit from help (Fisch; Friedman; Speck).

Regarding the therapeutic relationship, these authors address how the home setting lends a different context to the role of therapist, less in keeping with the psychodynamic tradition and more akin to a professional visitor, as we might think of the general practitioner or spiritual advisor who makes house calls (Fisch, 1964; Friedman, 1962). Fisch suggests that therapists with an organic¹ orientation will be most inclined to conduct home visits, while therapists working within a psychodynamic framework "rarely if ever venture forth" (p. 115). If psychodynamic therapists are reluctant to work in-home, it could be due to complications and wariness of the transference and countertransference issues that might arise from the therapist entering into the client's home. It could also be that, traditionally, this therapeutic orientation has demanded a specific and formal approach to therapy, with the therapist maintaining a neutral or anonymous role in order to facilitate the establishment of a transference relationship.

¹ While Fisch does not explicitly define his use of the word "organic," in the context of his article it can perhaps be best understood as akin to "eclectic." He likens organically oriented psychiatrists who see clients in-home and who "do not fit the visit into any operational concept of treatment" to general practitioners who make medical house calls (p. 115). In this context, a therapist who has an organic orientation can be understood as not specializing in one particular method of treatment, but rather drawing on knowledge of a range of theories or models. Based on Fisch's stated interest in developing a better understanding of families by seeing them in a more natural setting (p. 114), his use of the word organic might also bear some reference to the Rogerian idea of "organismic valuing process" (Raskin & Rogers, 1995), whereby individuals make decisions based on their direct, sensory experience of situations.

Certainly the client's home is a less than neutral territory, and the act of making a home visit carries several (social) associations. The therapist may be likened to a "family friend or minister" (Fisch, p. 117), or to a "warm parent or grandparent figure" (Friedman, p. 134) – transference that, as Friedman points out, contrasts interestingly with the Victorian tradition of the aloof father authority figure as therapist. Are these two perceptions apples and oranges, or two sides of the same coin? Transference is ultimately inevitable, and one projection might be as informative as the other. The home setting may influence the client's perception and opinion of the therapist, but a therapist who is aware of this effect will be able to utilize this much as he or she would transference material in a more conventional setting.

While Fisch (1964) and Friedman (1962) both emphasize the friendly connotations of a home visit, and the positive regard this might engender in clients, it is important to note that in-home therapy could also be potentially threatening or embarrassing for some clients. In this situation, transference and countertransference issues would likely be of quite a different nature than those mentioned above. Friedman does acknowledge that a home visit may be felt as an invasion of privacy, and can elicit fear in clients of having their secrets revealed (p. 139). He comments too, on how the entrance of the therapist into family dynamics can upset power and authority relationships –something which might cause alarm for the therapist as well as the family (pp. 139-140).

Further difficulties can occur if therapy is mandated, and clients face social or legal repercussions for not complying. In these circumstances clients may be anxious or angry about having to meet with a therapist (Borduin & Henggeler, 1995), and they, as well as the therapist, may be less motivated to engage in the therapeutic process (Christensen, 1995). Clients who are not involved in therapy of their own volition, and who have had previous negative experiences with social agencies or legal forces, may be suspicious or distrusting of a therapist entering into their home. In such cases it is likely the client will identify the therapist as an agent of the mandating authority, and trust will be difficult to establish. However, because home visits help remove barriers to receiving support services, receiving therapy in-home might be less anxiety provoking than having to visit an unfamiliar clinic, therefore facilitating clients' engagement in therapy (Borduin & Henggeler, 1995; Dittmar & Kinney, 1995).

Levitan & Rynolds-Mejia (1990), in examining countertransference issues that can arise in the in-home treatment of child sexual abuse, report on how the home setting can threaten the therapist's "sense of control, competence, and personal and professional adequacy, thereby compounding the therapist's anxiety" (p. 57), and caution that a therapist "disturbed and angered by powerlessness...may unwittingly retaliate with detachment or abandonment (termination or referral)" (p. 57). A therapist may feel overwhelmed upon entering the home of a client and being confronted with evidence of the difficulties faced by that client (for example, abuse, poverty, or chronic illness). In such cases, some of what the therapist experiences as a personal loss of power may in fact

be a reaction to transference from clients who feel helpless in their situation. In this sense, while daunting or frustrating, a strong emotional reaction to the client's home environment can also be instructive for the therapist as to what the client might be feeling.

A countertransference reaction, based in the therapist's personal sensitivity to the home environment, can also arise. As Levitan and Reynolds-Mejia (1990) point out:

going into the family home is often like "going home" to the source of the therapist's own childhood wounds and memories, a sense that colors the therapist's reactions to the family. The more closely it evokes the therapist's own family, the more seductive the family environment can be. (p. 59)

This is true, too, in visiting individual clients. The home environment is an emotionally laden one for many people, and is thus more likely to evoke a sentimental reaction in therapists than would a clinical setting. Personal associations to that which the therapist finds familiar about clients and/or their home life may influence the therapist's perception of clients and their situation. This can interfere both with the therapist developing an accurate picture of clients and client needs, and with his or her ability to remain objective when observing family dynamics.

McCollum and Synder (1999), in discussing the training of interns learning to do home-based therapy, cite a heightened sense of familiarity with clients as both a positive and anxiety-provoking aspect of working with clients in-home. Acknowledging that interns were drawn to the social or "friendly" nature of in-home therapy, a quality referred to by several authors including Fisch (1964) and

Friedman (1962), they describe how a deeper and more personal understanding of clients' circumstances, particularly when families lived in financial deprivation or in dangerous surroundings, led interns to question the effectiveness and relevance of therapy. Yet, McCollum and Synder add that working in the home environment helped interns to attain a more thorough knowledge of their clients, and better attune to the clients' concerns.

Entering in to the client's home does change the conventional structure of psychotherapy. The roles of host and guest are reversed, and this changes the balance of power in the therapeutic relationship (Christensen, 1995; Dore et al., 1998; Friedman, 1962; Levitan & Reynolds-Mejia, 1990; McCollum & Synder, 1999; Speck, 1964; Woods, 1988). Social customs dictating how one should behave as a guest in another's home can sometimes seem at odds with the therapist's professional role. According to Dore et al., "the most frequent dilemma posed by therapists is how to serve a *therapeutic* rather than a social function in someone's home" (p. 95). While the informal atmosphere of the home can facilitate the development of a more intimate relationship with clients (Bell, 1998; Bloomgarden & Sezaki, 2000; McCollum & Synder), something usually considered to be a positive advantage, it can also impede the therapist from making certain interventions due to concern for safety or boundary issues (Christensen).

In a study of therapist's perspectives on home-based therapy, Christensen (1995) reports that feeling like a guest in the client's home can affect the therapist's level of comfort when asking for such things as environmental

changes, or confronting clients on sensitive issues. Christensen observes there is a danger that therapists who work in-home “will not confront clients as often as therapeutically necessary” (pp. 311-312). If a therapist is uncomfortable with being in a position of authority in the client’s home, this can lead to overly cautious or accommodating behavior (Levitan & Reynolds-Mejia, 1990), or reluctance to structure the therapy (McCollum & Synder, 1999).

McCollum & Synder (1999), report that when therapist interns worked in-home they found:

social conventions dictated that clients...should control the very actions that are typically controlled, or at least guided, by the therapist, and which mark the site of authority in the hierarchy – arranging the seating, controlling access to the sessions, directing the process in the room, and so on. As a result, interruptions and distractions had a way of being mixed into the “business” of therapy, continuously blurring the boundaries between the two, and leaving the hierarchy of the relationship much less clear than it would have been in an office-based session. (p. 234)

While many therapists welcome the more egalitarian relationship with clients that the home setting supports, without some structure and guidance from the therapist the therapy session could easily become little more than a social visit. It is also important to ensure confidentiality with regard to what is seen and heard during therapy sessions. Thus, while acknowledging that the client is an authority in his or her home, and accepting that some difficult or unpleasant aspects of working in-home cannot be changed or controlled for (for example, unexpected visitors, phones ringing, degree of cleanliness), therapists retain a professional responsibility for ensuring that the home environment is conducive to therapeutic work.

According to Dore et al. (1998), "maintaining professional boundaries in the home begins with defining for families what the process of treatment entails, the ground rules for sessions, and what the home-based therapist's and family's roles will be" (p. 95). However, as discussed above, the home setting often presents challenges to traditional therapeutic roles. As a result, therapists choosing to work with clients in-home may go through a process of redefining their professional role within this environment (Bloomgarden & Sezaki, 2000; Fisch, 1964; McCollum & Synder, 1999). Dore et al. acknowledge that "the home-based therapist cannot have the same expectations for order, control, and structure," and add that "what is gained...is additional flexibility and creativity" (p. 95). This is, I think, a key point. Flexibility and creativity are required for responding to the unique challenges of working in the home environment, and an ability to adapt one's therapeutic approach to the demands of the setting and the needs of the client can become an important part of one's professional identity.

Because providing psychotherapeutic services for clients in-home is in many ways an unregulated method of treatment delivery, some means of ensuring ethical practice needs to be in place, as does a system of support for therapists who chose to work in this manner. Many authors comment on the importance of supervision and peer review in monitoring the appropriateness and effectiveness of interventions, helping the therapist recognize and manage countertransference, and easing the therapist's sense of isolation (Bell, 1998; Dore et al., 1998; Korittko, 1994; Levitan & Reynolds-Mejia, 1990; Stephens, 1978). Art therapists who work with clients in-home immerse themselves in their

clients' environments for the length of their therapy sessions, without the benefit of colleagues in close proximity for support. Maintaining a strong and consistent supervisory relationship and network of professional colleagues can help ensure that the art therapist retains a professional perspective while working independently.

Taking art therapy into the home environment creates an interesting encounter between a setting that demands a creative approach to therapy, and a therapy based in creativity. It also presents a context in which the traditional roles of therapist and client are altered, due to social conventions pertaining to the roles of host, and guest in someone's home. While working in the home setting can provide art therapists with greater insight about their clients and broaden their definition of their professional role, conducting therapy in clients' homes is still somewhat unconventional, and this can be cause for some anxiety regarding how to adapt to the setting, and avoid blurred therapeutic boundaries.

Bell (1998), an art therapist and part of a support team at a hospice, having worked with many dying patients and their families in their homes, writes of her own initial anxiety concerning the permeability of the home as a setting for therapy, with its "unpredictable hazards, such as unexpected callers and occasional interruptions by family members" (p. 92) which can undermine or hinder the therapeutic process. While acknowledging there are situations in which the home environment is too busy or unpredictable to provide a

confidential space for therapist and client, Bell describes how, through experience, she became more confident working in this milieu and more adept at handling interruptions:

I have become more proficient at negotiating with the family members for uninterrupted time with the patient in the home. I now feel better equipped to respond spontaneously to such an event and may even incorporate it into the therapeutic work...I now realize that most of my anxiety was unnecessary. (p. 92)

Bell identifies the flexibility to adapt appropriately to each home environment and to the lifestyles of clients and their families as a trait that therapists who work in-home require in order to respond therapeutically to clients and their circumstances in this environment.

Horovitz (1999) discusses how art therapy sessions with a child in residential placement for oppositional defiance and aggressivity evolved to incorporate activities outside the traditional bounds of therapy, including home visits. While Bell (1998) focuses on the need for therapists who work in-home to adapt creatively to this setting, in a sense Horovitz proposes the inverse – that adapting creatively to a client's needs can lead the therapist to choose a non-traditional location for therapy. She describes how working in unconventional settings away from the expected site of treatment, such as walks in the woods, skating in the park, and having a meal with the family at home, allowed her to better learn about and respond to this child's needs and interests. While her interaction with her client was not limited to the home setting, Horovitz (1999) refers to the value of home visits in providing the therapist with opportunities to

gain a different point view of family dynamics, to involve family members not ordinarily included in the therapy, and to role model appropriate interactions within the family during visits.

Although she primarily discusses the merits of stepping outside therapeutic convention, Horovitz (1999) also writes about the opposition she faced from colleagues and supervisors who disagreed with the informality of her therapeutic approach with this client, cautioning her about countertransference reactions and crossing professional boundaries. Reading her description of this case, it is not clear to what extent Horovitz questioned her own methodologies while working with this child, only that she felt compromised by “an agency that left little room for creativity and revolutionary methods of treatment” (p. 129). Although her commitment to helping her client is admirable, and her use of non-traditional means was apparently effective in treating both the child and his family, the concerns expressed by those who questioned Horovitz’s methods were not necessarily unfounded.

The act of taking therapy outside a professional therapeutic space where privacy and confidentiality, session length, and the neutrality and safety of the environment are controlled for, challenges values held by many therapists, particularly those of psychodynamic orientation (likely the most common orientation adopted by art therapists). There is a risk of becoming over-familiar with clients, blurring the boundary between professional and social relationships. The potential for clients forming a transference relationship with their therapist may be diminished, thereby rendering therapy less effective according to

traditional psychodynamic theory. Moving therapy sessions into an unconventional setting may also affect the therapist's and agency's liability should there be an accident or other difficulties. These are all reasons for valid concern and therapists who decide to work in non-traditional settings bear a professional responsibility to carefully consider the impact of setting on the therapeutic process.

There are of course situations in which the client's home is the best, and possibly the only, site for therapy to take place. Both Gibson (1994) and Bloomgarden and Sezaki (2000) address the merits of in-home art therapy as a service for homebound older adults. Gibson describes how the psychological needs of the homebound are often overlooked, and advocates for art therapy interventions as a means to help homebound older adults adopt new creative roles, despite their limited mobility. However, Gibson does not specifically address how the home setting can influence therapy, beyond that home visits provide these clients with access to a service that would otherwise be unattainable, and allow the therapist to facilitate interaction between clients and their family members.

Bloomgarden and Sezaki (2000) go into more detail regarding considerations that are particular to providing art therapy in-home. The authors present two case studies in an article based on Sezaki's Master's thesis and his one-year clinical experience working with older adults. Like Gibson (1994), Bloomgarden and Sezaki discuss the merits of art therapy in identifying and addressing the psychological needs of the homebound, and helping them to

define and develop new roles. However, they go further in exploring how art therapists must also learn “new roles, techniques, and obligations when they start to work with clients and their families in this specialized setting” (p. 283). They pay particular attention to the role of the art therapist and the therapeutic relationship, suggesting that in the home setting “the therapist’s position may be less authoritarian and this enables the therapist to create a more intimate and/or social relationship with the family” (p. 284). In both case studies, Bloomgarden and Sezaki discuss how clients’ family members were encouraged to participate in the therapy, either directly or indirectly, given that it was taking place in the home setting. They also describe how aspects of clients’ lives apparent in their home surroundings, such as gardens, photographs, and evidence of talents and interests, were easily and effectively incorporated into therapy.

For clients receiving in-home art therapy, does it enhance their experience of therapy by offering them a supportive service within the comfort of their own homes? Or do home visits leave clients feeling exposed, or concerned that their living circumstances will be judged? For whom is in-home service most appropriate, and when is it contraindicated?

These issues will be explored throughout this paper, and the content of the art therapy resources summarized above will be further integrated into the discussion of the data from the survey study. As mentioned earlier, the aim of this study is to look at the context of working in the clients’ home environment, and discuss how the home setting influences art therapy practice. Through the summarization and comparison of reports from several professional art therapists

who have experience providing in-home services, it is hoped this study will provide some insight into the particular conditions art therapists experience when working with clients in-home, the issues they feel are relevant to this practice, and how this sample of art therapists has approached working in the home milieu.

While I have drawn from the literature in several fields as relevant to this topic, the focus of this study is on the practice of home-based art therapy, specifically. To date there are few resources available on the subject in the art therapy literature, although there is evidence to suggest this is changing. While the earliest article on in-home art therapy that will be referred to in this study was published in 1994 (Gibson), three more works pertaining to this topic have been published in the past three years (Bell, 1998; Bloomgarden & Sezaki, 2000; Horovitz, 1999). Two of the art therapist participants in this study were, during this past year, also working on Master's theses on the subject of in-home art therapy. It seems that this aspect of the field is drawing more attention, and it suggests an exciting expansion of art therapy services in the future. The aim of this study then seems timely, poised at a point in the evolution of the field to contribute meaningfully to the professional literature.

Chapter Three

My Experience

My own experiences with in-home art therapy came about through my final practicum placement during the completion of my Master's degree. I knew I wanted to work with an older adult population in a community-based setting, and in the process of looking for an appropriate agency that would be interested in having the services of an art therapy intern, I was referred to a large urban community center for seniors. Prior to my enquiries, a representative of this organization had contacted the director of the art therapy program and expressed interest in art therapy as an outreach service that could be offered to members of the center who, for health reasons, are no longer able to attend activities or receive intervention services at the facility itself. On the recommendation of the program director, I contacted the center and put forth a proposal for an internship that could accommodate those in their membership who might benefit from participating in art therapy, on site or via home visits.

I began working at the community center in September 2000, and continued my practicum placement there until May 2001. During that time I worked with a total of eleven clients, five per week on average. Three of these clients were seen in their homes. Of my in-home clients, two were referred because progressing Alzheimer's disease (AD) had limited their activity. Both men, in their early 80's, retired from their careers due to symptoms of the disease and were dealing not only with the confusion caused by memory loss, but with the loss of former roles as well. It was felt that art therapy could be adapted to

the abilities of these two clients, at the early-moderate stage of the disease, and provide them with alternative means by which to process and express their experience of the transition brought upon by AD. As well, both men had previously expressed an interest in art and in attaining new skills in this area. Art therapy offered the opportunity for them to try new and creative activities at a time when several of their former activities were no longer possible.

