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An Exploration of Art Therapy and Attunement in Treating Families with DCFS Involvement

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An Exploration of Art Therapy and Attunement in Treating Families with DCFS
Involvement.

by

Amanda Gonzalez

A research paper presented to the

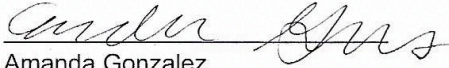
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Loyola Marymount University

In Partial Fulfillment of the
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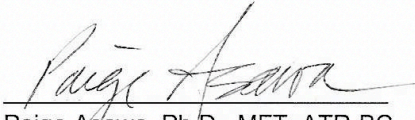
ART THERAPY AND ATTUNEMENT

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Abstract

This qualitative research aimed to explore how art therapy may enhance attunement when working with families who have involvement with Department of Children and Family Services (DCFS). The study utilized a focus group methodology to examine the experience of two art therapists with backgrounds in treating families involved with DCFS. Through the analysis of the participants' discussion, artwork and reflections, several subsequent emergent themes were revealed. These themes exposed various barriers within the system that may complicate the therapeutic relationship, as well as qualities within the art process, which act as an equalizer and source of containment. These themes illuminated findings that support the role of art in building attunement, as well as questions for future research regarding families with child welfare involvement.

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Introduction

Study topic

The research aimed to explore how art therapy can enhance attunement within the therapeutic relationship, specifically when treating parents with child welfare involvement and a history of trauma. To answer this question, the study examined the lens of art therapists who have experience in treating families involved with Los Angeles Department of Children & Family Services (DCFS). It was the goal of this research, to explore how art therapy may help clinicians attune with their clients amidst the complexity of the DCFS culture.

Significance of the Study

Current research has shown that many parents, who become involved in child abuse or neglect investigations, often have their own histories of childhood maltreatment or trauma (Heyman & Slep, 2002; Newcomb & Locke, 2001; Pears & Capaldi, 2001). The exposure to childhood trauma can result in outcomes such as, an inability to regulate difficult emotions, lack of interpersonal relatedness (Shonkoff, 2010) and the absence of secure attachment (Baer, Martinez, 2006). Research such as the Adverse Childhood Experiences (ACE) Study has highlighted that these outcomes can be life long, leaving these individuals vulnerable to additional dysfunction and impairment (Anda et al., 2006; Felitti et al., 1998). Yet, there is little research on how these challenges are addressed within the context of the therapeutic relationship working with families with child

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welfare involvement. For instance, once a family enters an investigation within the Los Angeles Department of Children & Family Services (DCFS), the caregiver is typically confronted with a system that is confusing and challenging to navigate that can also include the judicial system, which may leave them feeling stigmatized and labeled as a “bad parent.” Although many clinicians and agencies aim to eliminate these labels, the therapeutic relationship is not immune to the mandated reporting bounds that are an inherent quality of the system. It is the goal of this research, to explore how art therapy may help clinicians attune with their clients’ needs despite the implications of the DCFS culture. Art therapy may provide parents with a non-threatening modality that allows them to express themselves, and ultimately open the door for clinicians to understand how to best provide support in reaching a place of empowerment, empathy and authentic engagement.

Background of the Study Topic

Within the fields of public and mental health, child maltreatment continues to be significant matter, with over 3.4 million referrals for investigations of child abuse and/or neglect in 2011 (U.S. Department of Health and Human Services, 2014). Once a family enters an investigation, services aim to identify the best interests of the child at risk. This includes risk assessment, early intervention programs, and a host of assignments for parents. To provide effective and valuable treatment for child maltreatment, it is crucial to assess the needs of the parents (Dumbril, 2006), however current research results does not provide a clear guide. In one study focusing on service satisfaction, 74% of parents reported positive experience (Fryer, Bross, Krugman, 1990). However, in-depth qualitative studies highlighted that parents often feel afraid and misunderstood (Corby, Millar, & Young, 1996). In these situations, caregivers may be confronted with experiences that leave them feeling stigmatized and labeled as an “unfit” parent, a label that is layered with legalities that some parents with immigration backgrounds may not even have familiarity with.

In addition, parents who have experienced abuse and neglect themselves are much more likely to repeat the maltreatment with their own children (Heyman & Slep, 2002; Newcomb & Locke, 2001; Pears & Capaldi, 2001). In such cases, unresolved childhood trauma can contribute to parenting issues, which may result in repeated involvement with child protective services (CPS) (Lang, Garstein, Rodgers, & Lebeck, 2010). Yet despite this, the goals of many mental health services are more likely to be focused on helping children reach normal range of functioning rather than the parents (Barth et al. 2005).

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However, without proper resolution for parents who have experienced their own childhood adversities, negative experiences within CPS systems may hold the potential to hinder the caregiver's journey in self-growth that is necessary for repairing the relationship with their child.

There is currently an abundance of literature that has called attention to the many effects of child maltreatment and abuse. Research has highlighted that an individual who has been exposed to childhood trauma will face a multitude of both physiological and psychological lifelong challenges (Anda et al., 2006; Felitti et al., 1998). Catalysts to these challenges are due to trauma outcomes such as, interference with cognitive and brain development, inability to regulate difficult emotions, lack of interpersonal relatedness, (Shonkoff, 2010) and the absence of secure attachment (Baer, Martinez, 2006). Cook et al., (2005) points out that these problems may put children at risk for "additional trauma exposure and cumulative impairment" that may ultimately build into one's personality structure, obstructing their path to healthy relationships and engagements as they transition into adulthood.

Despite the prolific literature on the relationship between childhood traumas and the resulting complications that could effect parenting later in life, there is little research that identifies the ways in which caregivers unresolved traumas influence their involvement and overall treatment within the child welfare system. Much of the current research focuses on family preservation and prevention programs, which aim to lower the risk of potential child endangerment by working towards altering the parent's behavior. For instance, once a family becomes involved in CPS they soon after receive court orders that then mandates parents to participate in specific services which are intended to

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strengthen their ability to provide best care for their child (Barth et al, 2005).

Additionally, under the Adoption and Safe Families Act (1997), in order to regain custody, caregivers must show that they are working towards improving the situations that led to the removal of their children within one year. The focus of altering dysfunctional and harmful behaviors as well as assessing a child's needs is both a crucial and imperative component of CPS. Having said this, providing best treatment for parents is also a very significant piece that may get overlooked. Some recent research has pointed out challenges within the experiences of caregivers such as, difficulty in navigating the system, feelings of alienation and being "punished" as well as disingenuous engagement (Goffman, 1963; Smith, 2008; Yatchmenoff, 2005). However, more research needs to be conducted to understand how to best address caregiver's needs in regards to their own treatment and reunification requirements.

Literature Review

Introduction

This literature review is intended to synthesize the current research on caregivers and families involved with CPS within the context of trauma, attachment, attunement, CPS culture and art therapy. The literature review begins with a general discussion on trauma to facilitate an understanding of the layers of trauma that may generationally exist within family systems. Followed by this, a discussion on attachment trauma and attunement is presented to help highlight the various manifestations in behavior, which may impact how caregivers with trauma histories may interact with the system as well as how the system interacts with them. After this, the culture of CPS is reviewed to consider the structures of the system and how that may affect those with attachment traumas and cultural barriers. Lastly, art therapy literature is explored under the lens of trauma, attachment trauma, attunement and CPS culture to help support the research question of how art therapy may enhance the attunement when working with caregivers and families.

Trauma

According to the DSM-IV, a traumatic event must involve the experience, witnessing or confrontation with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others, and the individual's response must involve intense fear, helplessness or horror (American Psychiatric Association [APA], 1994). This can include exposure to extreme and chronic poverty, parental mental illness, parental alcohol or substance use, intimate partner violence, and child maltreatment (Harden, Buhler, Parra 2016; Shonkoff, 2010). Child

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abuse and maltreatment can include emotional abuse, sexual abuse, physical abuse, neglect and witnessing domestic violence (Cooke et al., 2005). Furthermore, Monahan (1997) noted that children who occupy the same home as their sibling who experienced abuse may also endure some of the same negative, toxic experiences in their family of origin. Skeffington and Browne (2014) describe this as secondary exposure to childhood trauma in which the witnessing or learning of intra-familial abuse can further complicate one's reaction and understanding about childhood events.