One of these two men was my first client via the center, and my first in-home client as well. We worked together for eight months. He and his wife live in an apartment, and had recently moved there from their family home. Conducting therapy in this environment proved to be poignant, because the impetus for the move was my client's AD (as well as physical difficulties experienced by his wife, also in her early 80's). The apartment symbolized the change in circumstances this couple was going through, and my client spoke about having moved to the apartment in connection with no longer being able to work. He felt current changes were imposed upon him by factors out of his control, namely age, memory loss, and well-meaning interventions from concerned family members.

While this setting seemed to encourage discussion about change and loss of control, it also afforded my client more control than allowed by therapy in an office setting. He chose the area of the apartment in which we would work, and assumed responsibility for preparing this area before my arrival each week. Because we were in his home, he felt free to adjust lighting and temperature levels, and to suggest brief breaks intermittently, something he might not have felt confident to do in another setting. His ability to adjust his home setting to his

needs was addressed in therapy as a personal strength, and a metaphor for how one adapts to changing circumstances. Through art making, in which evidence of the client's AD (rotation of features, perseveration, merging or confusion of boundaries) was present and at times frustrating for him, we were able to explore his felt response to change and loss, his desire to maintain his sense of ambition and agency, and ways in which he could continue to exercise his abilities and explore his interests.

For this client home visits represented something like a gift. He expressed gratitude for the service and appreciation for my taking the time to come to his home. Because he had experienced several recent losses, it is interesting that this client chose to frame our therapy sessions in this way. The issue of whether in-home therapy is funded by a social care program or paid for by the client is an area that deserves careful consideration with regard to power and transference dynamics. While this client's perception and acceptance of therapy as something being given to him seemed to have therapeutic benefit in and of itself, this would not necessarily be the case for others, and could indeed have an inhibiting effect should the client feel indebted to or patronized by the funding agency, and thus the therapist.

On the other hand, paying for therapeutic services received in the home may increase the client's sense of power in the therapeutic relationship. A positive example of this might be the client assuming greater responsibility for his or her therapeutic process and participating actively in sessions. A less positive example would be if the combination of paying directly for services and hosting

therapy sessions in his or her home leads the client to exert authority in the therapeutic relationship in a way that is detrimental to treatment, such as dismissing the service too readily or not cooperating with the therapist in maintaining an environment conducive to therapy. These were not possibilities that I thought to consider prior to beginning my internship, but the issue of who pays for in-home service can certainly have an impact on the dynamics of therapy.

How to maintain privacy and confidentiality in the home environment was one of my main concerns when I started making home visits. My first client's wife was present in their apartment for most of our sessions. Frequently at first, she would check during a session to see how things were going, despite careful discussions with the couple regarding the need for privacy and confidentiality during therapy. She was curious to see her husband's artistic efforts and wanted, I think, to make sure he was participating amenably. Initially I was quite concerned about this. I worried that his wife's presence would inhibit my client from talking freely, or that he would feel pressured to perform. Involving the wife in the therapy, which might have been beneficial for both in the couple, proved not to be an option: I discussed it with my client, but he preferred to keep sessions for himself alone.

After a meeting with the couple, in which the importance of privacy during therapy was reemphasized, the wife agreed to wait until the end of a session to ask after her husband, to not request to see her husband's artwork, and offered that during sessions she would watch T.V. in a room down the hall from where

we were working. This seemed to work out well until the day it became apparent that my client's wife was still able to overhear the content of sessions, as she called out from the T.V. room to correct her husband regarding something he was discussing.

I was very frustrated with the situation and by my seeming inability to establish proper boundaries for therapy in this home environment, until I began to notice that my client, when his wife was less present, sought her out. When she didn't ask to see his work, he would offer to show her. On breaks during the session, he would look in on her. Gradually, I came to understand that this couple, who shared so much of their lives together, were each other's security, and that perhaps this factor outweighed my insistence on privacy. I relaxed my approach, to allow my client to determine how he would share his therapy with his wife, working with him to establish stronger boundaries when he felt they were needed.

This was an important learning experience for me about my own confidence in my professional role, and how the home setting could unsettle my definition of what my responsibilities are as an art therapist. I no longer had the same control of the environment as one has in a clinical office or a studio. Instead of preparing a setting for the client to enter into, I was entering the client's environment. I now had to adapt to this setting and be aware of how my client functioned within his own environment and why. Working in the home

environment forced me to better understand my client's definitions of privacy and confidentiality, and adjust my own expectations to better respect my client's needs, and his reality.

The second man is a client whom I originally saw at the community center. When his wife experienced health problems during the winter, making it difficult for her to bring him to therapy sessions, it was agreed that home visits would be an ideal alternative. In-home art therapy was offered to this couple before therapy commenced, but at that time the wife felt her husband would be more inclined to participate in a formal setting. She likened it to attending art classes, in that traveling to sessions would set them aside as a special activity, and thus be a motivating factor. However, the unfamiliar setting actually seemed to distract him and detract from the therapeutic process.

In the office we used for sessions at the center, this client was often unsettled, preoccupied by the events of traveling to our appointment, and distracted by the unfamiliar furnishings and the noise from activities taking place down the hall. His attention span was very short, and I wondered if the therapy environment was exacerbating his difficulty maintaining focus on a topic, already present due to the effects of AD. Indeed, our later in-home sessions appeared to foster this client's ability to concentrate, perhaps because he was more confident and relaxed in his familiar environment. Working with this client in-home gave me quite a different perspective of his abilities than had I seen him in the center only.

Being in the home environment allowed for the inclusion of personal items in therapy, such as photographs, awards, and souvenirs. These acted as memory aids and fostered reminiscence. My client often used these items to illustrate discussions about important people and events in his life, and his past accomplishments. It was a fortunate coincidence that, working in his home office, we had access to a photocopier. The copier became an important creative tool.

This client found using art materials a painful reminder of his diminished capabilities (he had been a gifted painter in his youth, and was raised in an artistic family). As an alternative, we embarked on creating a journal together. He chose pictures and images to photocopy, and decided how these would be included in the journal. Thus my client could arrange images creatively, without having to create the images himself. Written entries were composed of notes kept by me as my client dictated his anecdotes on various topics. Because we were in his office, using his equipment and resources, the client's sense of ownership of the project was that much stronger, and his ability to sustain concentration on the task was enhanced.

Although family members were present in the home during sessions, this was not a large concern. Earlier experiences with my first client had already helped me adjust my expectations of working in the home environment, and with this client therapy was taking place in a more private area in the home. As with my first client, the presence of his wife was a reassuring factor for this man. Knowing his wife was in the house, he could enter into the therapy session securely. If she was away on an errand (even though other members were still

present), he was preoccupied by her absence and concerned for her safety. Only when she had returned was he relaxed enough to turn his attention to participating in therapy. This observation helped me to further understand the reasons why my client was agitated during our sessions at the community center, and to better appreciate his attachment for his wife. This client and I worked together a total of seven months, with just over two of those in-home.

My third in-home client I saw only briefly. Due of the brevity of our relationship I did not have opportunity to obtain this client's consent to discuss her case, therefore I will refer to my work with her only in minimal detail. This client was housebound for myriad health reasons, for which she had also experienced frequent hospitalizations. Her family, who lived nearby, reported that she showed little interest in any activities and indeed, because of her physical impairment, could partake of few. I was asked by her caseworker if I could offer some therapeutic activities this member could participate in and benefit from.

When I called to introduce myself and suggest a home visit, my offer was refused. The woman told me about her poor health, and said she did not feel up to seeing anyone. However, she added, I could call her again in a week if I wanted to. When I called back a week later, she agreed to see me.

Visiting with this client at home, I was able to observe how her limited physical abilities were impairing her quality of life, and how the solitude of living alone in her apartment was contributing to her depressed mood. I reported this to her caseworker, and she then made contact with the family regarding a

pyschogeriatric assessment to help determine what could be done to improve the woman's physical and emotional situation. Unfortunately, this client was taken to the hospital during the week, and passed away there a few weeks later.

With each of these clients, I feel visiting them in their home settings both enhanced and hastened my understanding of their daily circumstances, personal strengths and limitations, personalities, histories, and relationships with others. For my clients, home visits accommodated their circumstances and eliminated physical barriers to their receiving art therapy services. Communication was facilitated by the number of 'conversation pieces' that were readily at hand, and perhaps as well by clients' comfort in their home environments.

Working with these clients in their homes also improved my understanding of their faith and cultural practices. Coming from a different religious background than my clients, I found the research I did to increase my knowledge of their culture and religion was augmented by being in their homes and observing the preparations they made for their Sabbath, holidays, and special events. For my clients, these occasions allowed them to teach me about their beliefs and interests. They were also important times for reminiscence. For me, I was able to ask my clients questions and develop a fuller understanding of their values and personal histories. Language was not a barrier so these exchanges happened with relative ease. While our cultural differences did not seem to impede the therapeutic process, they did influence the therapeutic relationship by allowing for an elucidative comparison of different perspectives and experiences. This

might not have happened as readily in a neutral therapy setting, as our discussions about faith and culture were often prompted by environmental cues.

Countertransference and transference issues as they pertain to working with clients in their homes will be discussed at several points in this paper. While my own theoretical orientation is decidedly eclectic, I acknowledge that a psychodynamic understanding of the symbolic interaction between client and therapist can be very valuable, especially in the home, a setting so laden with cultural meanings associated to family, relationships, and security. However, having carefully considered any countertransference reactions I experienced while working with my in-home clients, I do not find any that were tied specifically to the home environment.

Most often my reactions had to do with the age difference between myself and my older clients, and associations that I made between my clients and my grandparents. These associations were not based on anything in my clients' homes per se, but rather on similar personality traits and the fact that at the time of my internship I was coping with the knowledge that my paternal grandparents were both in the latter stages of chronic and terminal illnesses. Perhaps visiting clients in the intimacy of the home setting increased the intensity of my countertransference, but I feel that to some degree these associations would have happened regardless of the therapeutic setting. On an unconscious level, my home visits with clients probably did connect with a wish to return to times when I could visit with my grandparents in their home, but I suspect that,

regardless of where the therapy sessions took place, my work with older adults was bound to stir an emotional response in me concerning the loss of my grandparents.

Conversely, the strongest transference relationship I experienced was in one client associating me with his with his daughter and granddaughter. My short haircut reminded him of his daughter, and his granddaughter and I share an interest in art. This man's daughter and granddaughter both live out of country and they are only able to visit a few times per year. There were several times during our weekly art therapy sessions when my client expressed the wish that his family lived closer, and when I sensed that he was experiencing my visits as a something of a substitute for the contact he would have liked to have with his family. We addressed this wish throughout the year, particularly following a vacation this client and his wife took to visit their daughter, during which they'd anticipated eventually moving nearer to her.

The transference relationship was especially strong, and took a particular turn, at termination. During our final session together, this client spoke to me for the first time about the accidental death of his son years earlier, remarking on the irretrievable nature of his loss. This man had not had the chance to say goodbye to his son, and seemed to be acknowledging this in his goodbye to me. His sense of loss was perhaps also connected to a process of mourning for his earlier self, as roles, abilities, and memories, were being lost due to the progress of AD.

I think I represented for this man, at times, his younger family members as well as his younger self, both of which were at a distance from him in the present. I feel that the termination of our work together, and his saying goodbye to me one last time, involved unspoken goodbyes to other people in his life. Again, given the strong symbolic connection between home and family and security that exists in many cultures, having received my visits in his home may have intensified for this client the development of a transference relationship. However, a similar process could have occurred in another therapeutic setting, based on age and other similarities alone. While I do understand how working with clients in their home settings could heighten countertransference and transference reactions in certain circumstances, I did not experience this as a difficulty in my work with these particular in-home clients.

For the most part, the difficulties I experienced that were specific to conducting art therapy in-home, aside from privacy and confidentiality issues, were practical concerns pertaining to travel, time, and materials. My clients lived in areas of the city requiring at least an hour's commute from my home. Although I tried to schedule all in-home sessions on one day of the week, this was not always possible, and often for every hour of therapy I was spending two hours in travel. This added up to a huge commitment of time. Also, because I did not have access to a car, this amount of travel was a particular challenge, especially during winter.

The first questions about in-home art therapy that I posted to the professional e-groups concerned how to select and transport supplies for in-home art therapy, and whether client artwork should travel with the therapist or remain in the home. Based on the advice of a respondent, I opted to use a small suitcase on wheels to transport a selection of materials, occasionally employing a large nylon portfolio to carry large paper. Generally, I chose lightweight and easy to pack supplies, such as pencils, watercolor pencil crayons, pastels, and paper small enough to be laid flat in the suitcase without folding. When a client expressed interest in other materials, such as paint or clay, these were repackaged to make carrying them easier. Paint was transferred into plastic film canisters, and clay was cut into small blocks and wrapped in plastic. To protect clients' homes and make cleanup easier, I brought with me a large plastic drop cloth to spread over our working surface, be it dining room table, coffee table, or desk. This was easy to wipe clean, fold, and pack. If clients offered their own art supplies, or showed interest in obtaining materials, they were encouraged to do so. Otherwise, I provided materials, which were purchased for the internship by the center.

I debated a great deal about the best arrangements for the safekeeping of artwork done by clients at home. For me, requesting to take the artwork with me felt very different from asking clients to leave behind work done in a clinical or studio setting. Because my in-home clients lived with their spouse only, or alone, the risk of their work being damaged or disturbed by others in the household was minimal. Plus, because I was working with adults, I felt it was best to allow my

clients to choose where their work would be stored. One client requested to keep the artwork at home, and arranged a special place for it to be stored safely between sessions. Another did not want to keep any work with him, and entrusted it to me to bring back each week. Only when therapy terminated did this client keep the artwork he had done through the year.

Traveling on the bus and subway with client artwork was sometimes awkward, particularly during peak travel times. Managing to get the suitcase on and off crowded vehicles was a feat at times, and I was always concerned the artwork might get damaged in the jostling. Fortunately the artwork made it through the year unscathed, and at worst I had a sore back from carrying the suitcase. However, because of the bulk, weight, and fragility, of three-dimensional work, I did not offer this as an option to my in-home clients as often as I would to clients in a clinical setting. The use of a car would have made the transport of art materials and client work much easier, and lessened the time spent traveling to and fro. I would hesitate to conduct home visits in the future, in any volume, without access to a car.

Based on my experiences of in-home art therapy during my practicum, I would like to include this service in my professional practice. However, I have concerns about the feasibility of such a service, both in terms of time and funding. It is not practical to spend more time traveling to sessions than in them. Extended travel is tiring for the therapist, and limits the number of clients that can be seen. Also, the money spent on travel costs could be a drawback, if one is also paying to maintain an office or studio based practice. I also wonder what

agencies would be willing to sponsor or insure in-home service, given the extra commitment of time and travel required, and the fact that the home environment is less controlled, and therefore less predictable, than a more conventional therapy setting.

Safety is something that must be considered when discussing the provision of mental health support services to clients at home. While I did not find myself in any situations during my experience that felt unsafe, the reality is that you cannot know what to expect when entering someone else's home. For this reason, I made sure my supervisor at the community center had a copy of my schedule, and a list of the names and phone numbers of my clients. She had access to the addresses of members of the center, and so could easily trace where I was supposed to be during my practicum hours. Had I been working with a population with which I felt safety risks were higher, I would have acquired a cell phone to take with me, or requested a co-therapist.

I was also had concerns about my responsibility for my clients' health and safety during visits. Working with an older population, with several clients who had chronic health conditions, I wanted to know what procedures to take lest a client need medical assistance while I was present. The community center has a protocol for such situations, established for volunteers who visit seniors at home, and I received instruction about this during the first weeks of my practicum. Should I continue to work with clients in-home, I will take it upon myself to get further training, especially in first aid and C.P.R.

I learned a great deal from working with clients in-home during my practicum, both about my clients and about myself. It has influenced my approach to art therapy in other settings, particularly in my awareness of the therapeutic environment and the influence it can have on the client's experience of therapy. I will also be more inclined, if not working with clients in-home, to inquire about their home environment, encourage them to do artwork at home, or give them opportunities to bring personal objects from home to incorporate into therapy. Where one lives has great personal symbolic significance for most people, and understanding how a client functions in his or her home setting can be a source of therapeutic insight.

I am a more flexible and creative therapist now than before, largely because of having to meet the special challenges and demands posed by working in a non-conventional setting. Having adapted to working with clients on their home ground, I am also more confident in my professional role, and better trust the effectiveness of the therapeutic process as it unfolds in any environment. This study began out of my curiosity about the particulars of conducting in-home art therapy, and about how other art therapists had experienced and adapted to the conditions of working in-home. Because so little was available on this subject in the literature, I felt a survey study could help draw attention to the scope and nature of this practice, serving as an interesting resource for art therapists who are already working in-home, for agencies

considering in-home art therapy as an outreach service, and for those entering into this aspect of the field who feel, as I did, that they are entering into uncharted territory. This paper is an attempt at mapping the terrain.

Chapter Four

Investigative Procedures

Method and Design of the Study

This is a qualitative study, a survey conducted via questionnaire. It was designed to record and summarize self-reports from art therapists who have recently worked with clients in-home regarding their experiences of providing therapy in this milieu. The purpose of the study is to examine how the home environment may affect various facets of the therapeutic frame and relationship, and to present an overview of the current practice of in-home art therapy as represented by the art therapists participating in the study.

To limit the effect on the data collection process of any biases I might have regarding the practice of in-home art therapy, questions for the survey were based on a review of literature, and what researchers in various fields have identified as important considerations when providing therapy for clients in the home environment. Apart from those pertaining to demographics, most questions were left open-ended to allow participants to respond in their own words whenever possible. For some questions, specifically those related to the material considerations inherent in art therapy, I drew upon my own experience, as well as information in the art therapy literature. Bias was further limited, and clarity enhanced, by having several readers (the ethics committee, my research advisor, and colleagues in art therapy and other disciplines) review and help refine the questionnaire. The results of the study come strictly from participant responses to the questionnaire, and these will be discussed in relation to what

was found in the literature. My own experience as an intern conducting in-home art therapy with an older adult population, described in the previous chapter, is offered as a supplement to the study.

The questionnaire was designed so that questions followed an organic yet logical sequence from demographic information to a description of primary populations worked with in-home; information regarding referrals; service provision (program, funding); therapist and client reasons for opting to have therapy take place in the client's home; session length compared to clinical session length; issues of privacy and confidentiality; where and how artwork was kept; the influence of the home environment on therapist's provision of supplies, and how materials were transported; advantages and disadvantages to conducting art therapy in-home; the continuation of this practice; and helpful resources. Completed questionnaires were reviewed individually, and responses to questions were condensed to point-form with regard to key words and thematic content. The condensed data was then charted so that answers from all participants could be easily compared according to topic, and analyzed for common emergent themes. The order (by topic) of questions on the questionnaire served to guide the charting of the data, and will be followed as well in the discussion of survey results.

Sample of Persons to be Studied

The participants in this survey study are art therapists and art therapy interns who were currently conducting art therapy sessions in client homes, or who had worked with clients in this way at some time within the three years prior

to the study. With one exception, all art therapists who participated in the study had practiced art therapy in clients' homes within that three-year margin. The one art therapist excepted from this condition was included because of the volume of her experience. In order to be able to reasonably ascertain level of training, only art therapists belonging to national, and/or provincial or state art therapy associations, or interns enrolled in a program recognized by such an association, were included in the survey. A total of 13 art therapists are represented in this study.

Method of Recruitment of Participants

Art therapists were recruited via notices about the study sent by email to professional internet correspondence groups, art therapy associations, and training programs. A snowball method of recruitment took place following these postings as art therapists responded to express interest in joining the study and/or to recommend other art therapists with the requisite experience. Direct invitations were sent, when possible, to the authors of published articles pertaining to the practice of in-home art therapy. Those art therapists who responded to my pre-study query about home-based art therapy were invited to participate in the study, as were two colleagues in my training program who were both involved in internships that required working with clients in-home.

Treatment of Participants in the Course of the Research

Participants were asked to complete a short questionnaire at home at their convenience, with a suggested return time of two weeks after receipt. As recruitment took place via the internet, it was anticipated that most of the surveys

would be sent and returned via email; however, when a participant needed or preferred to use regular mail, the survey package was posted to them with a return envelope and postage coupon included. Following the completion of the study each participant received a summary of the results, to which feedback was invited. Subjects did not receive payment for participation.

With respect for confidentiality, information that could be used to identify participants (names, addresses, etc.) is not included in the research paper. In the course of the project this information was only used for necessary correspondence, including the distribution of questionnaires and a summary of results. In the one instance where a recipient of in-home art therapy was referred to participate, the recipient questionnaire package was sent via the art therapist so that the client could remain anonymous. The completed survey was then returned directly by regular post.

For responses received by email, identifying information (name, email address) was deleted, and each completed questionnaire was given a code number, saved onto a computer disk, and printed as a paper copy. The original email message was deleted. As names are not attached to the saved or printed copies, no one viewing them will know who completed them. The only time anyone other than myself will see these papers is if I am asked to provide source material to verify my research. I have a master list of names and contact information for participants, and the printed questionnaires will be kept as evidence of original data, but the two will not be linked, thus preserving the confidentiality of responses to the questionnaires.

Analysis of Data

An ad hoc method was chosen for analyzing responses to the questionnaires, focusing on emergent themes, due to the qualitative questionnaire-based nature of the study and the small sample size. Results of the data analysis are discussed in terms of themes, counted number of responses, contrast and comparison, patterns, relationships, and fit with theory. In this way, participant responses can be succinctly described, compared, and discussed in the context of theory drawn from the literature review.

Once all completed questionnaires were received, they were reviewed independently of each other, and emergent themes were noted. Answers to questions were summarized in point form, and charted according to participant (each participant was given a code, and is identified by code in the chart) and question topic (see Appendix C, Chart of Survey Data). From the original list of themes compiled as questionnaires were being read, related statements were clustered and a descriptive statement created to succinctly describe their general thematic content. Each general statement of theme was then given a short acronymic code. Using the chart, the point form summaries of participants' answers were then coded according to theme. The number of times a code appeared across the chart in response to a particular question was tallied thereby revealing how many times a theme emerged with regard to each question. The results of this process were summarized (see Appendix D:

Summary of Analysis of Data), facilitating the comparison and contrast of responses, and allowing patterns and overall themes to emerge more readily. The summary of data serves as the basis for the following discussion.

Chapter Five

Results of the Survey

Demographic Information

Participants in the study received a short questionnaire asking for demographic information about themselves, their practice, and their clients. Questions then moved on to topics concerning referral and service delivery, therapist's and (therapist's impressions of) client's reasons for choosing in-home art therapy, session length as compared to clinical sessions, issues of privacy and confidentiality when working in-home, and the handling of artwork and materials. Art therapists were asked to give their opinion as to the advantages and disadvantages of conducting art therapy in clients' homes, and lastly, to cite what resources they have found helpful in navigating this aspect of their practice.

Of the 13 art therapists who participated in the study, 7 live and work in the United States, 4 in Canada, 1 in Australia, and 1 in the Netherlands. Ten have (or were completing) a master's degree in art therapy (or a related field, with a specialization in art therapy), 2 have (or were completing) diploma level training in art therapy, and 1 has a doctorate degree in the field. Twelve of the participants describe working with clients in urban areas, 2 have experience with in-home art therapy in rural areas, and 1 participant did not make a selection on this item. The number of clients they have seen ranges from 1 to 1500, depending on the length of their career and the composition of their practice, as those who work with families in-home can typically count a larger number of clients. At the time of this study, 3 of the participants were interns finishing their training.

Primary Populations

When describing the primary populations they have worked with, 11 art therapists indicated that they work with individual clients, 8 indicated siblings, 7 selected families, 6 indicated parent-child dyads, and 2 chose couples. Again, these results are influenced by the variety of each therapist's practice, and also by the fact that therapist's who work with families might opt to work with some members independently of others at times. When asked about the age of their clients, adolescents were the most indicated group, cited by 9 art therapists. Following this were children and adults, both selected by 8 art therapists each, and then older adults, indicated by 2 art therapists as the age group of their primary population.

Regarding primary population and gender, responses suggest that these art therapists, combined, have seen a slightly higher number of female clients in-home than male. This is difficult to determine accurately, as percentages were not always reported, and there is a wide range in the number of clients seen per therapist. If in future studies, with larger samples of participants, a higher percentage of female participation in in-home therapy continues to be indicated, this would raise interesting questions about the specific nature of in-home therapy and why it may draw more female recipients than male. Factors such as single parenthood, childcare, financial considerations, and the longer life expectancy of women, may come into play and could be examined in further research. It should be noted here that all of the art therapists who participated in

this study are female. The gender of the therapist can certainly have an impact on the dynamics of in-home services, and factors such as safety concerns may influence the composition of the therapist's in-home practice.

Participants were asked to describe their own cultural background, as well as that of their primary population. The reason this information was requested was so that a comparison could be made regarding the use of in-home art therapy in cross-cultural situations. Responses indicate that 11 of the 13 art therapist participants have used in-home art therapy when working with clients of a different cultural background than their own. Art therapists were not asked about cross-cultural therapy directly, but based on the findings of this section of the study, the potential of in-home art therapy within cross-cultural therapy has emerged as an area of interest, and one that would be interesting to explore further. This topic will receive more attention in the discussion section of this paper.

Referrals

Participants were asked to describe in their own words the reasons for which clients were referred for in-home therapy. From these descriptions, point form summaries were used (see Appendix C) to compare for similarities across participant responses, and group particulars under common or shared reasons. Please note that the figures in the discussion to follow indicate the number of art therapists who listed each reason, not the number of clients referred for these reasons.

The most indicated reasons for referral of clients to in-home art therapy were *behavioral problems*, and *developmental disability*, each cited by 5 art therapists. *Bereavement and grieving*, and *mood disorders* were next in frequency, selected by 4 art therapists. Following were *anxiety*, *difficulty verbalizing*, *enjoyment of art*, and having suffered *sexual or physical abuse*, with mentions by 3 art therapist participants. *Chronic or terminal illness*, *foster children* or issues pertaining to *adoption*, and *suicidality* were the next most frequently cited reasons for referral, selected by 2 participants. *Assessment for court*, a client's being *homebound*, *life transition*, and *trauma due to war* were also mentioned as reasons for referral.

Art therapists were asked to check off the sources of their referrals for in-home art therapy from a list on the questionnaire (see Appendix A). The referring agency in most cases (as indicated by 6 of the 13 participants) was a *community service agency*. A *clinical intake team* was the next most cited source of referral, with 5 mentions, followed by a *psychiatrist*, with 4. *Psychologist* and *social worker* both received 3 mentions as referring agent. *Other art therapist*, and *self-referral* by client were each selected twice, and referral by *physician* received 1 mention. Under the option of "other," the *client's spouse or other family members*, a *nurse*, *school*, and *lawyer or court*, were each indicated twice, and *state developmental services* were mentioned once.

Service Provision

In the majority of cases, art therapist participants report that they did not work with their in-home clients in another setting before beginning home visits. Seven participants indicated they had not seen their clients in another setting prior to beginning in-home art therapy. Four indicated that they had worked with their in-home clients in another setting previous to seeing them at home. One art therapist mentioned seeing some clients in another setting first. One participant left this question unanswered.

Given another list, participants were asked to indicate the nature of the program through which their in-home services were offered. For 6 of the 13 art therapists, at least part of their experience conducting in-home art therapy occurred during an *internship* while a student. This result was somewhat of a surprise, and will be discussed further in the discussion section of the paper. Following internship, *clinical outreach programs*, *community outreach programs*, and *private practice* were each selected 3 times, tying them for second place as the most common avenue for the provision of in-home art therapy services.

In keeping with the above, the most frequently cited source of funding for the art therapists' in-home services was *internships* (selected 6 times), wherein the therapists worked for free. *Payment by client* came next, with 3 mentions, followed by *grants*, *outreach programs*, and *state funding*, with 2 mentions each. Locating funding for in-home art therapy interventions is an important topic, and will be discussed further later in this paper.

Reasons In-Home Art Therapy was Sought, and Offered

When asked what they believed were their clients' reasons for choosing to receive in-home art therapy services, 9 of the 13 art therapy participants selected that clients chose this option because it was *recommended*. The next most frequently given reason was clients' *lack of access to transportation*, cited by 7 art therapists. Client *comfort* was the third most reported reason, selected by 6 participants. This was followed by clients' *physical mobility*, which was chosen 5 times, and clients' *health concerns*, as mentioned by 2 art therapists. *Lack of available childcare* was cited once. Under the option of "other," client's *financial difficulties*, and *increased access to therapist*, each received 1 mention.

In giving their own reasons for opting to conduct in-home therapy with clients, the most popular response was, for the *information provided by the home setting*, selected by 10 of the 13 art therapist participants. *Comfort of clients* came next, with 9 mentions. *Clients' lack of access to transportation*, and *clients' physical mobility*, followed with each being selected by 6 art therapists. *Clients' health* received 5 mentions, as did art therapy being *recommended* for particular clients by a referring source. *Lack of available childcare* (for clients) was indicated by 1 art therapist as a reason for choosing to work with clients in-home. Please note that these rankings, and those in the previous paragraph, do not indicate any priority given to reasons by the art therapists, and only represent the number of times each reason was listed when responses from all participants were compared.

Influence of Setting on Session Length

Based on the observation made by McCollum & Synder (1999) that in-home therapy (excluding intensive crisis programs) is time consuming, often resulting in sessions of longer length than those of clinical treatment, participants were asked to compare the length of their in-home sessions to that of their clinical sessions. Nine of the 13 art therapists responded that the length of their in-home sessions is approximately the same as that of their clinical sessions, contrary to the findings of McCollum and Synder. Four art therapist participants indicated that their in-home sessions do tend to last longer than their clinical sessions. No participants mentioned that in-home sessions were of a shorter length than clinical sessions.

It should be noted that 3 of the art therapists who indicated the length of their in-home sessions as being of the same as clinical sessions, qualified this by adding that sometimes, with some clients, the time is extended. The reasons given for such an extension include: to continue with goals being worked on in a session; interruptions or unexpected events occurring during a session; concern and pacing for a client's health; and a client being especially invested in a particular project. One art therapist acknowledged that she does not extend the length of the actual session, but might spend extra time in the home if a family has something they need to discuss or share.

Art therapists who indicated a difference in session length between their in-home and clinical cases were asked about the reasons for this change. Two art therapists described how the needs of their particular client populations

demanded a greater commitment of time. The informal atmosphere of the home environment and participation in social rituals as a guest in the client's home were cited by 2 therapists as the reason for extended session length. One art therapist conducted extended sessions in the client's home because the referring agent prescribed a longer amount of time. Six art therapists (including some who originally indicated in-home session length as being the same as clinical, but mentioned exceptions in certain circumstances) responded that both they and their clients experienced changes in session length as positive. One art therapist was neutral, feeling that in general extended session length did not have a positive or negative effect.

Privacy and Confidentiality

Privacy and confidentiality, conditions considered fundamental for a secure therapeutic frame, can be difficult to ensure in the home environment, where the therapist has less control over the setting and the structure of sessions. The presence of family members not involved in therapy, extended family, and/or guests, in the household when therapy is taking place can be distracting, disruptive or inhibiting for the client. Art therapist participants were asked how they handle issues of privacy and confidentiality in their in-home practice. Six of the 13 art therapists reported that they *establish boundaries with clients and clients' families prior to commencing therapeutic work*, sometimes including the signing of a contract. *Involving family members in the therapy when appropriate and possible* to do so also received 6 mentions from art therapists. Five participants described a collaborative process for determining the conditions

for therapy, in which issues are *discussed with clients* and resolved together. Three art therapists reported having *no concerns for privacy or confidentiality, because their clients were alone at home during sessions, or the entire family was involved in treatment.*

According to participant responses, creativity and flexibility play an important role in the process of defining a separate psychological, as well as physical, place in which art therapy can occur. *Utilizing physical boundaries* to differentiate therapeutic space from social space (using a separate room for example) was described as helpful by 3 of the 13 participants. Three art therapists indicated that, as *they became more flexible and creative* in adapting to working in the home setting, their concerns about privacy and confidentiality eased. One art therapist described how *the artwork itself acted as a private language* for a particular client; through the artwork this client found a space for personal creativity and communication despite the near proximity of other family members in the house.

Concerns regarding privacy and confidentiality differ depending on whether it is an individual client being seen, or the entire family, and whether the client lives alone, or with others. Concerns depend too on the therapeutic goals. For example, if the focus of therapy is on mastery of skill to help a client develop self-confidence, this perhaps requires less concern for privacy and confidentiality than would be needed if the focus of therapy was on helping the client express and explore personal issues. Of the 13 art therapists who took part in the study, only 3 worked strictly with individual clients in-home. Therefore, for the other 10

art therapists, negotiating boundaries for privacy and confidentiality with clients and their families within the home milieu was a necessary course of action.

The Artwork

The art product presents a particular challenge in home-based art therapy. Because it acts as a record of clients' participation in therapy and a container for the expression of their personal experience, what will happen to the artwork between sessions is an important consideration. Some home and family environments do not afford a safe place for storing the artwork, and clients may feel vulnerable keeping it at home. Other clients might benefit greatly from having time to work and reflect on their art between sessions, and will assume responsibility for its care. Art therapists, depending on the nature of the home environment, their theoretical orientation, and their personal beliefs on this matter, may have strong feelings about whether to take the artwork or leave it with clients. These feelings may be due, on one hand, to concern for the clients' privacy and confidentiality in-home, a desire to safeguard clients' artwork, and on the other the desire to empower clients by reinforcing a sense of ownership of their work, and not wanting to trespass social convention by removing client work from clients' homes.

When participants in this study were asked if they take client artwork with them after sessions or leave the artwork with clients between sessions, 6 of the 13 responded that they do both. Three art therapists stated that they leave the artwork with clients; 3 others reported that they keep their clients' artwork between sessions. One participant left this question unanswered.

The art therapists were also asked their reasons for choosing to take or leave the artwork. Reasons given for *taking* the artwork included: borrowing or keeping artwork for *record keeping* purposes; submitting artwork as *assessments* for family court; *clients not wanting to keep their artwork*; *clients feeling their artwork would not be protected in-home*; and needing the artwork for *supervision and/or to plan treatment*. Reasons given for *leaving* the artwork were, that *clients requested to keep and/or continue their work between sessions*; *it was clinically important that certain works stay with a client*; the goal of therapy was on development of skill and self-esteem, not insight; *wanting to empower clients*; and the art therapist *lacking a safe way of traveling with or storing the artwork*.

Seven of the 12 art therapists who answered this question indicated that client preference and response to the artwork are key factors in their decision to take or leave the work. According to participant responses, when artwork is taken, it is generally for safekeeping or assessment. When work is left with clients, this is usually done to facilitate the therapeutic process, but also sometimes for logistical reasons pertaining to travel and storage.

The latter raises some valuable questions. Without a safe and reliable means of transporting and storing client artwork, is the artwork any better protected in the care of the art therapist? What is potentially more upsetting for clients, having artwork disturbed or neglected in the home, or trusting the art therapist to keep artwork safe and having it returned damaged? The decision about whether or not to take the artwork is in many ways a value judgment, dependent upon the art therapist's sense of what is best clinically for each client.