Although the effects of trauma on individuals of any age is a pressing matter, an abundance of research has documented that trauma exposure, specifically in childhood, is connected to a multitude of negative physical and mental health outcomes in adulthood (Anda et al., 2006). For example, when development is not disturbed by traumatic experiences, children are much more likely to integrate self-soothing and regulating mechanisms that will support their ability to cope with anxiety and stress (Kozlowaska, Hanney 2001). Several authors have also stated that when these foundations are not properly formed and a child continues to be exposed to external threat, brain and nervous system structures can be disrupted (Damasio, 1994; Edelman, 1987; Kraemer, 1992; Schore, 1997). These disruptions can result in dysfunctional physiological and psychological responses to future stressors, limited cognitive development and increased lifelong vulnerability to stress related illnesses (Shonkoff, 2010). This is also supported by the Adverse Childhood Experiences (ACE) study (Anda et al., 2006; Felitti et al., 1998), which has highlighted the correlation of traumatic childhood exposure, with both life long physical and mental health problems. Additionally, the ACE research shows a link between childhood trauma and later life problems in adolescent and adult health such

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as teen pregnancy, smoking, substance abuse, sexual behavior, and the risk of re-victimization.

Over the past few decades, many studies have attempted to further investigate how these life long symptoms play out in the context of parenthood. Fraiberg and her colleagues (1975) used the metaphor “ghosts in the nursery” to describe how caregivers may inadvertently reenact with their children scenes from their own early relational experiences of helplessness and fear. Recent research has also supported the intergenerational transmission hypothesis, which proposes that parents who have experienced childhood trauma in forms of abuse, neglect and family dysfunction face a greater risk of maltreating their own children compared to parents who were not maltreated (Heyman & Slep, 2002; Newcomb & Locke, 2001; Pears & Capaldi, 2001). Putnam-Hornstein, Cederbaum, King, Eastman and Trickett (2015) further supported this, using CPS records to create a population-level longitudinal study on intergenerational maltreatment with adolescent mothers. They found that a history of maltreatment was a strong predictor of maltreatment and CPS involvement in the next generation. Despite this information, the literature regarding best approach to parent and caregiver’s treatment in CPS systems is minimally addressed, and even less acknowledged is their experiences within the context of their own maltreatment histories.

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Attachment

When considering the long-term impacts of childhood trauma, attachment theory offers a useful framework for understanding the connections between early childhood experiences and the manifestation of subsequent symptoms and behaviors (Sroufe, Carlson, Levy, & Egeland, 1999). Attachment theory is rooted in the idea that humans possess an inherent quality that seeks proximity to primary caretakers in order maintain feelings of safety and security (Bowlby, 1980). As the parent-child relationship develops, a child will internalize mental representations of relational experiences based on the availability of the caregiver, resulting in either a secure, avoidant, ambivalent insecure or disorganized attachment (Ainsworth's, 1969; Mayseless, 1996). Cook et al. (2005) explains that when a caregiver is able to repeatedly attend to their child's needs, a secure attachment is established that ultimately provides the child with the safety to develop appropriate emotional regulation in dealing with self and the environment. She states, "Early caregiver-child relationships are what form the foundational understandings of the child's representations of self, other and self in relation to others" (p. 392). Additionally, Cook et al. (2005) notes when caregivers have not been consistently available, neglectful, rejecting, or abusive, the attachment relationship is considerably endangered and likely to result in a disorganized attachment, what he describes as the most problematic of the insecure patterns. Furthermore, Freyd (1996) states, 80% of children who experience maltreatment from a caregiver develop insecure or disorganized attachments. Siegel (1999) suggests, "the parents of children with disorganized attachments have provided frightened, frightening, or disorienting shifts in their own behavior, which create conflictual experiences leading to incoherent mental models. Abrupt shifts in parental

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state force the child to adapt with suddenly shifting states of his own. When such shifts are early, severe, and repeated, these states can become engrained in the child as self-states” (p. 317).

This internal process can also be understood as the simultaneous activation of both the attachment system and the survival system, pushing the child into dissociative processes, which is why disorganized attachment is also understood as an early relational trauma or attachment trauma (Schoore, 2009). Thus, the disorganized child consistently endures a conflicting tension between two opposing forces: the impulse to retrieve soothing and help from caregivers as well as the instinct to protect from danger through survival responses. (Bowlby, 1969; Liotti, 2006). This disorganization essentially creates an internal incongruence for the child; the source of comfort is also the source of danger (Hesse, Main, 1999). In connection to this conflict, the disorganized child will often find safety through organized strategies such as, identifying with the threatening caregiver, as well as internalizing feared characteristics in the effort to protect against them (Freud, 1936). Schoore (2001) also noted that symptoms of disorganized attachment are pervasive and can be predictive of poor long-term developmental outcomes. Some of these outcomes include a deficiency in the ability to trust, self regulate, and create healthy boundaries as well as rigid, extreme, and dissociative behaviors, which revolve around themes of helplessness and/or coercive control (Cook et al., 2005).

Much of the research on attachment focuses primarily on the caregiver’s impact on the child’s functional and relational development. However, it is also important to consider how the caregiver’s attachment history informs their parental interactions. According to Fraiberg (1980), when parents are faced with the distress of their child, they

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are bombarded with themes of helplessness that stem from their own unresolved childhood needs. In these cases, the parent may view the child as if they were a figure from their childhood, lacking the realization that their child possesses their own separate and individual experience (Fonagy, Target, Steele, & Steele, 1997).

Although it has been noted that parents with insecure attachments often face difficulty in empathizing with their child, this is not always the case. Fraiberg and colleagues (1975) propose that parents who are capable of empathy also often demonstrate an ability to access painful affect from their childhood. Fraiberg asserts this access can be facilitated in treatment, in which it can act as a catalyst for attunement processes that may guide parents to act effectively for their child. Yet, what sets the stage for attunement? In cases of maltreatment that lead to CPS involvement, caregivers enter a system that may not be accommodating to their attachment histories. Familiar and historic themes such as helplessness and loss of control may be generated due to the high stakes involved, in which self-protective processes and defenses may be triggered, keeping them away from their path to repair and attunement with their child.

Attunement

Within the attachment literature, the topic of attunement has been heavily researched and defined in many ways. According to Fonagy, Gergely, Jurist, & Target, 2002, attunement can be described as a process in which a state of openness is maintained through awareness of the reactions within ourselves and within those around us. Similarly, Hopenwasser (2008) defines attunement as “a synchronized awareness of implicit knowing that is nonlinear and bidirectional” (p.349). Shaw (2003) notes that empathic attunement derives from the stimulation of somatic sensations such as seeing,

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hearing and touching, resulting in an activation of neural networks within the brain.

Conversely, when these activations stimulate somatic sensations without mental representations, Shaw (2003) defines this as “body empathy.”

Main, Kaplan, & Cassidy, (1985) suggest that the capacity for attunement develops through early attachment experiences in which the caregiver is able to respond to the child’s emotional expressions in a manner which allows them to feel understood. Stern (2000) suggests that in order for infants to feel as though their emotional experience is being heard and that they are not alone, the caregiver must be able to read the infants emotional state and provide a corresponding response, which in return teaches the infant self-regulation.

Although the attunement between parent and child is an important quality within the attachment relationship, the literature on attunement and the value of its enactment within the therapeutic relationship has also been acknowledged. Bass (2003) noted, “a crucial function of enactment is to allow opposing realities held by different self-states to coexist, thereby broadening access to a fuller range of self through the analytic relationship” (p. 669). Additionally, Black (2003) notes enactment involves the information the clinician receives through “felt experience,” an experience that is derived from the concept that our “our inner processes cannot be fully known to us” (p. 634). Many scholars, however, have described other therapeutic processes like countertransference in similar ways, noting that when trauma is involved therapists should pay attention to their countertransference in order to understand the unconscious traumatic memories that will surface through enactment in the transference-countertransference (Aguayo, 2009; Brandell, 1999; Gedo, 2013). Yet, how does a

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clinician access their inner processes and ability to attune when influences such as trauma and countertransference are layered within the therapeutic space? Although such attributes of the therapeutic relationship have been examined separately in the literature, the literature is lacking research within the context of clinical treatment in child welfare settings.

Culture of CPS

Providing protection and care to ensure child safety requires quick and immediate action, which is both warranted and necessary, however the urgency that is involved in these processes can result in rigid structures and requirements. Under the Adoption and Safe Families Act (1997), parents are given one year to exhibit an improvement within their circumstances that led to the removal of their children. Within this process, the parents are assessed for their abilities to provide adequate care and safety for their child (Cromer, 2007). Reunification programs involve various court orders that mandate parents to engage in services, which aim to prevent future maltreatment and promote parenting skills (Barth et al., 2005).

As parents face the enormous risk of losing their children, it is not uncommon that many find challenges in navigating the welfare and family court system. These challenges may be further implicated by oppressions of race, low income and poverty. According to The Center for the Study of Social Policy (2009), there is an overwhelming disparity of people of color as well as individuals with little to no financial resources. These disparities are crucial when considering that many of the caseworkers and people they will encounter within the system are likely to hold the dominant perception of parenting which Hays (1996), describes as being socially and historically constructed by

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the upper and middle class. Subsequently, these families become vulnerable to judgment based on a narrative that does not encompass the various intersecting systematic oppressions they face (Collins, 1992).

Although many clinicians and agencies aim to eliminate these stigmas and power differentials, the therapeutic relationship is not immune to the mandated reporting bounds that are an inherent and necessary quality of the system. These structured protocols may be triggering for parents who already lack power within the system. Additionally, caregivers with their own personal trauma may face difficulty in managing affective arousals such as, anxiety, distress, rage, and anger (Ainsworth et al., 1978) and may be challenged in experiencing emotions without deflecting, denying or defending against them due to their early attachment experiences (Schoore, 2003). Nevertheless, they are obliged to comply or else they face losing their family.

Thus, if an adult caregiver with a disorganized attachment enters the system, they may find themselves distancing from the process in its entirety. According to recent studies, caregivers involved in child welfare services reported viewing treatment mandates as punishment (Smith, 2008), and experienced caseworkers and the system as having power “over” them (Dumbrill 2006). Research on this topic has also highlighted that parents’ negative perceptions of the system resulted in a process of “playing the game” (Cleaver & Freeman, 1995; McCullum, 1995) and “going through the motions” (Yatchmenoff, 2005) where parents present as cooperative for the sake of keeping their caseworks pleased rather than true authentic engagement. Despite this, the literature does not yield sufficient research on how can clinicians properly form a relationship with caregivers when the interventions that are necessary to secure a child’s safety also set the

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stage for a reenactment of their own attachment experiences.

According to Schore (2001), the reenactment of attachment histories between the emotional states within the therapeutic relationship is a necessary component in repairing the client's attachment. Black (2003) suggests that the significance of enactment in the therapeutic space is found in the information the clinician receives through "felt experience," an experience that is derived from the concept that our "our inner processes cannot be fully known to us" (p. 634) However, those who have had poor attachment histories may present with dissociative shifts that are both nonlinear and difficult to follow, creating a conflict where the clinician's ability to stay present is hindered and therefore handicapped in their ability to stay empathetically attuned (Hopenwasser,2008).

Art Therapy

Although the field of art therapy has developed in the last fifty years, recently the effectiveness of art therapy and trauma has been well supported in the literature. Research on traumatic and stressful memories has shown that trauma is not easily accessed through language because it is recorded in sensorimotor form, accompanied with visual and kinesthetic qualities (Piffalo, 2002). This is further supported by Malchiodi (2014), who suggests that trauma is "stored as somatic sensations and images, it may not be readily available for communication through language, but may be available through sensory means such as creative arts, play, and other experiential activities and approaches" (p. 11).

In addition to this, Piffalo (2002) notes in cases of child maltreatment, due to lies, threats, or betrayal, verbal communication can often be tainted with distrust, creating a fundamental understanding that words do not hold truth – in which case, it is addressed

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that verbal therapy alone may be counterproductive. Miller (2017) suggests that many of those who experience abuse also experience pressure to keep their abuse hidden, which can further complicate how an individual develops the capacity to articulate their experiences. Furthermore, talk therapy and verbal communication in general may enable self-protective strategies such as distraction, diversion, changing the topic and/or selectively focus on pieces of a story that bypass uncomfortable feelings (Skeffington, Browne 2014). Art therapy however, can lend a new form of communication where the trauma can be externalized with protection of the creator's symbols and representations. Art, unlike words, is concrete and could be placed somewhere safe and then returned to when the client is ready. Additionally, images can give voice to complicated non-linear experiences, providing an outlet to express the confusing and contradictory emotions, thoughts and actions within their internal world. Haywood (2012) explains that as an individual's boundaries are psychologically and/or physically compromised during their abuse, they are met with their own uncertainty about what lies beneath their own personal "threshold". She suggests however, art therapy is special in that it can offer many experiences at once, which can open the door for clients to move towards thresholds and edges within.

Art therapy literature has also demonstrated how the art process holds the capacity for attunement. For instance, Henley (2005) discusses the process of engaging in the art and how the materials provide the client the choices of how to interact with the therapist such as talking or not talking, including the therapist with the materials and/or choosing to block the therapist out. According to Hopenwasser (2008), Empathic attunement can be "predicated upon the activation of neural networks within the brain that are directly

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stimulated by the experience of seeing, hearing, and touching.” The product and process of the creative expression becomes the holder for traumatic experiences, and opens the door for authentic expression (Pifalo, 2002).

Research Approach

A qualitative approach was implemented within this research as a means of approaching a broad question, on a topic that is sparse within the literature. When researching topics that are not well known, Patten (2004) suggests qualitative approaches since there is more leeway in asking “broad questions” in which they then can be “refined” through the course of research (p.21). According to Linesch (1995), “Metaphorically, qualitative research may differ from traditional research in that instead of "narrowing in" on data, this approach may emphasize the emergence of meaning” (p.261). This lends well when attempting to understand a multilayered and multidimensional topic, such as the exploration of attunement in the art therapy process and relationship.

In order to understand the experience of attunement from the art therapists’ perspective, focus group research was deemed to be the most effective methodology to gather data. Carey (2016) notes that focus groups permit the interaction between members, which may subsequently enhance the data. The group provides the opportunity for the responses of others, such as questions and feedback. This level of exploration may not be able to be accessed in individual interviews without the risk of researcher suggestibility.

Method

This section includes definitions of relevant key terms and concepts of this study.

Although these terms and concepts may have various meanings, they are defined here within the context of this study. Following the definitions will include an outline of the design of the study. This outline will discuss the recruitment of participants, methods of gathering data and a description of data analysis that will be applied for this proposed research.

Definition of Terms

Attunement is “a synchronized awareness of implicit knowing that is nonlinear and bidirectional.” (Hopenwasser, 2008)

Complex trauma in childhood is defined as “the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature, often within the child’s caregiving system” (Cook et al., 2005)

Engagement Horvath & Greenburg (1994) define engagement in the field of psychotherapy as an alliance between therapist and client

Maltreatment can be understood as “acts of commission, i.e. physical abuse, sexual abuse as well as acts of omission such as neglect, i.e. failure to provide food, hygiene, clothing, shelter, supervision and medical care” (Barnett et al., 1993).

Stigma- “a process by which the reaction of others spoils normal identity.” (Goffman, 1963)

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Trauma According to the DSM-IV, a traumatic event must involve the experience, witnessing or confrontation with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others, and the individual's response must involve intense fear, helplessness or horror (American Psychiatric Association [APA], 1994)

Design of Study

Sampling

Research mentor Dr. Paige Asawa, PhD, LMFT, ATR-BC recruited subjects who were 21 years and older graduates from Loyola Marymount University's Marriage and Family Therapy program by email invitations (Appendix A). Subjects were invited to participate in a focus group to explore art therapy and attunement in their clinical work specifically within the population of parents who have DCFS involvement. Subjects were 2 female practicing art therapists, chosen based on their past or current experience in working with parents with DCFS involvement through the modality of art therapy and availability. Subjects were chosen by the PI and research mentor.

Gathering of Data

Research mentor contacted subjects via phone or email to ask for participation. The data in this research was gathered in a two-hour focus group facilitated by the research mentor and observed by PI. Participants met at the LMU Marital and Family Department Art Studio on Sunday afternoon and were provided with free parking. PI provided the participants consent forms (Appendix B) and subject bill of rights (Appendix C) prior to the start of focus group activities. Participants were asked to engage in discussion about their experiences when working with this population and then create a piece of artwork as

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a reflection of their experiences. The following art materials were provided as options to creating the art: oil pastels, chalk pastels, paper of various sizes and colors, paint and brushes, markers, pencils, glue, tape, scissors, and colored tissue paper. Participants were then asked to share the meaning of the art piece and participate in a group discussion regarding the imagery itself and any common themes and experiences and/or lack thereof. Participants were then invited to create a second art piece reflecting on how art therapy has impacted the therapeutic relationship when working with parents involved with DCFS. Following this, participants were invited to discuss the meaning of this second piece of work. The research data consisted of the artwork and the audio transcript of the discussion during the focus group. Names were used while audio was recorded, however only pseudonyms were used in any other form of mentioning the participant

Analysis of Data

The audio recording of the focus group was first transcribed and then reviewed for accuracy. Following this, the researcher reviewed the transcription, artwork of participants and observation notes several times to assist in the identification of emerging themes. As these themes surfaced through the reviewing process, the researcher returned to the data to pull out specific examples, quotes and words to provide support within the findings. The artwork was also analyzed through identifying similarities in content, color, descriptions and process. Throughout the analysis process the researcher checked in with the research mentor through discussion and review of analysis to ensure accuracy

Results

Presentation of Data

The focus group was scheduled to meet on a Sunday afternoon at the art therapy studio in the Marriage and Family Therapy Suite at Loyola Marymount University. Four participants confirmed their participation after being contacted via Email by the focus group facilitator Dr. Paige Asawa, PhD, LMFT, ATR-BC. The day of the focus group, one participant canceled and two participants attended late due to transportation difficulties. The first participant arrived 15 minutes after the scheduled time. As the facilitator, researcher and participant waited for the other participants, causal conversation took place and the facilitator offered coffee and tea. The 2nd participant arrived approximately 20 minutes later. The two participants the facilitator and researcher agreed that they would wait 10 minutes to try and find a way to contact the third participant however after they were unsuccessful in their attempts, the facilitator made the decision to start the group without the third participant.