However, it is incumbent upon the art therapist who decides to keep client artwork to find secure means for traveling with and storing the artwork. An art therapist's concern for the safe keeping of artwork can demonstrate respect for the client's efforts and expression, and foster trust within the therapeutic relationship.

Those art therapists who chose to leave artwork with clients between sessions were asked about what arrangements were made to provide for its safekeeping in the home. Four of the 13 art therapists stated that this was something discussed with clients, and *arrangements were negotiated together*. Four therapists described *encouraging clients to protect the artwork*, via special closing rituals at the end of sessions, or with a gift of special materials. Three art therapists reported that they *place trust for the care of the artwork with clients and the clients' family caregivers*. Arranging for a *designated safe-place in the home where artwork can be stored* was an option cited by 2 art therapist participants. One art therapist reported *keeping a separate record of the artwork*, lest something should happen to the original. Another art therapist responded that no special arrangements were made with her clients regarding the storage of the artwork, because the goal of therapy was for clients to develop and display their artistic talent.

The Art Materials

The intrinsic material component to art therapy – the art supplies – also require special consideration when working in the home environment. How the art therapist travels to home visits may determine how many and what supplies

he or she is able to provide for clients, and concerns for tidiness in the home may rule out the use of certain materials, such as clay. However, working with clients in their homes opens up the possibility of including materials they might have on hand, allowing them to contribute to the art making in a way not usually possible in a clinical setting.

When asked about how they transport materials to sessions, 8 of the 13 participants in this study responded that they travel to sessions by car. Two art therapists reported using *a suitcase on wheels* to carry materials when traveling by public transit. *Other responses included: a decorated box; in a huge basket; a plastic tub with a lid; a craft case; a plastic-lined gardener's bag with pockets; and the combination of a knapsack and a plastic art tube.*

Participants were also asked if the home setting influences their choice of materials. Seven of 13 art therapists indicated that it does influence their decision as to what materials to bring; 6 reported that it does not. Art therapists who indicated that the home setting does effect their choice of materials tended to comment that *the necessity of transporting supplies limits the quantity and variety they are able to bring*. Others expressed concern for the family home, foregoing materials that might be difficult to clean up. *The amount of space available for use and storage of supplies* in-home was also described as a limiting factor.

Regarding who supplies the art materials when art therapy is conducted in-home, 11 of the 13 art therapists replied that they supply all the necessary materials. Two art therapists stated that, while they are the primary provider of the art materials, clients also contribute. In no cases were clients required to

supply materials. When asked if clients were given or loaned art supplies to use between sessions, 5 art therapists responded in the negative, 4 indicated that clients were given access to materials between sessions, and 4 other participants stated that this occurred only on occasion.

Advantages of Working with Clients In-Home

When asked to describe in their own words the advantages of working with clients in-home, 8 of the 13 art therapists cited *greater comfort and convenience for clients*. Following closely was *insight via having increased exposure to, and empathy for, clients' situations*, discussed by 7 art therapists. Also receiving frequent mention was *the opportunity to view family dynamics in situ, and involve all family members in the therapy*, reported by 6 of the art therapist participants. An *enhanced therapeutic relationship, due to an equalization of power*, was indicated as an advantage by 3 art therapists. Receiving 2 mentions each were: *having access to personal items that can be utilized in therapy*; the opportunity to conduct *assessments in the home environment*; the challenge adapting to working in-home presents to *the art therapist's personal growth*; *eliminating barriers to therapy* for clients who could not otherwise attend; and that *clients may keep artwork between sessions, which facilitates them wanting to make art at home*. One art therapist noted as an advantage that *home visits allow therapists to offer another aspect of service to their clients*.

Disadvantages of Working with Clients In-Home

The most frequently cited disadvantage to conducting in-home art therapy, mentioned by 5 of the 13 participants, is that *it limits the range of materials* therapists are able to have on hand during sessions, and requires special arrangements for the transport and storage of supplies. Four art therapists remarked upon *constraints of the home environment* (for example, the amount of space available to work in, and concerns about cleanliness), as being potentially problematic. *Interruptions and distractions* in the home also received 4 mentions, as did issues pertaining to *privacy and confidentiality*. The demands working in-home places on art therapists' *time*, particularly traveling to and from appointments, were indicated as disadvantageous by 4 art therapists as well. Three participants discussed how *the home setting, as a non-neutral space, might hinder work on some issues*. It was noted that not everyone responds well to receiving therapy at home. Three art therapists commented on *concern for personal safety* while working in-home as a disadvantage to providing this type of service. Disadvantages to home-based therapy each receiving a single mention included: *cancelled sessions due to illness in the home*; *having to coordinate sessions with other in-home services clients receive*; *having a less defined professional role*; and the *art therapist's sense of isolation*.

Influence of Setting on the Therapeutic Relationship

Despite the disadvantages to conducting art therapy in-home, 10 of the 13 participants in this study described the effect of working in the home setting as having enhanced the therapeutic relationship with clients. Two art therapists

reported that the home setting can either enhance or detract from the therapeutic relationship, and that it depends on the particular case. One art therapist felt that working with clients in-home had no significant influence on the development of the therapeutic relationship (i.e. it would progress in much the same way in a clinical setting). It should be noted here that, while art therapists were not asked to elaborate on this question beyond indicating whether the home setting had an enhancing, detracting, or neutral effect, some participants supplied further information. Two identified *extended session length* as a factor in the enhancement of the alliance, while 1 commented on how *blurred boundaries* when working in-home can detract from the therapeutic relationship.

Will These Art Therapists Continue to Offer In-Home Service?

When asked if, based on their experiences to date, they will continue to offer in-home art therapy to clients, all but one of the participants in this study responded in the affirmative. One was undecided. However, 3 of the 12 art therapists who indicated that they would continue to provide home-based services qualified their answer by adding that they would do so only if in-home therapy was indicated as the best option for a client. A fourth therapist, now semi-retired, will offer home visits but only as brief crisis intervention.

The most common reason given for continuing to work in-home, mentioned by 4 of the 13 art therapists, is that *they have found it effective with clients* in general, or with specific populations. Three participants mentioned that *they enjoy working within the home context and the insight it gives them into family dynamics*. Two of the art therapists responded that they will continue to

offer home-based service as a means of *providing clients with access to therapy*. One participant gave *the more equal power relationship with clients in-home* as a reason for continuing to work in this milieu.

The art therapists also offered some of their considerations for not continuing to work with clients in-home. These considerations included *travel time*, mentioned by 2 participants, as it is tiring for the therapists and limits the number of clients that can be seen. *Financial concerns* were also discussed, because fewer clients seen means lowered income for art therapists. One art therapist mentioned that a *lack of intake or screening procedures* regarding whether this is an appropriate intervention for some clients is also reason to hesitate to offer in-home therapy. Another discussed how *lack of recognition of in-home (art) therapy by referring and/or funding agencies* hinders successfully implementing services. *Safety concerns* were also mentioned as a possible reason for not working with clients in-home.

Helpful Resources

Due in part to my own search for helpful resources as I began conducting art therapy sessions in-home as part of my practicum, I was curious to know what the art therapist participants had found helpful to them in developing their respective approaches to this aspect of the field. By far, *the support of professional colleagues* was the most common answer to my query, receiving mention by 7 participants. *Determination and personal beliefs*, and *personal as well as professional experience*, both followed, reported as a resource by 3 art therapists each. *Articles and library resources*, and *online resources*, each

received 2 mentions. Two art therapists commented on the value of *supervision*.

Other helpful resources that were discussed, with 1 mention apiece, included:

continuing education and involvement in teaching; being inspired by the work of others; and membership in professional associations.

Chapter Six

From the Clients' Perspective: Component Two of the Study

While this study focuses mainly on the experience of in-home art therapy from the therapist's point of view, a counterpart to the initial survey, involving a second questionnaire to be distributed to recipients of in-home art therapy, was incorporated into the design. This component to the study was intended as an opportunity for recipients to express their perspective on in-home art therapy and to allow for comparison between therapist and client reports on various themes. Recipient participants were to be recruited via referrals from art therapists taking part in the initial survey. This necessitated that art therapists act as interlocutors between the researcher and past or current in-home clients, but allowed clients to remain anonymous to the researcher.

If requested, recipient questionnaires would be sent to the art therapist, who would then distribute them to clients interested in participating. Completed questionnaires could be returned directly to the researcher by email, or mail (with postage reimbursed via the referring art therapist). Any information, such as an email address, would be deleted without record. This method seemed the best possible approach to contacting recipients of in-home art therapy and for protecting their privacy and confidentiality if they chose to participate in the study. The client's return of the completed questionnaire was considered to indicate their "written consent" to participate.

As an art therapy intern cum researcher, while hoping to include information on the recipients' experience in my report, I was keenly aware of what my own response would be if asked to approach clients about participation in a research study. I would be hesitant to do so, due to concern that such a request might impose inappropriately upon the therapeutic relationship. To this point, all participating art therapists received a note stating explicitly that they were under no obligation to distribute the recipient questionnaire, and should do so only if it felt comfortable for themselves and their clients. Most of the art therapists opted not to involve their clients in the research.

However, one client response was referred and received. The completed questionnaire is from a parent whose son has received individual art therapy services at home for several years. I greatly appreciate the time and thought that went into the parent's completion of the questionnaire, and the art therapist's willingness to broach the invitation. What follows is a summary of this parent's answers to questions posed by the questionnaire.

The respondent is a mother whose adult son has developmental delays that make it difficult for him to integrate new information and sustain relationships with others. Art therapy was recommended by their state's regional developmental services, as a means to help this man develop social skills, and to encourage his latent artistic talent. The focus of treatment has been an emphasis on mastery of artistic skills, to enhance his self-esteem and sense of accomplishment.

The art therapist who visits this man conducts home visits as part of a private practice. In-home sessions were extended longer than a clinical hour, lasting approximately half a day, one day per week, to accommodate the client's ability to integrate material. Privacy and confidentiality were not really concerns for this client as he was alone at home during sessions, and the focus of treatment was not introspection, but rather the development of skills and self-esteem.

Artwork remains with the client at home between sessions, in order that he can continue to work on his projects. The art therapist provides some supplies, which the client has access to outside of sessions, and the client also has some materials of his own. As the artwork is intended for display and to be appreciated by others, no special arrangements were made for its storage in the home.

The mother reports that home visits have been very helpful for her son. He benefits from receiving therapy in the comfort and familiarity of his home environment, and has enjoyed the attention that his developing skills elicit from others. This man has entered artwork completed during therapy into exhibitions and competitions, receiving prizes and recognition for his work, thereby enhancing his self-confidence and sense of pride in his achievements.

According to the mother's observations, receiving art therapy at home seemed to enhance the therapeutic relationship for her son. Working in the intimate home setting, as opposed to a more formal environment, and having the length of sessions extended to accommodate his pace and needs fostered this

man's ability to interact with the art therapist and benefit from therapy. This is of particular value as her son has difficulty forming relationships, which is one of the reasons he was referred for participation in art therapy.

The mother's report of her son's experience of receiving in-home art therapy is congruent with the art therapist's description of the effectiveness of art therapy treatment for this particular client. Both report similar goals and expectations for treatment, and express a positive evaluation of the progress made in this man's development during his participation in in-home art therapy sessions. A benefit cited by both parent and art therapist is that in-home art therapy sessions made supportive treatment possible for this client, who would have had difficulty traveling to services in another setting. Thus, the art therapist's home visits overcame a barrier to receiving treatment that this client experiences due to his developmental impairment. For this man, in-home art therapy was a valuable service that opened opportunities for him to develop his skills at home, and to then share his achievements with the community.

While I would have liked to present a broader portrait of the experience of receiving in-home art therapy by discussing a number of cases, I am pleased to have permission to share this one example. A possible and important goal for further research into the nature and effectiveness of in-home art therapy, could be to look at recipient self-reports regarding their satisfaction with in-home art therapy as compared to receiving treatment in other settings, and to compare their perception of how the home environment influenced the therapy, with their

therapists' observations on the same matter. Such a study would have to be designed carefully, in order to provide participants with privacy and confidentiality, and to not impose on the therapeutic relationship.

Perhaps, rather than attempting to gather these self-reports randomly after clients have already engaged in and/or terminated therapy, a treatment program could be central to the design of the study. In this way, participants would know from the onset that they were taking part in research. Thus the therapeutic relationship would be formed with both the client and therapist fully aware of the conditions being studied, and in effect, they would be co-researchers in the process. This could be a motivating factor for recipient participation in the research, and frames treatment so that the research study becomes an integral part of the process rather than an imposition. While this was not possible to do within the scope of this study, I do think it would be an interesting pursuit for continued investigation. It would also be interesting to conduct interviews with clients who had participated in both clinical and in-home art therapy, and gather comparative perspectives.

Chapter Seven

Discussion and Reflection

Mapping the Terrain: General Considerations for In-Home Art Therapy

Space and time.

In choosing to make home visits, art therapists tacitly agree to place themselves in circumstances wherein clients exert significantly more influence over the conditions of therapy than would occur in a clinical setting. These art therapists must adjust to the pacing and the physical arrangements of life in clients' households, and enter into environments which clients have structured to suit their own needs. For professionals used to working in a clinical or office setting, this can make for quite an adjustment. It can also be an enlightening opportunity to meet clients on their own turf and learn about them in, and from, their surroundings.

How we structure and decorate our environment says a great deal about our values and interests. This is true of the therapist's office, as well as the client's home setting. In the office:

seating is essentially fixed by the tastes of the therapist; so are the number, size, configuration and décor of the rooms, the placements of ashtrays, Kleenex, lighting, etc. All of these are a product of the therapist's values, yet may determine the activity of the family in the office. Such questions as how territories within the home are arranged and communicated, who sits where, and how infractions are handled, as well as other "rules" regarding space cannot be completely dealt with, yet the uses of space are relevant to identity. The same may be said of time, which in the office is more rigidly set by the needs of the therapist. (Fisch, 1964, pp. 115-116)

When conducting home visits, the physical needs of the art therapist – be they for cleanliness, light, ample working space, storage for supplies, or a private space for sessions – are subject to the client's circumstances. As well, the art therapist must adapt to the comings and goings of people in the client's household, and may be required to be more flexible in adjusting sessions to fit the client's schedule than would be called for in a clinical or office setting. This necessitates that the art therapist relinquish a certain amount of control over the environmental context in which the therapy occurs; conversely the client gains greater influence in how the therapy will unfold.

In this more sociocentric way of practicing, the therapist who is unable to adapt to the shift of roles and power may feel his or her professional position is being compromised. This could influence the therapist's perception of the therapeutic process in a way that speaks more of his or her own difficulty adjusting to circumstances in the home environment than of what is in actuality occurring between therapist and client. For example, a mother with young children who asks the therapist to mind them while she answers the door is not making an unreasonable request if the therapist is the only other adult in the house. However, such an exchange is unlikely to occur in a traditional therapeutic setting and it could be upsetting for the therapist who feels his or her professional role diminished by it. Likewise being asked to sit in a particular chair or, furthermore, having one of his or her own requests denied because the client and/or family disagrees with the proposed action or change in the home environment.

The trade for being invited into the client's home and allowed to observe this setting and the interaction that takes place therein is a relinquishing of some of the controls a therapist traditionally holds. This also requires the therapist to reframe interpretations, given the context of the home environment. Reading a client's manipulation of time and space from a psychodynamic approach might be made more tentative due to the fact that the client is acting in his or her own dwelling, and the therapist is now exposed to factors in that environment which might necessitate the manipulation. For example, a tendency to miss appointments, which might be interpreted as resistance from a psychodynamic point of view, could be due to financial or even health reasons that become more apparent once when therapist witnesses the client's circumstances at home.

It seems that having therapy take place in the client's home would also impact a narrative approach, whether psychoanalytic or constructivist. When the client attends sessions in the therapist's office or studio, there is usually only a narrative truth – or what the client chooses to tell of his or her experiences – to work with. However, by entering into the client's home the therapist is exposed to evidence of the fit of the client's narrative truth with historical and contextual truth. It is likely that the client's narrative will not be quite the same when told in the home environment as would be if delivered in a more traditional therapy setting.

Advantages

Tailoring services to meet clients' needs.

When asked about their reasons for opting to conduct art therapy sessions in clients' homes, the majority of participants in this study gave responses related to providing accessible service and accommodating clients' needs. Concern for clients' comfort, their lack of access to transportation, limited physical mobility, and health, were some of the most frequently cited reasons for participants choosing to offer in-home art therapy. This was paralleled in the art therapists' reports about what they consider to be the advantages of in-home art therapy. Increased comfort and convenience for clients was the most common advantage identified, but involving family members, and enhancing the therapeutic alliance by equalizing power in the therapist-client relationship, also received several mentions.

Greater flexibility in tailoring therapeutic service to meet clients' needs is one of the advantages to home-based therapy discussed most in the literature. Several authors describe how a willingness on the part of the therapist to reach the client at home shows a respect for the client's situation, thereby fostering the therapeutic alliance (Adelson, Fraiberg, & Shapiro, 1975; Barton & Wood, 1988; Bell, 1998; Christensen, 1995; Dittmar & Kinney, 1995; Speck, 1964; Wellisch, 1995; Woods, 1988). As Woods states:

For families whose resources are taxed already, if getting help for themselves requires traveling to an office, that itself can be another overwhelming factor working against any potential benefit of therapy for the family. When these issues are not addressed, agencies that espouse the beliefs of a family system approach disregard the context of the family. (p. 212)

This is true of course for individual clients as well. If we don't acknowledge and respect the conditions they face that restrict their access to support services, how can we adequately understand or meet their needs for assistance? Working with clients in-home can facilitate assessments, allowing therapists to better observe clients' circumstances, particularly socioeconomic needs. Providing home-based therapy services is one means for overcoming barriers to treatment, and offering clients greater access to support. As several authors recognize, this has the added benefit of improving client attendance at sessions (Adelson, Fraiberg, & Shapiro, 1975; Barton & Wood, 1988; Borduin & Henggeler, 1995; Dittmar & Kinney, 1995; Falloon, 1995; Friedman, 1962; Speck, 1964; Woods, 1988).