The group started with the facilitator explaining the consent forms and distributing them to the participants. Upon collecting the signed consent forms and providing each individual with a copy of the Experimental Subjects Bill of Rights, the facilitator then invited the researcher to introduce herself. The researcher thanked the participants for their involvement and shared with the participants her personal interest of the research topic, explaining that her research questions were sparked by her experience at her 2nd year practicum site, which mainly consists of cases with current or past DCFS involvement. The participants were then asked to answer several questions such as their

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title, theoretical orientation, how long they have been practicing, and what type of agency they were currently working at and/or where they were working when they were treating families with DCFS involvement.

Participant #1 (S) shared she was a LMFT, ATR-BC and has been practicing 2009 at her student practicum. Upon her graduation in 2010, S explained she began working in a community agency in Long Beach, CA, where she gained experience with a variety of different age groups but primarily focused on the 0-5 population. S shared in 2014 she moved to another community agency in Inglewood CA which is where she still currently working. Within this agency, S explained she continued to work with a variety of age groups and has been a clinical supervisor over the past year. When addressing her theoretical orientation, S shared that she is trained in Parent-Child Interaction therapy (PCIT), which she described as “strictly behavioral.” S explained that she practices art therapy predominantly from a psychodynamic perspective, however she also integrates evidenced based practices such as Trauma-Focused Cognitive Behavioral Therapy (TFCBT) which is narrative therapy mixed with cognitive behavioral therapy and Managing and Adapting Practice (MAP) which she explains draws from a lot of theoretical perspectives. S then stated she likes to approach treatment from a humanistic and family systems approach.

Participant #2 (M), also a LMFT, ATR-BC, shared that she has been in private practice for the last 13 years however for the past 6 ½ years she has also been working at a community based non-profit Department of Mental Health (DMH) contracted agency in which she is both a clinical supervisor and school based coordinator. At this site, M

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explained she does not have her own cases however she often will work with parents and provide family therapy for the clients of her staff as extra support is sometimes needed. Within this agency, M explained some of the cases she comes across have DCFS involvement however the majority of her experience with DCFS come from other community based, non-profit, DMH contracted sites where she previously worked as an onsite manager and as a supervisor for various outpatient programs with both adult and children. In addition to this, M shared her second year practicum site, a non-profit LA country DMH contracted agency wound up being her first job in which she received 8 years of experience. M stated to the group, “ At least half of my client case load was DCFS.” M shared her theoretical orientation stating that similar to S, she also is “eclectic” and integrates many orientations into her practice. M explained within art therapy treatment she is psychodynamically oriented as well as object relations however she also utilizes theories such as eye movement desensitization and reprocessing (EMDR) and brain spotting. M explained that she also uses a humanistic approach and quoted David Grand the founder of brain spotting, “Client’s are the comets and you are following that tail of the comet” M then went on to say that she also considers herself CBT oriented at times when using EMDR. She explained, “When you’re working as a trauma informed art therapist you always want to not only work on desensitizing but also integrating information.”

Following introductions, the facilitator moved the discussion on to the next phase of the focus group, which prompted the participants to reflect on the culture of DCFS. The facilitator asked both of the participants, “Overall, what are your experiences? How do you see the DCFS system and then how do you view your clients responses to that

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system? S answered first and stating she viewed the system as “multifaceted.” S then went on to share how she has experienced “every single case” to be different as a result of the variation in DCFS caseworkers. S stated, “Some work quickly, some take their time, some villainize the parent, some villainize the child. It’s so diverse, every experience is so different.” She went on to explain the hotline for reporting is a “big neon sign of inconsistency.” M continued, “Sometimes they will open an investigation because a parent gave their teenager a sip of wine, and then sometimes they wont go out when you’re saying the child is reporting sexual abuse by the father.” S added, “Its so strange how it can have a very concrete law that guides our reporting and then the outcome can just be all over the place.” The facilitator responded to M’s experience of DCFS and asked, “Is it like throwing darts?” S nodded in agreement and replied, “Like throwing darts blindfolded.”

At this point, Participant M also responded and expressed her agreement. M discussed the inconsistent experiences she has had when making reports, which in some cases, she explained she had to call multiple times for a report to be taken. She stated, “The word broken system comes to mind.” M addressed some of the improvements DCFS has recently made in regards to trainings for foster parents and kinship caregivers, yet despite this, she stated that children are often “re-traumatized” and experience “more damage” when placements are not adequate.

The facilitator responded to the participants with a follow up question “How do you feel your clients experience the DCFS system?” S responded first stating, “In just as many variety of ways.” She explained that when the DCFS system works how it is intended to, families are able to “reunify in a really beautiful way.” However, when this

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is not the case, which she stated was “the other 80%” of the time, she then feels as though the treatment she provides must be “extra special” and “extra supportive.” She expanded on this explaining that this involves being “thoughtful,” “finding all the resources” and “working with as many people in the system” as she can.

The facilitator highlighted the 80% ratio S declared and asked M to share her opinion. M laughed and reported that her experiences of DCFS working effectively may be even less, stating, “I feel more like, 5 to 95%.” M explained that at her past agency she often worked with many clients of different cultures, which frequently resulted in misunderstandings of the various DCFS expectations. M added, “ There was not a culture sensitivity.” The facilitator asked the participant to share more of her experience surrounding this. Following the facilitator’s request, M shared a story about a case involving a Cambodian mother who was a refugee with a history of trauma and symptoms of PTSD. She explained that this client was involved with DCFS due to a report based on her daughter not attending preschool. M shared that at the DCFS meeting this mother was “cornered” by the assigned investigators and as a result, she became dysregulated, which lead to the staff removing the child in the meeting. M then went on to address how the language and cultural barriers were not acknowledged which added to her level of dysregulation. M stated, “She was of a different culture and had mental health issues. That’s two different kinds of culture that they were not attuned to.”

S responded to M’s story expressing a similar observation and conversation within her agency. S stated, “There is a lack of understanding of mental health concerns within the family system at that level.” She then added, “They (DCFS) are so black and white but they are inconsistently black and white.” S then quickly addressed the recent

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addition of Multidisciplinary Assessment Teams (MAT) and how she has been pleased with the integration of cultural considerations and concerns, but that it was still fairly new.

Following this, Participant M then shared with the group that she did not only view DCFS to be “broken” but saw the mental health system to be broken as a whole. M addressed how many caregivers who become involved in the system have mental health issues of their own, including depression and history of trauma. M stated, “When kids are placed somewhere else and the parent is left to work on their own, there aren’t enough resources.” She continued, “Resources for these parents are not easily accessible, whether its parenting class, the time frame, or the place in which they occur – none of that is quite workable for a lot of them.” M then added, “They really have to go through the hoops.” M also shared how accessing resources are even further complicated after their children are removed because they no longer have access to insurance.

The facilitator then suggested a metaphor of a maze to summarize her understanding of the difficulties discussed. She then asked the participants, “What metaphor would you use for them and their experience of this?” Participant S responded, “Maze might be a good one. Maybe a hamster wheel on both ends because they have to run in place for a while in the beginning and run in place for a while at the end and then cross their fingers and hope that everything is going to work out.” M referenced a metaphor she heard through a past client who said he was “trying to keep his head above the water.” M added, “So not just being in the maze but it’s also flooded.” The facilitator clarified with the participants, “it’s a flooded maze with the hamster wheel at both ends?” M nodded in agreement and added, “And you don’t know which way is which.”

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Participant S also nodded in agreement and brought up a case about a mother who experienced so much frustration within the system, she decided to keep her pregnancy to herself. S shared, “She didn’t know if she was going to get so fed up with the system that she would decide to just give the kids to her mom.”

During the next phase of the focus group, the participants were asked to create an art piece reflecting their personal experience of the various aspects of the therapeutic relationship within the framework of working with families with DCFS involvement. The participants were invited to use materials that were provided on the table including but not limited to, oil pastels, markers, colored pencils, collage images, papers of various sizes and colors, colored and printed tissue paper, paints and brushes, scissors, and glue. After approximately 20 minutes the participants were invited to share their artwork with the group.