Provision of optimal information.

In this study, the most common reason cited by art therapists for choosing to work with clients in-home, is the information the home provides about a client. Greater exposure to, and thereby empathy for, clients' daily circumstances was the second most referred to advantage of in-home art therapy. Other related advantages receiving mention included, being able to observe the symbolic content clients invest in their homes (for example, artwork, religious articles, collections, prized possessions), and having access to personal items that can be incorporated into the therapy (for example, family photographs). Many practitioners espouse the belief that working in the home environment provides the therapist with optimal information about clients (Barton & Wood, 1988; Bloomgarden & Sezaki, 2000; Dittmar & Kinney, 1995; Falloon, 1995; Fisch,

1964; Friedman, 1962; Hansen, 1968; Korittko, 1994; McCollum, 1999; Woods, 1988), and the results of this study support that this is a primary advantage to home-based therapy, from the therapists' perspective.

Modeling and transfer of skills.

Conducting therapy in the home environment can also increase the generalizability of skills learned in therapy, eliminating the need for the transfer of these skills from a clinical setting to the home by the client alone. While this was not an advantage reported often by the art therapists who participated in this study, it is a benefit of in-home therapy frequently referred to in the general literature on this topic (Borduin & Henggeler, 1995; Dittmar & Kinney, 1995; Falloon, 1995; Fraser & Haapala, 1987; Friedman, 1962; Ryan, 1978). As Dittmar & Kinney observe, "ultimately, families need to be able to use new skills at home. If they learn them in the office, skill generalization is often a problem" (p. 33). In this study of art therapists who work with clients at home, the advantages they described related to transfer of skill tended to pertain to normalizing the art making process, and encouraging clients to pursue creative activities in the home, outside of therapy sessions.

Several articles in the literature are concerned with brief and intense crisis intervention programs, and many of these contain a psychoeducational component in which clients receive life skills training. Therefore it is understandable that the transfer of skill would be a more apparent, important,

and reported advantage in documentation of these programs. However, it seems that transfer of skill is a positive factor in home-based supportive art therapy treatment as well, particularly as it pertains to the creative process.

Being able to observe and respond to events as they happen in the home gives the therapist opportunities to model behavior in situ, enhancing the development and transfer of certain adaptive skills. The therapist can become a role model (Horovitz, 1999), demonstrating appropriate interactions and coping skills in the environment where the client will most often need to employ them. Many authors in the literature recognize the opportunity for modeling behavior as an important component of in-home therapy (Fisch, 1964; Fraser & Haapala, 1987; Haapala & Kinney, 1978; Ryan, 1978), particularly in intensive services.

In art therapy, the fostering of clients' creative self-pursuits also often takes place through a process of modeling and skill transfer. The art therapist may demonstrate techniques for the use of certain materials, or methods for generating creative thoughts. The therapist can also make these methods context-specific, tailored to the client's home needs. Having had the creative process modeled for them during home visits, clients may be more inclined to continue artistic pursuits on their own at home. This can lead to clients taking on new roles, as they develop skills which they can then share and teach to others, thereby raising their own self-esteem (Gibson, 1994).

Although (for budgetary or organizational reasons) it may not always be practical for art therapists who make home visits to leave art supplies with clients for use between sessions (only 5 of the 13 participants in this study reported that

they consistently do so), it would seem that having access to materials between sessions is beneficial for clients. While only mentioned as an advantage to in-home art therapy by 2 of the art therapists in this study, providing clients with some art supplies to have at home, or encouraging those who are interested and able to purchase their own, could help ease the most commonly reported *disadvantage* of working in-home: limitations on the kind and volume of materials art therapists can transport to sessions. Assisting clients to provide for themselves when possible can empower them, as it allows clients to exert greater ownership in, and responsibility for, their creative efforts.

Equalized relationship.

As discussed in the Literature Review section of this paper (see pp. 9-20), the home environment is conducive to an equalization of power in the therapeutic relationship, largely due to societal conventions and expectations regarding the roles of host and guest. When the therapist enters the client's home, the traditional roles of the therapist as host in his or her office accommodating the client as guest are reversed. The client becomes host, and the therapist must reconcile professional role with the obligations of being a guest in the client's home. This can be an informative process for the therapist, allowing for less formal interaction with clients, and the chance to assess his or her own flexibility:

In the home setting, the family is in its natural habitat and the therapist is the intruder. Much understanding of human relationships can be gained when roles are reversed. When a family comes to a professional's office, they often dress in their "Sunday best" and treat the therapist with deference. The therapist often assigns seats and roles, and much of the family's normal spontaneity is cut off by the artificial

setting of the office. At home, the family is more apt to play their everyday roles; if anyone has to undergo an unnatural role shift, it is most likely the therapist. (Woods, 1988, p. 212)

While this shift of roles may initially be unsettling for both parties, generally the equalization is described by practitioners as advantageous and benefiting the therapeutic relationship. An enhanced therapeutic relationship, due to a more equal balance of power between therapist and client, was cited as an advantage to in-home art therapy by 3 of the participants in this study.

Ego enhancement.

Another contributing factor to the empowerment of clients when therapy is conducted at home, is the opportunity for clients to present themselves in "a more ego enhanced way"² (Fisch, 1964, p. 119). Receiving therapy at home allows clients to share with the therapist aspects of their lives with an immediacy that wouldn't be possible in any other setting. Fisch describes how a home visit from the therapist enables the client and family:

To present themselves more as they normally feel, an intact family in the home but now troubled and trying to cope with a sick member, and they can also show their successes in the community, the street they live on, the state of the house, furnishings, evidences of hobbies and interests, opportunities for offering the therapist food and drink, etc.. (p. 118)

However, It should be noted that home visits could also be embarrassing for some clients if, for example, they live in poverty and have little to display or offer.

In such cases, clients may find it more difficult to present their strengths in the

² Clients presenting themselves in an "ego-enhanced way" can be understood as distinct from the display of "Sunday best" persona mentioned by Woods (1988, p. 212). Whereas the presentation of persona can indicate an attempt by the client to keep up appearances and disguise difficulties, Fisch's argument is that visiting the client at home can help reduce defensiveness and lessen any need the client may feel for façades. This thereby allows the client to share more directly the real circumstances of his or her life with the therapist, including those things of which the client is proud or experiences as personal strengths.

home setting; thus visits from the therapist might be experienced as invasive and increase client defensiveness. Because in-home therapy may initially increase clients' feelings of self-consciousness, and also out of respect for social conventions regarding the behavior of a guest in someone's home, some researcher-practitioners recommend that therapists make a point of noticing and commenting on positive features in clients' homes, saving a more straightforward approach to the environment for when the therapeutic relationship is formed (Dore et al., 1998). While not in keeping with the "neutral therapist" role favored by some psychodynamic schools, such an approach is in keeping with initial supportive approaches in therapy to build rapport. The therapist can move toward ways of working that facilitate insight as the therapeutic relationship consolidates.

Inclusion of family.

While not reported as a reason for conducting home-based art therapy, the opportunity to involve family members in the therapy and observe family dynamics, was cited by 6 of the 13 participants in this study as an advantage to working in-home. This complements a prevailing opinion in the literature, especially research pertaining to family therapy crisis intervention, that the home setting is the best location in which to reach members of a family (Barton & Wood, 1988; Booth et al., 1985; Christensen, 1995; Dittmar & Kinney, 1995; Falloon, 1995; Fisch, 1964; Friedman, 1962; Ryan, 1978; Speck, 1964; Woods, 1988). Even if other family members do not participate directly in the identified client's therapy, visiting the home often gives the therapist additional

opportunities to get to know the family and observe interaction in the home, and thereby learn more about the client's relationships, and role within the family dynamic.

Disadvantages

Travel time and cost.

When the art therapists who participated in the survey for this study were asked whether or not they would continue to offer in-home service, and why, all the considerations they gave for not continuing this aspect of practice concerned the logistics of working in-home. Travel time was the most frequently reported drawback, and participants discussed how traveling between home visits is not only tiring for therapists, but limits the number of clients they can see. Financial concerns also received mention. If home visits limit an art therapist's client base, the therapist's income is also restricted.

Transportation costs can be a further liability, unless these costs can be reimbursed by a sponsoring or referring agency, or medical insurance. The only alternative to reimbursement, or the therapist absorbing the loss, is for the therapist to charge more for in-home sessions. Often, though, the clients who would benefit most from receiving art therapy at home are the ones who can least afford to pay more for the service.

Lack of recognition for services.

A lack of recognition from referring and/or funding agencies for in-home therapeutic services is also problematic for those seeking to offer home-based therapy to clients, particularly for the creative arts therapies which are still gaining

a professional foothold compared to other more established fields such as psychology and social work. As Gibson (1994) reports, regarding referrals for in-home art therapy under current conditions in the United States:

With present insurance guidelines, physician, nurses, and social workers are case managers in home health care. Most case managers are familiar with the benefits and the nature of creative arts therapies and would prescribe these treatments in home care settings if there were financial reimbursement for these services. The prescribers, our colleagues, are there; today the payment for services is not. (p. 46)

Art therapists determined to include in-home therapy as part of their professional practice need to be resourceful in securing funding and referrals. Agencies capable of providing referrals and/or financial support for therapy services may be skeptical of a proposal for home-based interventions and wonder "what this new treatment service can provide that hasn't already been tried" (Dore et al. 1998). They may be cautious too about increased risk for liability. Preparing a successful proposal requires researching an agency's mandate, outlining how in-home art therapy services can further that mandate, and anticipating both what the agency's concerns about supporting such a service will be, and how these will be addressed and resolved.

At this point, it is incumbent upon therapists who wish to work in the home environment to promote and prove the benefits of this treatment service. This can be quite a pressure for therapists who are just starting out, particularly so for creative art therapists, who are often in the position of explaining their profession as well. Further research about the effectiveness of in-home therapy, continued

practice, and networking between professionals working in this milieu may help ease the pressure on therapists and facilitate the introduction of new home-based services in the future.

Materials and the home environment.

The most common disadvantages reported pertaining to actually conducting art therapy sessions in-home concern materials and the home environment. Five of the 13 art therapists in this study stated that the necessity of transporting supplies and artwork to and from home visits limits the variety and volume of materials they are able to provide for clients. Some have opted to store materials on-site, but this is not always an option, as ample or safe storage may not be available in the home setting. Providing materials at each home site would also be expensive if the therapist's in-home practice was large.

Four art therapists discussed feeling constrained by working in-home, describing difficulties finding an area of the home in which to conduct art therapy sessions comfortably and privately, and being restrained in the supply and use of materials out of concern for cleanliness. These limitations require some ingenuity on the part of the art therapist, as well as clear communication with the client and/or family about what their expectations are and what the therapist is able to provide. Art therapists who are used to working in clinical or office settings tailored for therapy and where materials are readily on hand, may find relinquishing this control and convenience a difficult trade for the nomadic practice of home visits.

Privacy and confidentiality: Interruptions and distractions.

Concerns for privacy and confidentiality, and disruption of sessions due to interruptions and distractions tied as the next most commonly reported disadvantage to providing in-home art therapy, each receiving 4 mentions by art therapists. Much of the literature cited in this paper discusses therapy situations wherein the entire family is involved, and therefore concerns for privacy and confidentiality do not receive frequent mention. However, most of the participants in this study work primarily with one individual in the household, and because of this, issues of privacy and confidentiality factor more importantly in their satisfaction with working in the home environment. The art therapists reported various ways of adapting to a more permeable therapy setting, including establishing ground rules with the family before therapy commences, involving family members when possible, implementing physical boundaries (for example, working in an area of the home removed from the family's usual traffic pattern, such as the basement) to distinguish the area of the session, and discussing and determining the conditions of therapy together with the client.

In the literature, several authors describe interruptions and distractions as a primary difficulty with conducting therapy in the home setting (Bell, 1998; Borduin & Henggeler, 1995; Christensen, 1995; Dore et al., 1998; Fraser & Haapala, 1987). While such disruptions can be challenging for the therapist, they also provide opportunities for exploring boundary-setting and for modeling problem solving skills. In fact, the results of a study by Fraser and Haapala suggest that interruptions might be positively associated with successful

treatment if therapists take advantage of such events to demonstrate effective responses to problems as they occur, thereby increasing the generalizability of therapeutic interventions to life in the home. Thus, therapists with the proper training and awareness may be able to incorporate into therapy those same interruptions and distractions which for others could prove disruptive to the therapeutic process.

Over-involvement and countertransference.

While not mentioned as problematic by any of the art therapists participating in this study, over-involvement and heightened countertransference reactions are possible pitfalls to working with clients in their homes, because the home environment presents therapists with a more intimate perspective of their clients. Dore et al. (1998) observe that:

Familiarity with family members breeds induction into their dynamics. Working in such proximity, the home-based therapist will rapidly and unwittingly begin accommodating to the emotions, transactional structures and communication rules of the family....Despite the best intentions, *any* therapist can be lured into the family pattern.
(pp. 133-134)

This is perhaps a greater risk for therapists who work intensely with families for several hours each week, as in Homebuilders™ style programs. However, even if a therapist only visits a client at home for one hour each week, for that hour the therapist is immersed in the client's environment, and the dynamics of household. As a guest in the client's home, the therapist is welcomed into the client's life in a way that is more intimate than occurs in a clinical or office setting. This can be seductive, in the sense that a heightened familiarity with clients can lead to over-identification, and a blurring of professional boundaries.

Professional isolation.

The onus is on the therapist to maintain a professional context to home visits, but this can be difficult without proper professional support, and requires of the therapist a high level of personal awareness:

it should be clear that the therapist must continually question and monitor both internal and external reactions to the client family. This process is particularly critical in in-home work because the professional is called upon to react spontaneously and without environmental supports and protection. Supervision and peer review of work is essential throughout. (Levitan & Reynolds-Mejia, 1990, p. 60)

Working alone with clients in their home setting may make it more difficult for the therapist to remain objective during treatment. Because of this, several researcher-practitioners advise therapists of the importance of participating in professional forums, such as supervision, a treatment team, and/or a network of colleagues, where issues related to the therapist's involvement with the family, and countertransference reactions, can be explored and feedback and support received (Bell, 1998; Dore et al., 1998; Korittko, 1994; Levitan & Reynolds-Mejia, 1990; Stephens, 1978).

Safety.

Concerns for personal safety while working with clients in-home was mentioned by the art therapists who participated in this study, not only as a disadvantage to home visits, but as a consideration for not continuing this practice. One art therapist reported feeling increasingly cautious about working in-home, having had a colleague who was recently killed by a client. It is impossible to know what one will find when entering into the client's home, even

if working with populations that are considered a low-risk for violent behavior.

Therapists who embark on home visits should take safety issues very seriously and prepare with appropriate precautions.

The following safety measures are easy to implement, and can give therapists extra peace of mind during home visits. Therapists should make sure that someone, most likely a supervisor, has a schedule of their appointments. Arrange to call and check in with this person at consistent times during home visit days. Carrying a cell-phone for emergency calls is a good idea, as is having a small first aid kit. Being aware of the client's neighborhood is also important, as it is not just in the home that difficulties can occur. As Dore et al. (1998) report:

safety policies are derived from specific knowledge of communities and families served by home-based programs. For example, one program providing services to a location known for high drug sales mandated no in-home visits to that area after 2:00 p.m. on Fridays when welfare checks were received. Another designated a public housing projects as off-limits for in-home workers because there was only one route in and out of the project. (p. 72)

In choosing to offer clients in-home service, therapists are agreeing to leave the more controlled and predictable clinic or office setting, for the (at first) unknown, and often unpredictable, locale of clients' homes. Being aware not only of the personalities of one's clients but also of family circumstances, and the environments in which clients live, is necessary so that the therapist can prepare to meet clients as confidently as possible. Liability insurance is a must for any practicing therapist. Those who work with clients in-home need to check with their insurance provider, and make sure that they have appropriate coverage for these circumstances.

Populations

For whom is in-home art therapy effective?

The art therapists who participated in this study were asked to describe the primary populations they have worked with in-home. Adolescents were the most frequently reported group, followed by children and adults, with older adults being the least reported group. Most art therapists indicated that they see individual clients in-home. Siblings, family groups, and parent-child dyads, each received several mentions. For this sample of art therapists, couples were the least reported in-home clients. Reasons for clients being referred for home-based art therapy were various, and included: behavioral problems, developmental disability, bereavement, mood disorders, anxiety, difficulties with verbal expression, enjoyment of art; sexual or physical abuse, and chronic or terminal illness (either oneself, or in the family). Others included being a foster or adopted child, suicidality, assessment for courts, being homebound, experiencing a life transition, or having suffered trauma (specifically war). Generally, both clients' reasons for participating in art therapy at home (as reported by the art therapists), and the art therapists' reasons for choosing to work with clients in this environment, concerned clients' comfort, physical mobility, and health.