Participant M used collage images, pen, and a 12 “x18” white drawing paper to create her artwork (Figure 1). M glued a total of 14 images, some of which she used scissors to manipulate the original shape and pen to draw on top of one image. M also glued down 3 images of text. When discussing her artwork M held up her piece and pointed to the images she was referencing. M first referenced the image of text “on the verge” glued at the bottom of the center of the page. She stated how this text made her think of the parents she has worked with that are often on the “verge of breakdown” due to so many challenges such as “poverty,” “lack of resources,” and “feelings of shame.” Above the “on the verge” text image, Participant M glued an image of a black woman holding her baby. She used pen to make a scribbled line between her and her child. To the right of this image she placed an image of a white woman holding a baby with a

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Ferris wheel in the background. M cut out the face of this image and placed an image of an eyeball with a baseball cap over it pointing in the direction of the Black woman and her child. M explained these pieces stating, “More often than not I think there is a disproportionate level of minority groups (in DCFS).” She then stated she chose the “big eyeball” for vigilance and the hat to represent shame. M then referenced the image of a woman lifting weights placed to the right of the Ferris wheel and stated “they have to go through a herculean effort to really get through the program and get things to happen.” Following this, M moved on to discuss the two dolphin images that she glued on opposite sides on the page. One of these images showed a dolphin under water surrounded by a net, which was glued at the bottom left corner of the page. The second dolphin image was placed on the top right corner of the page and showed a dolphin jumping out of the water. She referenced these two images and stated, “Just as DCFS is out of picture, parents think they’re free and they don’t really focus on the needs of the kids.” She then pointed to the image to the left of the jumping dolphin, which was a metal rabbit sculpture with various holes throughout the rabbit’s body. She stated, “The kids are left with all these holes that need to be filled.” She added, “Then there’s that gap that service providers have to bridge too.” M then moved on to several images placed in the center of the page including another eyeball, viewing binoculars, milk flowing out of a carton, human brain cell, and a mandala. In this section she also placed the text “unforgettable” slightly overlapping the image of the viewing binoculars. M referred to this section as the therapist’s perspective and stating that the eyeball represented being “vigilant” while also providing “nurturance” for parents as she referenced the milk. She continued to explain, “we have to believe that they are capable of being good enough, right?” She then pointed

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to the mandala-like image and stated, “we are changing their energy to something that is more holistic.” Following this statement, she pointed to the image of the viewing binoculars and continued to explain the importance for therapists to keep the “vision of long term goals” for parents. She shared, “they might want to give up because it’s just too much.” She also stated that in order to “hold the space” for parents, the therapist must maintain their ability to “keep them (parents) accountable and at the same time believe in the positive outcome of reunification.” Following this, M moved into the top left corner of her paper and pointed to the cut out of a fill in the blank text that read “This week I struggled with _____” and “what I did to positively cope with it was _____” M shared with the group that she included this because it reminded her of coping skills that are often used with the DCFS population. M expressed to the group “ It is my opinion that coping is not healing, coping is just managing stress.” She continued, “Healing doesn’t seem to occur until they’re grounded and not threatened.” The facilitator then pointed out that participant M did not mention the boat image on the bottom right corner of the page. M responded to the facilitator stating that the boat represents the parents having “a long way to go” she then continued and said, “I may share some vision of where they might go but its really up to them to sail where they want to go to, so at some point I just have to let that go”

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Figure 1. Participant M

The focus group then moved on to Participant S and her artwork. Participant S used an 8 1/2”x 11” orange construction paper, oil pastels and white and orange tissue paper. S started by using the white pastels and drawing lines on the orange construction paper. At certain points when the lines intersected, she shaded in circles connecting the two points. S also drew several cube shapes on the paper. Following this, S took several pieces of orange tissue paper and began forming 3 dimensional forms. S appeared to put in a lot of effort in working with the delicate medium to create the shape she wanted to make. After gluing down three tissue paper shapes on the construction paper, S took a sheet of white tissue paper and cut three even strips. She carefully placed them over the tissue paper forms and glued the edges to the bottom of the construction paper. Lastly, S took another piece of orange tissue paper, folded it into a much smaller spherical shape and placed it next to the other tissue paper shapes. S shared with the group that she

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decided to use the construction paper to represent the “therapeutic holding space” She explained to the group that she chose orange because she wanted to show the “electric” qualities DCFS brings to the holding space. She stated, “ It’s so electric, that holding space. It constantly has a lot of extra emotions, a lot of fear by the family and the parents that causes the therapist to work extra, extra hard to create a safe holding environment.” S further delved into the meaning of the color sharing that she views the DCFS therapeutic space to be “neon electric” when she would prefer it to be “cool green and blue” where it feels “safe and calm.” S then stated, “its impossible for that (feeling safe and calm) when DCFS is involved.” S then moved in to discussing her use of oil pastel on top of the orange construction paper and explained her process. She stated, “I created an underlying network in white pastel under here, and I chose pastel because I feel like it has the potential to get really out of control.” She explained that she drew “see-through boxes with a bunch of connecting lines” to represent a process traveling information from DCFS to the families involved in investigations. She explained that the expectations and recommendations from DCFS are “passing through” or “bouncing off.” S then pointed to the tissue paper structures she created stating that she made the pieces to represent the families. Referencing these structures she explained, “the big pieces in between are the client and the family and they are full of lots of different experiences and emotions that need to be attended to. They fill up the whole space.” Following this explanation, S moved on to discuss the meaning of the white tissue paper. She described the tissue paper to be a reflection of herself as the therapist who is following the DCFS expectations, but with a more “smoothed out,” “gentle” and “open” framework. She showed the group how her art piece allowed for movement under these white tissue paper strips by lifting it with

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her finger and stating, “things are able to move underneath it according to what the client needs or client directs.” S also discussed the use of the color white and shared how her choice to make both the representation of her and DCFS as white was intended to show the “disparities in the system” and demonstrate how often times DCFS can represent a “white system.” S stated, “I think since I’m operating as part of that identity as a white female in the system, I needed myself to match that color because I have to always be aware that they’re identifying me to match that system.” Participant S then turned to participant M and shared that there was something that she said about her artwork regarding the client’s ability to trust that resonated with her. S moved on to share the last part and pointed to the small tissue paper spherical shape and told the group this was her “trying to identify with them”. She explained that this represented how she attempts to come down to where her clients are and “be in it with them.” She stated, “that little, little circle. Just trying to be in it with them.” S clarified the various parts of her piece and pointed to the small tissue paper structure and said, “This is me,” and then pointed to the white tissue paper surface and stated, “This is what I’m trying to get them to perceive me as, being this flexible space for them.”



Figure 2. Participant S



Figure 3. Participant S



Figure 4. Participant S

Immediately following the participant's reflections about their artwork, the facilitator asked the participants questions regarding possible connections in their artwork and reflections. Yet before moving on, the facilitator asked M to hold up her artwork for S to identify the part she resonated with. As M held up her artwork the facilitator pointed out the center mandala-like image and asked participant S if this was what she was referring to, in which participant S agreed. The facilitator then asked M to repeat what she had said earlier regarding the center image. M stated, "that the parents are not purposely intentionally trying to hurt the kids." The facilitator invited both participants to reflect on the significance of this image in which S then pointed out how she noticed this center image had similar "bright" orange color that she used to represent the electric qualities of the therapeutic holding space in her artwork. S also identified a similarity of circular shapes between M's center image and the tissue paper structure S used to symbolize her self. At this point S continued to reflect on what her self symbol meant in

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her piece. She shared with the group, “I want them to not just accept that I mean what I say when I’m coming into the space to be with them, but to expect me to be here when they’re expecting everyone else to be apart of the system.” Participant M then added, “I think it’s easy for the therapist to adapt the viewpoint of DCFS and get burnt out.” She then explained how clinicians in community mental health get assigned many cases involving child abuse and neglect, which can increase the chances of resorting to “villainizing” the parents. S shared how as a supervisor she is “constantly reminding” her supervisees to have empathy for the parents. The facilitator inquired further with the participants, inviting them to discuss why this occurs. M responded stating, “I think they (DCFS) have to make a black and white decisions in order to do such an extreme thing such as take away parental rights.” M expanded on this thought and explained how clinicians often operate from an understanding that it is “the behavior that is unacceptable” however, she explained that in the case of DCFS workers, most are not trained in mental health, contributing to their likelihood of villainizing the parent. The facilitator then clarified and asked, “So does the clinician get sucked into that dynamic?” M nodded and stated, “I think so.” M explained how therapists working with this population face expectations from various angles such as the social workers, family members and sometimes school involvement. S also nodded in agreement and discussed observing countertransference processes often “getting in the way.” She expanded on this addressing how she frequently finds her supervisees over identifying with the client rather than seeing the family system “as a whole.” S stated, “they focus in on the child and become the champion for the child instead of seeing the parent as the champion for

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the child and so they try to take on that responsibility and in order to take that responsibility on you have to justify it.”

The facilitator then asked the participants to share their understanding of countertransference and invited the participants to discuss how they viewed countertransference in comparison to other qualities of the therapeutic relationship such as attunement. The participants engaged in a brief dialogue in which M defined countertransference as “counterproductive” when it goes unchecked. Both participants then came to the conclusion that the lack of self-awareness or the lack of processing/identifying countertransference can deplete the ability to hold the space and attune to the client. Following this agreement, S also added her thoughts around the reasons why this happens. She stated, “I don’t think it (letting countertransference go unchecked) comes from a lack of ability or education, but I think in our community agencies we are so inundated and overwhelmed that we don’t actually have the time to do self reflection in between our clients.” She then noted the potential for vicarious trauma due to the many stories of trauma. The facilitator delved into the participant’s response further and asked, her to identify the qualities of the mental health system that contribute to this. S replied explaining that in her experience the mental health system has been “completely overworked” and “overrun.” The facilitator then summarized their responses and reflected back to the participants stating, “the system itself is broken, its not just DCFS that’s broken, it’s the mental health system itself that overwhelms the therapist? Both participants then expressed their agreement.

At this time, the facilitator acknowledged the time and asked the participants if they would be okay to stay past the scheduled time due to the late start of the group. Both

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participants verbally agreed that they were okay to stay over the scheduled time in which the facilitator then moved into the next phase of the group. The facilitator began by asking the participants to define how they view attunement within the therapeutic relationship. Participant S answered first stating that she views attunement as “The ability to observe in multiple levels at one time and the ability to be present at multiple levels at one time” She then briefly discussed an example of attunement when working with a parent and child and how she will often lend attunement to the dyad rather than the child directly. S explained that in order to do so she must be “constantly observing” the interactions between parent and child while also “holding the space” so that the parent can attune with the child. The facilitator repeated back to the participant what she heard from her response and stated, “What I’m hearing you say, attunement is not just something that happens in the space but it’s an action that the therapist engages in?” S responded to the facilitator stating, “ It’s an enactment. I am enacting attunement into the space.” The facilitator then directed the question to participant M. M responded with first expressing her concurrence with participant S’s definition and then expressed how she has attuned through being “present” and being the “grounding force” for the client. M explained, “it could be that the person is here, but also somewhere else, whether its past, present, or future.” She continued, “It’s dual attunement” and “a temporal sense” of “being here” while also “being wherever they are at the same time.” She also added the therapist must be the “grounding force.” The facilitator responded with asking the participant, “so they can go wherever they need to go?” In which M replied, “exactly, so it’s dyadic in that sense.” M also added the importance of picking up on any nuances the client may have to help identify how to check in with client and help them feel “heard,”

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“seen” and “supported” which in return becomes a “visual process” for the therapist as well. Participant S also added another thought regarding attachment and expressed how many clients in this population have had “skewed experiences of co-regulation” which is why she views co-regulating with the client to be an important piece of attunement as well. S stated this is done by the therapist being “super present in the moment” and “observing what their regulation is” as well as using their moments of dysregulation to “enact the co-regulation process that the mother would have done.”

Following the participants’ responses, the facilitator opened another dialogue opportunity and asked the participants to share how they view attunement in comparison to joining or countertransference. M responded first describing the picture that came to mind in response to the question. She explained, “I am picturing someone just standing next to each other, looking at the same thing perhaps, joining in that sense.” She then continued on to compare attunement stating, “In Attunement, there is more of an engagement and a dance that goes on.” S responded in agreement stating that she had a similar thought. S shared with the group, “I think with attunement we stay two distinct selves and when we join, it’s almost like we’re becoming part of their self in a way, so you have to be really careful when you join. Very, very careful.” She continued, “Attunement is a little more flexible.” The facilitator then asked participant S if it was possible to “over join.” S responded nodding yes and stating, “you can over join quickly.” She then explained that attunement provides the therapist with more flexibility in being able to “bounce back and forth for a little bit” and to “allow space for both two distinct selves to be experiencing something at the same time.” Participant M responded also adding how she views attunement to happen on a neurological level when you “tune

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to the level of the client” which she explains also requires the therapist to “retune” or “recalibrate” themselves afterwards. The facilitator followed up with both participants asking them to specify how they see the difference in countertransference. M responded to the facilitator’s question explaining that countertransference involves “experiencing the past in your own mind” and “bringing in your own issues.” Participant S then responded, “I think countertransference can happen when the rest of this is going on, but its own distinct process.” She then continued with her explanation stating that a therapist who experiences countertransference can be pulled out of attuning with their client. She expressed the main difference being “attuning to yourself instead attuning to your client.” She explained further, “As therapists, we often have to bounce back. We have to stay present here, and notice and let that go to the back of our mind and come back to the present and constantly do that dance.” The facilitator then clarified her understanding with the participant and asked, “If the countertransference is so overwhelming will it prevent the attunement to the client?” Participant S agreed and stated “It will prevent them from coming back” and explained the potential for countertransference to flood the therapist, which can lead to overwhelming the client. Participant M also pointed out the potential for the therapist to “dissociate” in response to high levels of countertransference.

Following this discussion, the facilitator invited the participants to observe where attunement was placed in their art. Participant S responded first pointing out the small tissue paper circle she addressed earlier as the symbol for herself. She explained that the different shape and size makes it clear that she is her own “distinct self” however; the use of the same color and placement of her symbol in relation to the placement of the clients’

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symbols is how she viewed herself attuning. M then looked at her art work and pointed to the center mandala-like image discussed earlier in the group and the image of the brain cell. Referencing the brain cell image M explained that this part of her artwork is where she is creating “a neural pathway to attunement.” The facilitator then asked participant M if she could hold up her artwork so she could see it from a distance. The facilitator then asked M if there were any similarities between the two images in which M observed her artwork and pointed to the lines in the mandala and “dendrites” branching out. At this point, participant S added an additional thought and said “One more thing I want to say about attunement and the parents in relationship to the child and the DCFS system is that these parents are not operating in their prefrontal cortex, they are in their brainstem. She went on to explain the temptation for many clinicians to use theoretical approaches such as CBT because there is less potential for the therapist to feel “flooded” or “overwhelmed” when they are working with the prefrontal cortex. Despite this, S argued that CBT could be too “overwhelming” to their system because “they’re not able to be in their prefrontal cortex” which can then throw off the attunement in the therapeutic relationship.. At this point S then introduced the topic of art and how she finds it valuable in joining and attuning with clients who are “in their brainstems.” The facilitator then informed the participants that they would move into the next phase of the focus group and begin exploring the role of art.

The facilitator invited the participants to have a dialogue about how the art impacts the therapeutic relationship when working with families with DCFS. She asked both participants to first address what happens in the therapeutic space because of the art and then discuss how the art affects that therapeutic relationship. M replied first stating

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how the art provides a more “transparent” tool for the therapist to better “empathize” and “attune” with their client. Participant S then responded sharing how she has experienced art to bring out the “hidden demons” very quickly. She provided a brief example of a parent that may yell at their child for spilling glue and explained that the art process could quickly enact something in the family system that shows the clinician a direction for treatment. S continued to explain that seeing these enactments in action allows the therapist to “call attention to it, or at a later time when it’s appropriate.” S then added another realization, explaining that the art is “equalizing” between parent and children. She expressed how she has seen the art process provide the opportunity for parents to “swing away” from their defenses and move into a more “positive space” when viewing their child engage in the art. The facilitator then asked the participants, “Does the art creates a more neutral environment?” Both participants agreed and Participant M added, “and the bridge to their communication and emotions” The facilitator continued to hone in on the topic asking, “Does the art enact attunement as well?” Participant S responded in agreement and shared how she has experienced the symbolic nature of art to be more tolerable for parents when their children share their experience of them, compared to when things are pointed out in reference to something they said or an argument. Participant M then added how she also views art to have a “transformative element” in which it provides both “potential” and “action” when they may be feeling “stuck” and not able to “move on by their own accord.” She added, “in art they’re free to do whatever they want to do and express whatever they want to express. There’s no right or wrong so its really liberating.” Participant S and M added their summarizing thoughts with S first stating, how art provides “access” to vulnerable emotions without “directly exposing.”

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She added, “its amazing how art offers that whole continuum – from being able to protect myself through the visual images to being able to expose myself through the visual images.” M then added, “and when having that enacted, that’s when we can instill them with faith in the process.”