The majority of the literature pertaining to home-based therapy discusses family therapy, wherein the entire nuclear (and in some cases extended) family receives treatment, but one member is the identified client. Most often the identified client is a child or adolescent, at risk for being removed from the home for reasons of abuse, neglect, or behavioral problems (Adelson et al., 1975;

Baglio et al., 1994; Barton & Wood, 1988; Borduin & Henggeler, 1995; Christensen, 1995; Dittmar & Kinney, 1995; Dore et al., 1998; Fraser & Haapala, 1987; Haapala & Kinney, 1978; Heying, 1985; Korittko, 1994; McCollum & Synder, 1999; Ryan, 1978; Stephens, 1978). In this situation, the family is usually referred for therapy because they are in a crisis state, and intervention is intense and short term. Programs offering family therapy in this manner are widely regarded as effective in averting the removal of the identified client from the family (Borduin & Henggeler, 1995; Fraser & Haapala, 1987; Heying, 1985; Kinney & Dittmar, 1995). However, some researchers question claims made regarding the efficacy of these programs, noting that studies supporting their success often lack proper comparison groups and concern projected rather than actual costs, making comparisons between intensive home-based services and more conventional interventions difficult (Baglio, Barton, & Braverman, 1994; Barton & Wood, 1988).

Home-based therapy is also reported as an option for families struggling to cope with other conditions. Falloon (1995), and Friedman (1962) both describe working in-home with families in which a member has schizophrenia. Wellisch (1995) discusses the value of home visits in helping families cope with the unstable illness of a family member, specifically cancer. Yager (1995) reports on anorexia nervosa and family treatment, and gives an example of how home visits can aid assessment. With each of these populations, the benefits of in-home therapy as described by the authors include being able to observe family interaction in the home, and intervene in situ. Wellisch stresses that what may at

first seem a hesitancy to attend therapy sessions in a clinic or office may in fact be a reasonable response by clients to real limitations they face in seeking treatment. He adds that when this is the case, accommodating clients' needs by meeting them at home can result in clients' feeling more at ease and making greater effort in therapy.

Also in the literature are two articles, both written by art therapists, pertaining directly to working with older adults in-home. Gibson (1994) advocates for making art therapy an accessible service for the homebound elderly. She discusses how, while older adults are provided with medical treatment, their psychological needs are often overlooked, and suggests ways in which art therapy might ease the sense of loss and confinement the elderly experience when impaired health restricts their mobility. The second article, by Bloomgarden and Sezaki (2000), describes the latter's internship working in-home with older adults. Two case studies are presented, through which the authors explore and elaborate upon Gibson's treatment goals for the homebound, as well as discussing in more detail the effect of the home environment on the therapeutic relationship.

While certain populations -- particularly families in crisis, wherein children are at risk of removal from the home -- have traditionally been more frequently considered for in-home treatment than others, the appropriateness of this service for clients needs to be considered on a case-by-case basis. In-home therapy may be indicated as the best option for treatment if the client faces personal or environmental restrictions that impede his or her ability to attend sessions at

another site. These may include (but are not limited to): lack of access to affordable transportation, or childcare; restricted physical mobility; health difficulties; and a work schedule incompatible with the therapist's office hours. Home therapy may also be opted for if it is felt that observing the client in his or her home setting will provide information facilitative to the therapist's making accurate assessments and effective interventions.

Contraindications.

There are of course situations in which in-home therapy will be contraindicated. As three of the thirteen art therapists in this study noted, not every client responds well to receiving therapy in a non-neutral environment. The home setting is perhaps too busy for privacy, or too emotionally laden for clients to work on some issues, and thus it can hinder the therapeutic process.

Christensen (1995) names sexual abuse as an issue that might be difficult to address in the home environment "particularly when the therapist is in the lair of the perpetrator. The therapist may want to add an element of ability and neutrality, which may be missing when this issue is raised in the victim's home" (p. 313). If working in-home places the client in a vulnerable or unsafe position in the home, therapists must proceed cautiously. Christensen includes an account from a therapist who observes, "Families can be explosive, and I am concerned for family members that remain in the home after I leave...I am cautious not to arouse too much emotion and tension" (p. 311). In such cases the merits of working in-home, as compared to a more neutral setting, should be carefully weighed, so as to minimize any risk for clients.

Therapists should also heed concerns for their personal safety and not continue in-home therapy in situations where they feel they are at serious risk for harm. To enter alone into clients' homes does put therapists in a vulnerable position, and all reasonable precautions should be taken. Therapists who are consistently uncomfortable working in the home environment should also question the appropriateness of this type of practice for themselves professionally.

Cross-cultural therapy

An interesting and unexpected finding of this study is that 11 of the 13 participants report having used in-home art therapy in cross-cultural situations. While participants were not asked about cross-cultural therapy directly, they were asked to indicate their own cultural background and those of their in-home clients. This allowed for a comparison of culture between the art therapists and their clients, as well as an indication of the many cultural groups represented by recipients of in-home art therapy. Although cross-cultural therapy was not an intended focus in this study, that so many of the art therapists surveyed reported using home-based art therapy in cross-cultural situations leads me to believe this would be an interesting area for further study.

Does working in the client's home environment facilitate the therapist's developing a better understanding of the client's culture? Some researcher-practitioners believe so. Bloomgarden and Sezaki (2000) write that through home visits, "the therapist becomes familiar with the clients' individual history, culture, and information that help create a holistic treatment approach" (p. 284). Hansen

(1968) reports on how her first experience conducting in-home therapy helped her to develop a quality of understanding that "was particularly important to me with this family because there were so many parts of their lives that were unfamiliar to me, both personally and culturally" (pp. 74-75). The interns in the McCollum and Synder (1999) study "remarked that they had experienced a sense of their clients' spirituality in the home in a way that they never had in the clinic" (p. 240). While the home setting may provide information that aids the therapist in developing a better understanding of clients' culture, therapists should also develop their own cultural awareness and sensitivity regarding behavior in the home. Dore et al. (1998) suggest that supervisors have a role to play in helping therapists increase their awareness, by having them explore their "own values, ethnicity and culture" (p. 191).

One possible advantage to home-based therapy in cross-cultural situations is that it moves therapy services away from the formal medical context that can be intimidating for clients, particularly those unfamiliar with such environments. Fisch (1964) discusses how the more social and less formal home setting draws "therapy away from a medical context towards a more social one" (p. 114). Bloomgarden and Sezaki (2000) comment on how, in the home environment, "the therapist's position may be less authoritarian and this enables the therapist to create a more intimate and/or social relationship with the family" (p. 284). Crabtree (1996), in a statement that refers specifically to the elderly, but which applies to other populations as well, says that medicalization of clients'

needs "imposes a strong paternalistic and authoritarian approach" on care (257). It is interesting to compare these points of view with the ethnographic work of Kleinman (1988), concerning culture and psychiatry.

Kleinman (1988), based on his research of the qualities of symbolic healing in several cultures, designed a cross-cultural grid for comparing psychotherapy and indigenous healing systems. Within this grid, forms of symbolic healing, including psychotherapy, are compared across seven dimensions, including: treatment setting, qualities of interpersonal interaction, traits of the practitioner, the characteristic style of communication, clinical focus and expectations, stages and techniques of therapy, and "extratherapeutic aspects" such as ethics, costs, social and political circumstances, etc. According to Kleinman's grid, symbolic healing systems can be divided generally into either egocentric or sociocentric therapies, with egocentric therapies typically situated in a professional institution, with a formal and dyadic therapeutic relationship, and sociocentric therapies occurring in the folk arena, within the family group or community, with an informal relationship between therapist/healer and client.

Following on this system of comparison and classification, the practice of in-home art therapy appears to combine qualities associated with sociocentric therapies, including a less formal setting and more permeable therapeutic boundaries, with characteristics that are more typically western or egocentric, such as an egalitarian relationship between therapist and client, a continuous rather than episodic treatment schedule, warmth and empathy as valued traits in the therapist, and a practice based on special interest and skills (including the

incorporation of symbolic expression through art making). Because relocating therapy to the client's home setting seems to provide a compromise between egocentric and sociocentric therapy systems, it is perhaps a more appropriate means of providing therapeutic services to clients who are unaccustomed to western, egocentric, therapeutic practices, and thus this approach may have merit in cross-cultural therapy.

However, some other considerations may need to be in place in order for cross-cultural therapy in the home environment to be effective. If language is a barrier, or the therapist is completely unaware of the client's cultural practices and experiences, then the services of a culture broker or translator may be required. This would of course impart a very different dynamic to the therapy, not only requiring communication to be channeled through a third party, but thereby incorporating this party into what is usually a private and confidential interaction between therapist and client. The broker and/or translator would necessarily be required to adhere to a confidentiality agreement. It is also essential, given the reversal of the roles of "guest" and "host" that occurs when the therapist visits the client's home, that the therapist research the norms and mores of being a "guest" or "visitor," as well as a "healer," in the culture of the client. This can go a long way in helping the therapist to be aware of expectations the client may have, and can increase the therapist's understanding of how to best define his or her role in a way that makes sense for both therapist and client.

Professional Development

Training, support, and supervision.

The art therapists who participated in this study were asked where and when they received their professional training, in order that a comparison of training levels and locations could be made. However, participants were not asked to what extent their training included information about, or prepared them for, working with clients in-home. This was an oversight on my part, perhaps due to an assumption that most training programs do not include home-based art therapy as a topic of study. That said, based on many of the initial responses received from art therapists interested in participating in the study, and from answers to the survey question asking participants what resources they have found helpful in their in-home practice, it does seem that art therapists who choose to work with clients in the home setting go through a process of educating themselves through trial and error about the nature of working in this milieu.

Several participants commented on a lack of written resources pertaining to this aspect of the field, and many reported that what they found most helpful in navigating the process of in-home therapy was the support of professional colleagues, determination, and their own personal and professional experience. Only one art therapist mentioned that continued education had proved helpful, although participants stated that participation in supervision was beneficial. It

would be interesting to know if practitioners of in-home art therapy feel they would benefit from further training specific to working in the home environment, and if yes, what they would like to see addressed in such a program.

The association of home and family is a strong one, and in situations where the therapist sees an entire family in therapy, or has opportunity to observe and interact with a client's family independently of sessions, some knowledge of family therapy theory would be helpful. Some researcher-practitioners would say it is essential. Christensen (1995), discussing the interruptions to therapy that can happen in the home environment, states that those therapists "without family therapy training seemed to be unable to use the home context to an advantage and saw it as a deterrent to therapy (p. 310). Christensen goes on to recommend that therapists and their supervisors receive specialized training addressing issues unique to working in the home environment. Dore et al. (1998) also stress the importance of training in family therapy for therapists who intend to work with clients in-home, noting that:

typically...the home-based practitioner is a master's or bachelor's level clinician who has had little formal training in family theory, family therapy skills, or home-based family service practice. Often the practitioner's supervisor lacks formal training in these areas as well. This is not surprising, since traditional professional schools at both the undergraduate and graduate levels rarely incorporate instruction on family-centered therapy or home-based practice in their curricula. (p. 244)

Working in the home environment exposes the therapist to family dynamics with an intimacy and immediacy that is often more intense than what occurs in an

office or clinical setting. In entering into the home, the therapist enters the seat of family life. Familiarity with family therapy theory can only help prepare therapists for this encounter.

Because of the professional isolation therapists who work alone with clients in-home might feel, supervision and the support of professional colleagues take on a special importance. These relationships help in easing loneliness, assisting the therapist to maintain a strong sense of professional identity despite working in an unconventional setting, be aware of and process transference and countertransference issues, and review decisions regarding interventions and ethics in the home environment. For art therapists who opt to work in-home, it can be helpful to have professional colleagues in fields such as social work where home visits are more typically conducted, as they are more apt to be familiar with issues unique to working in the home setting.

Funding, program development, and further research.

Without agency sponsorship and funding, an in-home art therapy practice can be difficult to sustain. The majority of participants in this study indicated that they conducted home-based therapy as part of an academic internship, a telling fact I think. While these interns did receive agency sponsorship in terms of supervision, referrals, and possibly supplies, there was no financial award for their services. Those art therapists conducting home visits as part of their professional practice tended to report that their services are offered through

clinical-sponsored outreach programs and/or community-sponsored outreach programs. Only three indicated that they offer home-based therapy as part of a private practice.

The costs incurred in running a private practice based on home visits may be less than those for an office based practice, as the expense of maintaining an office is lessened or eliminated. However, when one factors in that time spent traveling to and from sessions limits the number of clients that can be seen, and that referrals for in-home art therapy may be more difficult to secure, these limitations combined with costs may be prohibitive. For those trying to maintain an office-based practice as well, the extra time and cost involved in making home visits may not seem worthwhile. In order to make home visits a feasible option for professional practice, most art therapists will need to secure extra support and funding.

Doing so will involve proving to potential sponsors the value of home-based art therapy as a treatment option. Substantiating the effectiveness of in-home therapy has proved difficult so far, due to a variety of practice with a variety of populations in generally uncontrolled research situations. The home environment is not conducive to controlled experimental research, and much of the evidence for the effectiveness of home-based therapy comes from therapists' accounts of their successes, and their observations regarding the appropriateness of this type of intervention for certain populations. Further

research is necessary to clarify the merits and drawbacks of in-home therapy. However, as Bloomgarden and Sezaki (2000) point out, research is also dependent on the availability of funding.

Thus, art therapists looking to establish home-based services need to be resourceful in searching for support for their practice, as well as support for further research to confirm the efficacy of this aspect of the field. Gibson (1994) offers suggestions for locating sources of funding, and emphasizes that “advocates for arts therapies must use determination, imagination, and ingenuity to make art therapy housecalls a reality” (p. 46). She adds that association with an established institution will be helpful, and in some cases necessary, when applying for grants and other forms of project funding. There is certainly room for home-based art therapy services to grow, and while this practice presents many challenges to art therapists, it also offers the creative challenge of helping to develop an unconventional and relatively unmapped aspect of the field.

Chapter Eight

Suggestions for Continued Practice and Further Research

In June 2001, as I neared completion of this paper, I sent an email message to all of the art therapists who participated in this study, sharing my preliminary results with them and asking for any feedback they might have about the study and my findings. I also included a list of questions, pertaining to further research interests related to the topic of in-home art therapy, which emerged for me during the course of the study. That list of questions is as follows:

1. *a) How would you describe your theoretical orientation?*
b) Do you feel this orientation has influenced your interest in working with clients in-home? If so, how?
c) Do you feel this orientation has influenced your ability to adapt to working with clients in their home environment? If so, how?
2. *Have your experiences with in-home art therapy influenced other aspects of your practice?*
3. *Have you developed ways of physically marking or differentiating the therapeutic space during in-home sessions, and if so, what are they? (For example, using a special table cloth.)*
4. *What is your relationship with the referring agent as in-home therapy progresses - do you work collaboratively with the referring agent (you are both involved in the client's case and confer), or do you carry on from the referral (you primarily work alone regarding the client's case)?*
5. *Have you ever worked with clients in your home, and how does this experience compare for you to working in the client's home, particularly in terms of transference and countertransference issues?*
6. *If you have conducted cross-cultural therapy with clients in their homes, did working in the home environment influence your understanding of your clients with regard to culture, and if so, how?*

The responses I received to this mailing were positive, however, my timing coincided with many participants being away on holidays, and few were able to

respond in depth to my queries before the deadline to submit the paper came due. Nonetheless, the above questions indicate areas that I feel would be interesting topics for further research. This study was intended to be gathering of general information about the practice of art therapy within a particular context. More depth would be possible in further studies that can examine a particular facet of this area, such as those listed above, in detail.

As well, further studies pertaining to the clients' experience of receiving in-home art therapy would be valuable. Recording client self-reports, in combination with studies comparing therapy in the home milieu and therapy in the clinical setting, and including outcome research, could go a long way toward substantiating the effectiveness and appropriateness of this form of service for certain clients and populations. It would be very interesting to conduct these studies within an ethnographic framework, and involve clients as co-researchers in exploring the differences between art therapy in the clinic and at home.

Training for preparing art therapists to work with clients in-home is also an area deserving of further attention. The home setting places a different set of demands on therapists, particularly in terms of defining professional role and boundaries. Training could be delivered through academic programs as either a specific course or special unit, or in professional development workshops. It could include discussion of the advantages and disadvantages of working in the home environment, instruction in family systems theory, an exploration of safety issues, and perhaps information on working with specific populations in-home. It could be grounds for an original study if a group of art therapists with experience

working in-home was to meet and workshop the design of such a course, later implementing it for others wanting to learn about home-based art therapy. It would be interesting to explore the development of such a training program.

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Appendix A

Sample Questionnaire – Art Therapists

1.

Art Therapy in the Client's Home: A Questionnaire for Art Therapists

1. You currently live/practice in (please place an 'x' beside one, or both if this applies to you):

Canada United States

Province or State:

**2. Your professional training in art therapy was from which institution(s)?
(Please include years attended.)**

3. Are you currently a member of an art therapy association, and if so, which one(s)?

4. With how many clients have you conducted art therapy sessions in their homes?

5. Have you conducted art therapy sessions in a client's home within the last three years (1998-2001)? (Please place an "x" to the right of your answer.)

Yes No

6. If yes (to Question #5), please describe the primary population that you worked with in home-based sessions during this time.

a) Place an 'x' beside as many as apply:

- Individual clients • Couples (spouses/partners)
- Family groups (3 members or more, with at least one adult)
- Parent-child dyads • Siblings

b) Age group(s) (place an 'x' beside as many as apply):

- Children • Adolescents • Adults • Older adults

c) Gender of clients (please indicate approximate percentages):

Male Female

d) Cultural background(s):

e) Setting:

urban rural

7. Why were these clients referred for art therapy?

8. These clients' were referred to you for art therapy by a (place an 'x' beside as many as apply):

- Physician • Psychologist • Psychiatrist • Clinical Intake Team
- Social Worker • Community Services Agency • Self referral by client
- Other Art Therapist • Other

9. Did you see these clients in another art therapy setting (clinical or community) prior to beginning sessions with them in their homes?

Yes No

10. Did you conduct home visits as part of (place an 'x' beside as many as apply):

- Your own private practice • A clinical outreach program
- A community outreach program • An internship • Other

11. How were your home visits funded? (place an 'x' beside as many as apply.)

- By an outreach program • By a grant • By the clients
- As part of an internship (free service) • Other

12. What do you feel were *your clients'* reasons for deciding to have art therapy sessions in their home environment? (Please check as many as apply, and add your comments below.)

- Health • Physical mobility • Childcare unavailable
- Transportation (e.g. client does not have a car and lives in an isolated area)
- In-home art therapy was recommend (by their doctor, social worker, etc.)
- Clients felt that in-home therapy would be more comfortable (less intimidating)

Comments:**13. What were *your* reasons for deciding to conduct art therapy in your clients' home environment? (Please place an 'x' beside as many as apply, and add your comments below.)**

- Clients' health • Clients' physical mobility • No childcare available
- Transportation (e.g. client does not have a car and lives in an isolated area)
- In-home art therapy was recommend (by a doctor, social worker, etc.)
- It was felt that in-home therapy would be more comfortable (less intimidating) for the client(s)
- It was felt that the home environment would provide the art therapist with helpful information about the client(s)

Comments:**14. On average, your in-home sessions (please place an 'x' beside one):**

- were shorter in length than a clinical session
- lasted approximately the same length of time as a clinical session
- extended beyond the length of a clinical session

15. If the length of in-home sessions differed from clinical sessions:

a) What were the reasons for this?

b) Did you and your clients experience this change in session length as positive?

16. How did you handle issues of privacy and confidentiality, if clients shared their homes with family members or others?

17. Did you leave artwork with clients between sessions, or take it with you?

6.

18. If clients kept their artwork, what arrangements were made to ensure its' safekeeping?

19. Did you provide art materials or did clients supply their own?

20. If you supplied materials, did the home setting influence your choice as to what materials to provide?

21. How did you transport the materials?

22. Were clients given or loaned supplies so that they could continue to work between sessions?

23. From your experience, what do you feel are the main advantages to conducting art therapy in the client's home?

24. What do you feel are the main disadvantages of conducting art therapy in the client's home?

**25. Based on your experience, do you feel that working with clients in their homes
(Please place an 'x' beside one):**

- enhances the therapeutic relationship
- detracts from the therapeutic relationship
- does not significantly influence the therapeutic relationship (relationship would have evolved much the same in a clinical setting)

26. Will you continue to incorporate home visits into your practice? Why, or why not?

27. What resources were helpful for you in this way of working? (e.g. A supportive network of other Art Therapists in your work environment or city, advice from professionals in other fields, articles on this subject, on-line resources etc.)

Thank you for taking the time to complete this survey. Your contribution to this study is greatly appreciated! ☺

All participants in the study will receive a summary of the research results by late summer, 2001.

*Completed surveys can be returned to **Art Therapy Survey** by email at _____, or by mail at the following address:*

Appendix B

Sample Questionnaire – Recipients of In-Home Art Therapy

1.

Art Therapy in the Client's Home: A Questionnaire for Recipients of In-Home Art Therapy

1. Where were you living when you received in-home art therapy? (Indicate by placing an 'x' to the right of your answer.)

Canada United States

Province or State:

Area: Rural Urban

2. Did you receive in-home art therapy sessions (place an 'x' beside as many as apply to you):

- As an individual client • As a couple (with your spouse or partner)
- With your family (3 members or more, with at least one adult)
- With a parent • With a sibling

3. Please give a brief description of yourself:

a) age b) gender c) major occupation

d) cultural background:

4. What are your reasons for participating in art therapy?

5. In what year did you begin receiving in-home art therapy?

6. For how long did you receive in-home art therapy? (Please indicate the number of months or years, and mention if the therapy is ongoing.)

7. a) Had you participated in any other form of therapy (aside from art therapy) prior to starting you in-home sessions?

Yes No

b) If yes, what form(s) of therapy did you participate in, and for how long?

8. What were your reasons for deciding to receive art therapy sessions in your home? (Please place an 'x' beside as many as apply, and add your comments below.)

- Health • Physical mobility • Childcare not available
- Transportation (e.g. you live in a remote area and do not drive a car, therefore attending sessions elsewhere would be difficult)
- In-home art therapy was recommended (by your doctor, a social worker, etc.)
- You felt you would be more comfortable/at ease receiving art therapy sessions at home

Comments:

9. a) Did you make the initial contact with your art therapist?

Yes No

b) Or were you referred through:

- Physician • Psychologist • Psychiatrist • Clinical Intake Team
- Social Worker • Community Services Agency • Another art therapist
- Other

10. Had you received art therapy prior to starting your in-home sessions?

Yes No

b) If yes, was it with the same art therapist?

Yes No

11. For in-home sessions, did your art therapist provide you with art materials, or did you supply your own?

12. a) If your art therapist provided art supplies, did you have access to them between sessions?

Yes No

b) If yes, was this helpful to your therapy? Yes No

c) If art supplies were not available, you would have liked them to be?

Yes No

13. a) Did you keep your artwork in between sessions, or did your art therapist keep it for you?

b) Which would you have preferred, and why?

14. Did you have any concerns regarding confidentiality or your privacy during in-home art therapy sessions (e.g. interruptions, or being overheard by others in the household), and if so how were these handled?

15. What do you feel was beneficial about receiving art therapy sessions in your home?

16. Was there anything about in-home art therapy that you found problematic or uncomfortable?

17. Do you feel that having art therapy sessions in your home (please place an 'x' beside one of the following):

- enhanced the quality of your relationship with the art therapist
- detracted from the quality of your relationship with the art therapist
- did not significantly influence the quality of your relationship with the art therapist (relationship would have evolved much the same in a clinical setting)

Thank you for taking the time to complete this survey. Your contribution to this study is greatly appreciated! ☺

All participants in the study will receive a summary of the research results by late summer, 2001.

*Completed surveys can be returned to **Art Therapy Survey** by email at _____, or by mail at the following address:*

Appendix C

Chart of Survey Data

Please note that the following chart is arranged so that the first seven participants' records are on pp. 124-132, and the final six are on pp. 133-141. Individual records are listed vertically, and responses for any given question subject can be compared horizontally. Page numbers had to be repositioned for this Appendix, and can be found at the right margin of each page, centered under the bottom edge of the chart.

code:	B017S	J018R	J019B	J020T	M021S	R0220	S023D
Residence	USA - CA	USA - OK	Canada - QC	Australia	The Netherlands	USA - OR	USA - IL
Cultural background	Caucasian - Anglo	Caucasian (Native American, Anglo, German)	Jewish - Canadian	Caucasian - Irish/Australian	Caucasian - Dutch	Caucasian - Irish/Jewish	Caucasian
Training	Masters	Masters	Masters (thesis pending)	Masters	Phd	Masters	Masters
Professional association	AATA, SCATA, ING/AT	AATA, ATA0	None yet	ANATA		IATA	AATA, IATA
# of clients in-home	2	approx. 25	1	approx. 12	1500 clients, short and long term, over span of 30 years	approx. 30	5 families
In-home in last 3 years	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Primary population							
- individual or groups	Individual	Individual; family groups; parent-child dyads; siblings	Individual	Individual; family groups; parent-child dyads; siblings	Family groups	Individual; couples; family groups; siblings	Individual; family groups; parent-child dyads; siblings
- age	Adults	Children; adolescents; adults (identified client usually child 5-9 yrs)	Adolescents	Children; adolescents; adults		Children; adolescents; adults	Children; adolescents; adults
- gender	50/50	M - 60, F - 40	F	50/50		M/F (% not indicated)	50/50
- cultural background	Caucasian - Anglo	Caucasian, African-American, Hispanic	Jamaican-Canadian	Australian, Lebanese, Afghanistani, German		Bosnian, Somali, Bulgarian; Cambodian, Latino, African-American, Guatemalan	Caucasian, Latin
- setting	urban	urban	urban	urban		urban	urban
Reason for referral	Home-bound, cognitively and physically impaired; enhance latent talent, self-esteem, self-expression	Recommended for AT due to enjoyment of art, difficulties verbalizing, and/or borderline intellectual functioning	Transition: recent transfer from school for blind to regular high school; love of art	Intellectual disability - client only able to communicate using symbols; assessments for family court		Treatment for war trauma, torture, PTSD, sexual and physical abuse, depression	Death of a child (part of a support program - art therapy groups offer families more individual attention)

Referring agent	State developmental services - regional chapter; Spouse of client	Physician; psychologist; psychiatrist; clinical intake team; social worker; community services agency; self-referral by client; other: hospitals, department of human services, schools	Intendent at school for blind	Community services agency; other art therapist; other - lawyers		Psychologist, psychiatrist, community services agency	Other (not indicated)
Seen prior to in-home	No	No	No	No		Yes	Yes
In-home program	Private practice	Clinical outreach program; community outreach program	Internship	Private practice		Community outreach program; internship (unpaid)	Internship
Funding	Clients; Other (State?)	Grant	Internship (unpaid)	Outreach program; clients		Internship (unpaid); Other (not indicated)	Internship (unpaid)
In-home - client's reasons	Health; physical mobility; recommended	Transportation; recommended; comfort	Transportation	Physical mobility; recommended		Recommended; comfort	Comfort; suggested by therapist (in-home therapy a research interest for thesis)
In-home - therapist's reasons	Client's health; client's physical mobility; recommended; client's comfort	Transportation (client); recommended; client's comfort; information from home setting	Transportation (client); lack of other available space	Client's physical mobility; client's comfort; information from home setting	Client's health; client's physical mobility; no childcare available; client's comfort; information from home setting	Most "clinically" appropriate setting for clients; home-based therapy essential in cross cultural therapeutic practices - creates an equalizing environment between client and therapist	Information from home setting

Session length	Longer than clinical	Same as clinical	Longer than clinical	Same as clinical	Longer than clinical	Same as clinical	Longer than clinical	Same as clinical (usually)
- if differed, why?	Client's needs demanded slower pace				In-home atmosphere more relaxed/informal		When invited into client's home (social) rituals lead up to therapy session: tea, meals, visits with extended family	Varied for clients according to goals, issues being worked on
- + change?	Yes				Yes		Yes. Social rituals perceived as strengthening therapeutic process	Yes
Privacy & confidentiality	Not applicable; clients alone at home during sessions	Explained as a requirement for the service	Initially difficult; therapist became creative in re-defining therapeutic frame/adapting to home setting; client found privacy in artmaking, which functioned as confidential language		Uses a separate room for therapy sessions	Family signs contract regarding in-home therapy, based on goals agreed upon; family members come & go during therapy & contribute as it fits them to; when privacy is an issue, it becomes a goal the family works on	Client decides whether to include family members in session or not. Cross cultural considerations: many clients looked at issues in collective context, & it made sense to include siblings & parents when appropriate.	Discussed with client; client asked to choose place where she/he feels comfortable /safe working. Let parents know importance of privacy when working with children/ teens; time offered at end of session if child wants to share something with parents
Artwork - leave or take?	Left with client	Both	Taken with therapist	Both			Both	Left with client

- why?	Emphasis on mastery to increase self-esteem/sense of accomplishment, not on insight	Depends on client's response to artwork (desire to keep, continue, protect)	Discussed with client. Client requested therapist keep artwork - did not trust it would be protected in home	Assessments for family court are taken with therapist		Client's decision & right as artist to determine what will happen with artwork	Lack of storage & no safe way of travelling with artwork. Artwork created as memorial pieces - very precious, important they be kept by families. Opportunity to continue work & share it with others between sessions
Safekeeping of artwork in-home	No arrangements. Objective was to exhibit achievements	Discussed with client. When choosing to keep it, client verbalizes responsibility for artwork		Small ritual at end of each session involves ensuring artwork is treated respectfully		Encouraged clients to take care of artwork by giving them sketchbooks/portfolios. 3D work was a challenge. With video therapy clients could easily store video tapes	How to treat artwork was clients' decision. Families worked hard on these pieces & made effort to preserve them
Who provides materials?	Therapist and client	Therapist (most of the time)	Therapist	Therapist	Therapist initially. As therapy progresses materials available in-home are used	Therapist (majority of clients could not afford art materials)	Therapist (unless family requested something specific and expensive)

In-home - choice of materials	No influence	Influence. Only transportable items	No influence	Influence. More limited range. Does not use clay	No influence	Influence. Concern for family property & safety. Educated family about safe supplies for children	No influence
Transportation of materials	Car	Car. Bag with misc. materials	Car. Otherwise setting might have influenced choices	Car. Uses decorated AT box that is part of encounter, especially relevant with children		Car. Used huge basket	Car. Used large plastic tub with lid
Materials between sessions	Yes	Not usually	No	No	Yes	Yes	In some cases
In-home advantages - therapist	AT available to clients who would otherwise not have access (home bound cognitively and physically impaired)	Client comfort & empowerment; asstmt. for clients of lower socio-economic status - home environment helped therapist assess basic needs before working on more abstract issues	Client comfort; home setting forced therapist to become more flexible/creative in methods	Greater insight about client's resources (family dynamics, strengths, support); home setting "normalizes" artmaking, facilitates client making art between visits	Exposure to client's home setting & daily life allows therapist to better attune to client's abilities; client benefits from therapy in home context; in-home experiences contributed to design of therapist's own clinical method	Home environment fostered client's sense of safety in therapy; therapist learned quickly about customs & family history; therapist could provide therapy to family system as well as each client	Access to photos & personal items that tell a lot about family/person; in vivo exposure to family environment & interaction; comfort & convenience for family

In-home disadvantages - therapist		Safety/colleague killed by client); comfort with space & cleanliness; limitations re. materials	Maintaining privacy/confidentiality (mainly verbal); depending on client & reason for therapy, neutral space might be more beneficial	Interruptions; safety (carries mobile phone & informs someone of location/schedule; makes assessment re. safety by phone before visiting home); time consuming	Over-involvement (becoming too much a part of family system); therapist processes this via own AT process, and by having students assist (brings fresh perspective)	None	Interruptions; time spent driving to/from visits; not having wide variety of materials on hand; storage of work
In-home - therapeutic relationship	Enhanced. Setting made relationship possible. Extended session length also a factor	Enhanced	No significant influence on relationship	Enhanced	Can enhance, detract, or have no significant influence	Enhanced	Enhanced
Continue in-home?	Yes. Not long-term, only brief crisis intervention.	Yes	Yes. If benefit for client is indicated	Yes	Yes	Yes	Yes
- why?		Has worked well with population		(See advantages)	It works for clients		Great way of working for bereaved population

- why not?	Semi-retired	Will be more aware of safety issues					Difficulty is many agencies do not value home visits - regard them as time consuming &/or a liability	Requires some method of intake/screening to determine appropriateness of this service for clients
Helpful resources	Professional colleagues (interdisciplinary support group)	Professional colleagues (weekly meeting with others working in-home)	Supportive & creative supervisor; trust in (non verbal) art therapy process	Professional colleagues (AT peer group); library; on-line resources	Professional colleagues (other ATs); supervision; assistance of students; continuing education part-time; becoming a teacher; professional associations & certain training programs	The work of Jane Adams & Robert Coles		
Grief process?	Yes. Workplace trauma - family							Yes. Bereaved families (loss of child)
Safety concerns?		Yes - colleague killed by client		Yes				
Supervision			Yes		Yes			
Colleague support	Yes	Yes		Yes	Yes			
Longer session length?	Longer	Same	Same	Longer	Same	Yes		
Gross cultural?	No	Yes	Yes	Yes		Yes		Yes

code:	S024M	J025H	D026G	F027F	M028O	A029M
Residence	USA	Canada - BC	USA - AK	Canada - QC	Canada - BC	USA - PA
Cultural background	Caucasian	Canadian of mixed descent (Chinese, Anglo)	Caucasian (Anglo, German, French, Native American)	Caucasian - French	Canadian - Ukrainian	
Training	Masters	Graduate diploma	Masters	Masters (thesis pending)	Graduate diploma	Masters
Professional association	AATA, DVATA	BCATA	AATA, ATCB	QATA	BCATA, CATA	AATA
# of clients in-home	approx. 30	5	approx. 10	15	approx. 140 over 7 yr span	5
In-home in last 3 years	Yes	Yes	No	Yes	Yes	Yes
Primary population						
- individual or groups	Family groups	Individual, siblings	Individual; parent-child dyads; siblings	Individual	Individual; family groups; parent-child dyads; siblings	Individual; couples; family groups; parent-child dyads; siblings
- age	Adolescents; adults	Children; adolescents	Children; adolescents; adults	Older adults	Children; adolescents; adults; older adults	Children; adolescents; adults (identified client is 8-17 yrs)
- gender	M/F (% not indicated)	M - 40, F - 60	M - 30, F - 70	F - 100	M - 50, F - 50	M/F (% not indicated)
- cultural background	European, African	First Nations	Caucasian, Hispanic	Caucasian - French	Chinese, Canadian, East Indian, Trinidadian, Japanese, French	Caucasian, bi-racial (African-American/Caucasian) Native American
- setting	rural	urban	urban	urban	urban, rural	urban, rural
Reason for referral	Adolescent victims of sexual abuse and their nonoffending family members	Foster children who have experienced trauma & multiple losses; fetal alcohol syndrome; separation anxiety, anxiety, nightmares; suicidal ideation; acting out behaviours; written & expressive language difficulties	Dealing with illness/grieving loss of family member	Mood disorders: depression, anxiety; mourning issues	Behaviour problems; chronic & terminal illness; grief & loss; attachment & adoption; dual diagnosis	Oppositionally defiant; ADHD; suicidal behaviours; acting out behaviours; sexual abuse/perpetration; learning disorders; depression