Following the participant’s comments, the facilitator moved into the final phase of the group and introduced the art directive. She invited the participants to take a moment to reflect on one of their past or current DCFS cases by imagining what the art provided in treatment and then what this case would have been like without the art. She then invited the participants to take one piece of 12 “x18” white drawing paper and fold it in half. The Facilitator instructed the participants to chose one side of this paper to represent this case with the art, and the other side to represent the same case without the art. The participants took approximately 20 minutes to complete the art directive.

For Participant M’s artwork (Figure 5) she used collage images, stating that she wanted to stay with the same medium. On the left half of the paper she depicted her case with no art. This side of the paper had a total of 7 collage images of text. These texts included, “the case of,” “hot wheel,” “holds secrets.” “Another culprit to watch,” “when people are powerless,” “lost” and “mindful.” This half of M’s art also included an image of hands holding poker chips, a woman’s hands in a yoga pose, and an image of an onion cut in half. On the right half of the paper M represented the same case but imagining it with using art. She used a total of 4 text collage cut outs to put together the phrase “the real knowing” and added another precut text that said “you’ll get there.” In addition to this she added 6 precut rock and shell collage images and an image of two scuba divers underwater holding a net. M held up her artwork and began sharing with the group the

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first case that she thought of which involved four brother siblings one of which she saw for individual therapy. M explained that it was later revealed that her client and the oldest brother were sexually abusing the two younger brothers, however this information was not known during treatment. She referenced the text “mindful” and “another culprit to watch” when expressing the complexity of the case. She then referenced the image of the woman’s yoga pose and onion and shared her effort of trying to maintain a “meditative mindful stance” however the many “layers” of the case made it difficult for her to see things in a “transparent” manner. She explained that she was the only art therapist and was not able to have “good collaborative work” with the other therapists assigned to the case. While explaining this, M referenced the picture of hands with poker chips and shared that not being able to work with the system as a whole left her feeling “lost” and unaware of what was happening. M then moved on to the right half of her artwork and shared what she would have imagined this case to be like using art therapy to work with the family as a whole. M pointed to various images including the scuba divers and the seashell and rocks. She stated how art therapy would have provided this family a “safety net to go deeper” and to “pick up all the treasures.” She then shared how she was looking for the words “real lived experience” but then decided to choose “the real knowing” to express a place the art therapy could have brought this family. The facilitator then asked M if “real lived experience” and “real knowing” had any connection to attunement.

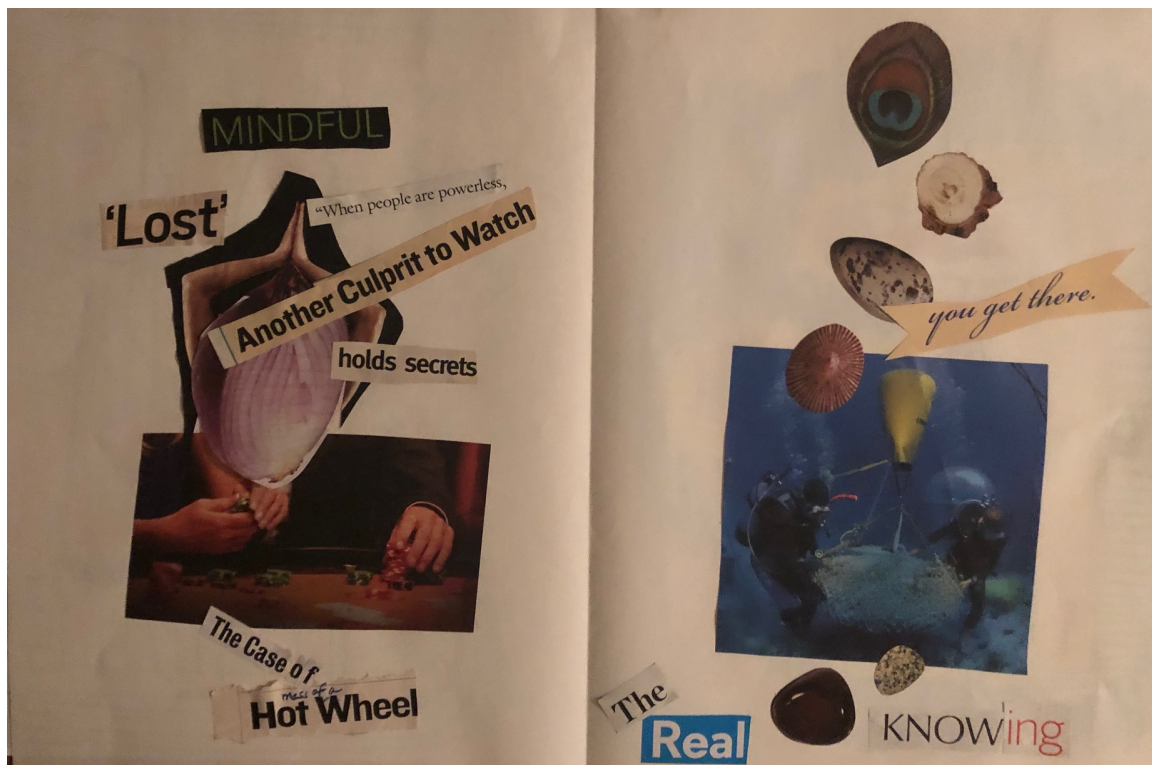


Figure 5. Participant M (Left: without art side, Right: with art)

Participant S switched her medium to colored markers for the second art directive. She began discussing her artwork by first holding it for the group to see (Figure 6) and stated that she would talk about the right side, or the “without art” side first and pointed to three figures at the bottom of the page. She shared that the figure with the “seeing eye” on the right corner represented the therapist where the other two figures represented a mother and child in treatment. She explained that she gave the “seeing eye” or “third eye” to the therapist to represent the therapist’s attempt to attune with the dyad. She also pointed out that she added colors inside the figures to represent feelings and the surrounding “bubbles” represent how these feelings “float into the air” and get “stuck” making it difficult for the therapist to know if “they’re going to come down.” Participant S then moved on to the left side of her art, or the “with art” side. S pointed out the three figures in her drawing and shared that she intended to make them all equal distance and

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size to represent the “immediate accessibility” of thoughts and feelings through the “concrete” qualities of the art. Participant S also referenced the green lines she created on both sides stating that on the left (with art), the lines are more “root like” providing a more “grounded” and “containing space.” In comparison, S stated the green lines on the right side (without art) were more “ethereal” and possibly “entrapping.” She continued to describe the differences between these lines sharing that on the left (with art) the lines show a “well defined space” where the family can feel “grounded” and able to “function within the same conceptual space.” S referenced the blue mark making surrounding the family on the left side stating that the blue shows a “containing space.” S briefly shared the family she was thinking about was the mother she addressed earlier in the discussion that hid her pregnancy. S shared this mother benefited from art therapy “through observing her son’s art marking, seeing the symbolic imagery he was using and providing him with a safe mode of expression, she was able to name specific ways she was able to protect him and then was able to go in real life and do those things for him.” S continued to reflect on how the art served this family and shared how her son struggled with communicating to DCFS about how he did not want to live with his father, which at the time was the primary placement. S shared how through the art, this child was able to explore his feelings and reactions through the imagery he created in sessions and eventually use these pieces to tell the social worker what he wanted and why it was important to him.



Figure 6. Participant S (Left: With art, Right: without art)

At this point S referenced a lecture from her time in the Marriage and Family Therapy program at Loyola Marymount University, in which the facilitator was the professor. She stated to the facilitator, “I think that you talked in a lecture about art being the artifact that allows us to really be concrete about what’s going on and in this family’s case that’s exactly what saved this boy and preserved his placement with his mother.” The facilitator nodded in agreement and asked participant S to hold up her artwork again. The facilitator asked S to expand on the green lines and their meaning on each side. S replied with a brief summarization, “I think the green lines (referencing without art side) are like an axis that the information or the feelings travel on, and in this case (referencing art side) they don’t even have to go on the axis because they are immediately accessible

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here.” S then pointed to the longer green lines on the non-art side and stated, “Over here, is the attempt to ground something but the inability to really concretize.” She then noted in verbal therapy, the content revealed in sessions “floats around” and unless the therapist immediately makes a note of a direct quote, making that content tangible is “impossible.” The facilitator pointed out the blue that was used in both spaces and asked participant S to comment. S pointed out the differences stating that on the art side, the blue feels “sturdy” and “strong” where on the non-art side, she sees “a lot of open space” and “not really knowing what’s there,” adding that it is “diffuse.” Participant M then pointed out a similarity in her depiction of the therapy space without art and suggested that they both displayed “floating” and “confusing layers.” S nodded and also added a realization about the “big happy mouths” she made on the non-art side and explained that with words it is very easy to “disguise your mood,” in comparison to the art she explained, the client is “tapping into the art making process” which she described as “a direct conduit from your emotional state into the visual image.”

At this point the facilitator then shared some of her observations of the similarities including the “surrounding” and “holding” blue space on the art-side of S’s drawing, as well as the scuba diver net in participant M’s collage having a similar containing qualities. The facilitator then pointed out the similarities of the visual aspects in both participants’ artwork starting with the non-art side pointing out how both sides may depict an inability to see. The facilitator pointed at M’s collage and how she used an onion to cover the face/eyes of an image and in S’s non-art side the only figure with an eye is the therapist. She then acknowledged how all figures had an equal eye on the art side of S’s picture and in M’s collage image the scuba divers have masks to help them

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see. M also shared her recognition of both non-art sides showing a lot of “busy work” and how there is “data and information” on the non-art side, however she explained, “it is not solid.” In response, S shared how she realized that she possibly used the vertical direction of her artwork to show how something is missing, that is “out of reach” and a “lack of access.” M then asked S where in her drawing represents the art. S shared she imagined the circles that she in the middle of the lines between all three figures represent the art process and the how the “contents of the meaning can be accessed and shared by all equally.” S then moved on to another thought and shared how in her experience the art has allowed her to “join in a safe way.” She continued to explain further sharing her perception of the client’s experience and stated, “They feel so safe for some reason. Because you’ve provided the art materials perhaps, you have come with them and put them down so in a way what’s inside of you is accessible to them.” In response to S’s thought, the facilitator pointed to the milk being poured in M’s first collage image and said, “The art supplies are like nurturance?” The facilitator then referenced the three figures being connected by lines and the scuba divers on each side of the net and pointed out, “Both of them have this shared space that’s happening.” Participant S pointed at the connecting lines between her figures and stated “it’s almost like these lines are that netting that are holding in the little dots in the middle, that piece that they’re finding together.” M then referenced the word “artifact” that was previously used and stated, “Something precious and beautiful, they could be digging for it, looking for it.” S also returned to her previous thought about the art in relation to the therapist and shared with the group, “I think the therapist becomes less of ‘the other’ and less of the ‘all knowing being’ in an art therapy context.” She continued to explain that through the process of

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providing the materials and all the various physical requirements the art therapist must engage in to assist the art making process results in a form of “hospitality.” S also added, “all those kinds of gestures cause me to be a human person in the space.” The facilitator then clarified with participant S asking, “it feels like you’re talking about a social relatedness on a human level?” Participant S agreed and M then added, “It’s like earlier when I first came in you asked me ‘can I get you something to drink, do you want this kind of tea that kind of tea’ I think we do that with art supplies in the space that we create. I think it has that level of hospitality. You’re the host and also the privileged witness.” At this point, M referenced the shells she added to the art-side of her artwork and stated, “ Rather than just interviewing or gathering data we’re collecting treasures.” Following this, S elaborated on the differences between verbal therapy and art therapy and explained how art provides the therapist to be curious about their experience “in real time and real space” versus being curious about a fight that happened at home which S explains could feel “anxiety producing” for clients. She summarized her thought stating how the art “diffuses and activates at the same time” and that “clients are able to talk about what’s real instead of what they need to pretend it is.” The conversation then shifted to a discussion about language barriers in DCFS and the challenges of language in general. M stated how having English as a second language, she has personally experienced how “language can fail” an individual. S then shared how in her experience working with a translator when art is involved becomes a “fascinating process” and “much easier.” She explained to the group how parents would become active in their translation because “they’re looking at the art with the translator” and “identifying” how they want it to be described. S added how the art “pulls everyone into a common purpose

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so that the focus is on understanding rather than blaming.” M agreed and added, “it’s an integrative experience.” S then stated she wanted to make one final point about art in DCFS cases and shared how she has seen art bring a “collective curiosity” to not only the families but the DCFS caseworkers as well. She explained, “when you bring art into the room everyone becomes curious about it together and now everyone in the room is focusing on a mutual curiosity and then that curiosity leads them to be curious about other things they might not have been curious about, they might have dismissed it out right.” Following this the facilitator made closing statements and thanked the participants for their time and participation and closed the focus group.

Analysis Of Data

The researcher's analysis process started with listening to the audio recording several times while also looking at the artwork to assist her in identifying common words, topics and concepts. Following this, initial themes were created and then further analyzed by categorizing color- coding words, direct quotes accordingly. In addition to this, the researcher included content from the artwork to help support the emergence of themes. This process was repeated in order to narrow in on the most salient themes of the data. These themes included, internal barriers of the DCFS system or "broken system," cultural intersections and subsequent implications, containment versus entrapment and lastly, art as an equalizer.

Internal Barriers - Broken System.

Throughout the focus group, participants shared experiences that illustrated flaws within the DCFS structures as well as the mental health system as a whole. Both participants referred to their experiences with DCFS as "inconsistent" and "overwhelming" at various points of the group. The data also revealed DCFS as a system that lacks internal organization, support and guidance despite the extensive expectations placed on the families. This theme was further compounded when the participants collectively described the DCFS system as a flooded maze with hamster wheels at either end. Participant S stated, "they have to sort of run in place for a while in the beginning and run in place for a while at the end and cross their fingers and hope that everything is going to work out." This lack of predictability and direction was also shown in S's art process and

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artwork. S stated she chose oil pastels for her medium to represent the potential for parents to lose their sense of control. In addition to this she also drew “see through boxes” to display how information is “passing through” parents or “bouncing off” in various directions. Participant M chose imagery of a woman lifting weights, which she explained was demonstrative of families having to put forth a “herculean effort” to meet expectations and to “get things to happen.”

The discussion surrounding the difficulties families face also highlighted the parallel process that caseworkers and clinicians may also experience due to the “broken” aspects that exist not only within the DCFS system but also within the community mental system as a whole. In M’s second piece, she represented her experience in a case with a collage image of a poker game. Similar to how the participants described families to lack direction, participant M shared the gambling image represented her uncertainty of “which way to go” with treatment interventions due to poor collaborative work within her agency and within the system. Furthermore, both participants referred to clinicians in community mental health often being “overwhelmed” with workloads and “flooded” with their own emotional reactions to their stress levels and vicarious trauma. This can also be observed in Participant S’s art work in which she chose an orange colored piece of paper to represent the therapeutic space as “electric” stating that the therapist has to work “extra hard” to create a “safe holding environment” as a result of the “extra emotions” and “fear” families experience from the system. This color was also depicted in a similar way in M’s artwork in which she explained the center orange image represented her attempt to hold the belief that “parents do not intentionally hurt their kids” and essentially maintain an unconditional positive regard for parents.

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The artwork and discussion around the “electric” and emotionally charged therapy space also revealed an additional sub theme of the potential of “villainizing” parents due to various conflicts such as feeling the burden of responsibility and needing to “justify” very difficult circumstances, as well as lacking the time and stamina for self reflection to identify “burnout” and “countertransference.” Additionally both participants expressed how they often have to remind their supervisees to discuss their countertransference and have empathy for the parents.

Cultural Implications

As the first theme delved into the barriers families face as a direct result of the flaws within the system, the second theme of cultural implications addresses oppression within the larger system due to risk factors such as such as poverty, race, mental health issues and limited English proficiency. These risk factors and barriers were revealed through both discussion and artwork of the participants. In M’s collage, she chose an image of a black woman to represent a parent involved with DCFS and placed it next to a white woman whose face was replaced with a big eye. As M reflected on her piece she expressed that there is “disproportionate levels” of minority groups in DCFS involvement, stating that very few cases involved Caucasian families. This theme was also displayed in participant S’s artwork in which she explained her intention of using the white tissue paper to represent the people who are “the helpers” or the DCFS staff who are often times white or represent a white system. She shared how she added this to her art to express the importance of recognizing that her client’s are identifying her to match a white system, which may further contribute to the inherent power differentials of the

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therapeutic relationship. In addition to this, the focus group also explored the matter of pre-existing mental health issues and the resulting implications. M shared an experience of working with a client who was not only disadvantaged by her language barrier but also her symptoms of PTSD. M expressed there was a disregard for the client's cultural differences and diagnosis of PTSD, which resulted in a lack of attunement within the meeting. Furthermore, S pointed out that in some cases, even clinicians do not appropriately address mental health barriers and use theoretical approaches such as CBT that require the client to access their prefrontal cortex which is not possible for the clients that are in "survival mode." She explained that past layers of trauma could inhibit the access to this prefrontal cortex, leading to the attunement of the relationship to be thrown off if not addressed by clinician in the beginning of treatment.

Containment Vs. Entrapment

Through the unfolding of the data, the researcher also observed a dichotomy within the reflections of DCFS space and the therapeutic space. Although the data revealed several dichotomies, the most predominant one observed by the researcher was containment