Referring agent	Other - the court system	Clinical intake team; Other - clinic nurse specialist & the children's caregivers	Clinical intake team; social worker; community services agency; self-referral by client; Other - teacher	Psychiatrist; clinical intake worker; Other - nurse	Psychologist; psychiatrist; clinical intake team; social worker; community services agency; other art therapist; Other (not indicated)	Community services agency
Seen prior to in-home	Yes (usually)	No	Some	No	Yes	No
In-home program	Clinical outreach program	Clinical outreach program; internship	Community outreach program; internship	Internship	Private practice; clinical outreach program	Clinical outreach program (non-profit organization) [referrals from courts, schools, families]
Funding	Grant	Internship (unpaid)	Outreach program; internship (unpaid)	Internship (unpaid)	Clients; Other (not indicated)	Other - state funded through medical assistance
In-home - client's reasons	Physical mobility; transportation; comfort	Transportation (several children in household); recommended; increased access to therapist (when parents needed to discuss issues related to the children)	Physical mobility (parent dying); recommended	Transportation; recommended; comfort	Health; physical mobility; transportation; comfort	Childcare unavailable; transportation; recommended; financial reasons (most clients culturally poor & program is funded through medical assistance)
In-home - therapist's reasons	Transportation; client's comfort; information from home setting	Recommended (because therapist offered service); client's comfort; information from home setting	Client's health; client's physical mobility; recommended; client's comfort; information from home setting	Client's health; client's physical mobility; transportation; recommended; client's comfort; information from home setting	Client's health; client's physical mobility; transportation; recommended; client's comfort; information from home setting	Transportation; client's comfort; information from home setting; extended length of time to work with client

Session length	Same as clinical	Same as clinical	Same as clinical	Same as clinical	Same as clinical	Longer than clinical
- if differed, why?		Some sessions longer due to interruptions by other persons in home or unexpected events during therapy. Happened less than more		Some sessions lengthened due to client's health, or investment in project	Sometimes longer if family needed to talk. Actual session not lengthened, just time therapist is present in home	Psychologists prescribe great amount of time for each client, & state pays for service. Can be reduced as required, but needs of clients/families demand greater commitment of time
- + change?		Neutral. Children didn't seem to mind. Sessions finished regardless		Yes		Yes. Allows therapist to better observe family dynamics
Privacy & confidentiality	Not applicable. All family members are involved	Groundwork done with family about boundaries re, privacy & confidentiality. Any difficulties re. these issues are discussed. Sometimes a balancing act between therapist's needs, client's needs, and those of other persons in home. Client's privacy & confidentiality are priority	Family involved in therapy. Family explained reason for therapist's presence to extended family	Not applicable. All clients were living alone. Occasionally children were present. Therapist was preoccupied by this (issue) at beginning of practicum, but it proved to not be a problem	Established with caregiver at beginning that quiet & safe place is required for work. If home setting cannot offer this, an alternative is found. Therapist needs to be flexible & prepared for anything	Space often an issue. Sometimes child is taken to different environment; sometimes family members are included. Work with parents regarding boundaries & privacy during sessions, but also include parents when they show interest
Artwork - leave or take?	Taken with therapist to office & kept as part of client's file	Left with client	Both	With one client	Yes	Both

- why?		Felt taking artwork away from client would be misuse of power. Wanted artmaking experience to be empowering & felt this was facilitated by having children keep artwork. Built time in at end of session to document work in photographs, therefore therapist had a record of work	When clients asked to keep artwork it was left with them, otherwise therapist took artwork for safekeeping in one place, and to discuss in supervision in order to plan treatment measures	Client wanted to continue working during week. Therapist prefers to keep work and bring it to every session	Clients are given the option	If client 'owned' work, & it was clinically important that the work stay with the client, it was left with client. Sometimes therapist borrowed work to take notes, then returned it. Some clients did not want to keep their work
Safekeeping of artwork in-home		Arranged with caregivers for artwork to be kept in safe space between sessions. Wet work was left out to dry after sessions, therefore confidentiality difficult to maintain. Therapist had to trust caregivers. Bristol board folders were used to store artwork. 3D pieces kept in designated place in basement	Discussed (importance of artwork) with clients	Trusted client's judgement. If therapist sensed keeping or displaying work might have negative effect on client's self-esteem, this was discussed with client	A special folder is made for artwork. Therapist will keep artwork client feels is too powerful to be kept at home in folder. Folder is kept in a safe place in the home, chosen by client, staff, or family	Therapist scanned some images to store on computer as a record. Office keeps record of art assessment images & write-ups
Who provides materials?	Therapist	Therapist (funds for supplies provided by practicum)	Therapist	Therapist. One client brought art supplies	Therapist	Therapist

In-home - choice of materials	No influence	Influenced quantity, since therapist transported materials on foot. Important to therapist to offer variety of materials. Later storage space was arranged in-home	Influence. Aspects of setting(eg. carpet) limited what materials could be used	Influence. Size of paper was limited as all work was done on kitchen table. Heavy materials such as clay were demanding. Collaboration of client is essential	No influence	Influence. Usually does not invest as much in supplies due to space available in home. Not having materials/tools on hand limits what activities can be done
Transportation of materials	In a large craft case	On foot. Used suitcase on wheels, knapsack, & plastic art tube	A plastic-lined gardeners bag with many pockets	Car (especially during winter)	Several methods, including a travel suitcase with wheels, & a folder for paper	Car
Materials between sessions	No	No. But suggestions were made for inexpensive materials caregivers could provide	Yes	With some clients. Therapist paid for all materials, & budget was restrictive	A few clients (maybe 5%)	Yes, but not all, & only on occasion. Many were empowered to buy their own supplies. Parents seem to use supplies as rewards
In-home advantages - therapist	More family members are involved; members who refused to come to office felt more comfortable at home	Convenience & comfort for client; more equal sense of power in therapist-client relationship; ability of therapist to make direct observations, gain heightened sense of client's reality, observe symbolism in the home, & interact with increased spontaneity; opportunity for art to remain with client between sessions; availability of client's personal items to be brought into sessions	Safety/comfort of clients; therapist's exposure to home dynamics; more open verbal expression	Enhanced relationship with client; home visits a sign of respect for clients - showing them they are important/valued; home organization & safety can be evaluated; therapist gains access to client's inner world as symbolized in home environment; trust between client and therapist established more quickly in home environment	Offering a service & choice of therapeutic environment; opportunity for therapist to get to know family and client on different level and better understand client's needs	Viewing family dynamics - being able to observe & work with family system, rather than just the identified client

In-home disadvantages - therapist	Transporting materials; assuring the care of the family home	Distractions/interruptions; maintenance of therapeutic boundaries (privacy & confidentiality); less well defined professional role; less control over time & pacing of sessions; lack of locked storage area for artwork; cancellation of sessions due to illness in home; absence of coordinated team-based approach - therapist's sense of isolation (absence of peer contact)	Distractions/interruptions; limited materials	Need to adapt to client's setting; time & energy expended in travel; issues of privacy & confidentiality; not appropriate for some clients (can be felt as invasive; some need to manifest themselves actively by going to appointment); informality can lead to requests for other services (errands, etc); coordination with other services client receives (eg. doctor's appointments, visits by nurse, homecare etc)	Not everyone responds well to in-home therapy - therapist must be aware and respond quickly; too volatile for clients who have been abused or continue to be abused in home	Lack of space; safety issues for therapist; difficulty setting boundaries & limits in another person's home; time wasted in travelling (limits number of clients that can be seen & is expensive if time/mileage are not reimbursed)
In-home therapeutic relationship	Enhanced	Enhanced	Enhanced	Enhanced	Enhanced	Can enhance or detract. Allows for longer term therapy, but boundaries can get blurred
Continue in-home?	Yes, when indicated	Yes	Yes, when indicated	Yes	Yes	
- why?		Enjoys more equal power relationship, & experiencing client in his/her own environment	If people desire care but cannot get to treatment, therapist will go to them	Believes home-based services are future of health services for older adults; believes in home AT can help diminish depression & improve quality of life for this population	Therapist's private practice is based on location work; referral base is established on this being one of the main services offered	It is a great way to view family dynamics

- why not?	Travel cuts into time available & limits number of clients seen						Threat of burn-out due to travelling & limited hours. Can only see clients after their school hours, which does not allow enough income for practice & repaying student loans
Helpful resources		Therapist's own personal & professional experience (background in social work; understanding of rural community life; belief in non-hierarchical ways of working with power; experience as a foster parent)	Professional colleagues (network of other AT's/ professionals in other fields)	Therapist's own faith & determination; support of Art Therapy Department (at University) and practicum site; experience as director of a day centre	Learned from own mistakes since going into this aspect of work "completely green" 7 years ago	Professional colleagues; articles on subject (limited number available); on-line resources	
Grief process?			Yes	Yes	Yes		
Safety concerns?					Client safety (abuse in-home)	Yes	
Supervision				Yes			
Colleague support		desired more contact	Yes	Yes		Yes	
Longer session length?						Yes	
Cross cultural?	Yes	Yes	Yes	Yes	Yes	Yes	

Appendix D

Summary of Analysis of Data

Residence of Art Therapists

USA 7
Canada 4
Australia 1
Netherlands 1

Training

Masters 10
Diploma 2
Doctorate 1

Number of In-home Clients

Range 1-1500, depending on length of career and composition of practice

Have Art Therapists Worked In-Home in Last Three Years?

Yes, all but one

Primary Populations

Individuals or groups: Individual 11
Siblings 8
Family 7
Parent-child dyads 6
Couples 2

Age

Adolescents 9
Children 8
Adult 8
Older adult 2

Gender

Responses suggest that these art therapists, combined, have seen a slightly higher number of female clients in-home than male. This is difficult to determine accurately as percentages were not always reported, and there is a wide range in number of clients seen per therapist.

Cultural Background

11 of 13 respondents report having used in-home therapy in cross-cultural situations. Art therapists were not asked about cross-cultural therapy directly, but were asked to indicate their cultural background, and those of their in-home clients

Setting

Urban 12
Rural 2
Unanswered 1

Reason for Referral

Note: This list indicates the number of art therapists who listed each reason, not the number of clients referred for these reasons.

Behavioral problems 5
Developmental disability 5
Bereavement/grieving 4
Mood disorders (depression) 4
Anxiety 3
Difficulty verbalizing 3
Enjoyment of art 3
Sexual or physical abuse 3
Chronic/terminal illness 2
Foster children/adoption 2
Suicidality 2
Assessment (court) 1
Homebound 1
Life transition 1
Trauma (war) 1

Referring Agent

Community service agency 6
Clinical intake team 5
Psychiatrist 4
Psychologist 3
Social worker 3
Other art therapist 2
Self-referral by client 2
Physician 1
Other: Client's spouse/family 2
Nurse 2
School 2
Lawyer/court 2
State developmental services 1

Did Art Therapist See Client in Another Setting Prior to In-Home?

No 7
Yes 4
Some 1
Unanswered 1

Programs Through which In-Home Services were Offered

Internship 6
Clinical outreach 3
Community outreach 3
Private practice 3

How Were In-home Services Funded/Paid For?

Internship 6
Clients 3
Grant 2
Outreach program 2
Other: state funded 2

What Did Art Therapists Feel were Clients' Reasons for Receiving In-Home Art Therapy?

It was recommended 9
Lack of access to transportation 7
Comfort 6
Physical mobility 5
Health concerns 2
Childcare unavailable 1
Other: Financial difficulties 1
Increased access to therapist 1

Art Therapists' Reasons for Working with Clients In-Home

Note: These rankings do not indicate priority of reasons, only the number of times each reason was listed.

Information provided by home setting 10
Comfort of client 9
Clients' lack of access to transportation 6
Clients' physical mobility 6
Clients' health 5
It was recommended 5
Childcare unavailable 1
Other: Belief in efficacy of in-home therapy 1
Cross-cultural considerations 1
Extended time with client 1
Lack of other available space 1

Session Length, Compared to Clinical

Same 9*
Longer 4
Shorter 0

*Note: *Three art therapists who indicated session length in-home as being the same as a clinical session qualified this by adding that sometimes, with*

some clients, the time is extended, for the following reasons: goals being worked on, interruptions, unexpected events, health concerns, client's investment in project. One art therapist acknowledged that while she does not extend the length of the actual session, but might spend extra time in the home if the family has something to discuss with her.

If Session Length Differed, Why?

Needs of client demanded greater commitment of time 2
Informal atmosphere/social rituals when a guest in client's home 2
Amount of time prescribed by referring agent 1

Were Changes in Session Length Positive?

Yes 6
Neutral 1

Privacy and Confidentiality

How were issues handled?

Boundaries established with client/family prior to commencing 6
Family members included as appropriate and possible 6
Discussed with client, conditions determined together 5
Not applicable (clients alone in-home, or family is involved in the therapy) 3
Physical boundaries established (e.g. use of separate room, different environment) 3
Therapist became more creative/flexible in adapting to home environment 3
Artwork acted as confidential language for client 1

Note: Concerns regarding privacy and confidentiality differ depending on whether an individual client is being seen, or the entire family; whether the client lives alone, or with others. Concerns depend too on the goals of therapy (e.g. master of skill, or processing of personal issues). Of the 13 art therapists who took part in the study, only three worked strictly with individual clients in-home.

Was Artwork Left with the Client, or Taken with the Therapist?

Both 6
Leave 3
Take 3
Unanswered 1

Why?

Reason's for taking artwork: Artwork borrowed/kept for therapist records
Assessments for family court
Client did not want to keep work
Client felt artwork would not be protected in-home
Supervision and treatment planning

Reasons for leaving artwork: Client requested to keep/continue work
Clinically important certain works stay with client
Emphasis on mastery for self-esteem, not insight
Empowering client

No safe way of traveling with/storing client work

Note: Seven of the 12 art therapists who answered this question indicated that client preference and response to the artwork are key factors in their decision to take or leave the work. When work is taken it is generally for safekeeping or assessment; when work is left with the client, this is usually to facilitate the client's therapeutic process, but also sometimes for logistical reasons.

Arrangements for Safe Keeping of Artwork In-Home

Discussed with client 4

Client encouraged, via closing ritual or gift of special materials, to protect work 4

Therapist placed trust in client and family caregivers 3

Artwork kept in designated safe-place in home 2

Therapist keeps own record of work 1

No arrangements made (goal was to develop and display talent) 1

Who Provides Materials?

Therapist 11

Both 2

Client 0

Does the Home Setting Influence Therapists' Choice of Materials?

Yes 7

No 6

Note: Art therapists who indicated that the home setting does influence their choice of materials tended to comment that the necessity of transporting supplies limits the quantity and variety they bring. Others expressed a concern for the family home, foregoing materials that might be difficult to clean up. The amount of space available for use and storage of supplies in-home was also described as a limiting factor.

How do Therapists' Transport Materials?

Car 8

Suitcase on wheels 2

Other responses: decorated box; huge basket; plastic tub with lid; craft case; plastic-lined gardener's bag with pockets; knapsack and plastic art tube

Were Clients Given Materials to Use Between Sessions?

No 5

Yes 4

Only on occasion 4

Advantages to In-Home Art Therapy

Comfort and convenience for client 8
Insight: exposure to/greater empathy for client's situation 7
Involving family members/viewing family dynamics 6
Enhanced therapeutic relationship/equalizing power in 3
Access to personal items that can be utilized in therapy 2
Assessment 2
Challenge to therapist's professional growth 2
Eliminating barriers to therapy (for clients who otherwise would/could not attend) 2
Fosters client making art at home/client can keep art between sessions 2
Symbolic information available in the home 2
Allows therapist to offer another aspect of service 1

Disadvantages to In-Home Art Therapy

Limitations regarding materials (transport, storage) 5
Constraints of home environment (space, cleanliness) 4
Interruptions/distractions 4
Privacy/confidentiality 4
Time (travel) 4
Non-neutral space: can hinder work on some issues/not everyone responds well 3
Personal safety concerns 3
Cancellations due to illness in home 1
Coordination with other services client receives 1
Less defined professional role 1
Therapist's sense of isolation 1

In-Home Art Therapy and Therapeutic Relationship:

Enhanced 10
Setting can enhance or detract 2
No significant influence 1

Note: Two art therapists identified extended session length as a factor in the enhancement of the therapeutic relationship. One art therapist commented on how blurred boundaries in-home can detract from the therapeutic relationship.

Will Therapists Continue Offering In-Home Art Therapy?

Yes 12
Unanswered 1

Note: Three of the 12 art therapists included in the affirmative qualified their answer by adding that they would continue only if in-home therapy was indicated as the best option for a client. A fourth therapist now, now semi-retired, only offers in-home service as brief crisis intervention.

Reasons for Continuing

- It works with clients/population 4
- Therapist enjoys home context/insight into family dynamics 3
- Provision of accessible service 2
- More equal power relationship with clients 1

Considerations for Not Continuing

- Travel time (is tiring & limits number of clients that can be seen) 2
- Financial concerns 1
- Lack of intake/screening regarding appropriateness of service for clients 1
- Lack of recognition for service from (referring/funding) agencies 1
- Safety concerns 1

Helpful Resources

- Support of professional colleagues 7
- Determination/personal beliefs 3
- Personal/professional experience 3
- Articles/library 2
- Online resources 2
- Supervision 2
- Continuing education/involvement in teaching 1
- Inspired by work of others 1
- Professional associations 1

Appendix E

Sample Consent Form for Use of Case Material

Consent Form

I _____ give my consent for Cindy Newton to use photographs of my artwork made during art therapy sessions with her and to discuss the therapy, for teaching purposes and publication. I understand that my name and identifying details will not be used, so that my privacy can be kept, and that the photographs and case information will be used in a professional manner to help illustrate an art therapy process.

I have the right to withdraw my consent at any time, and can do so by leaving a message for Cindy (with *name of supervisor*) at *name of practicum site, phone number and extension*.

Signed:

Date:

Witnessed:
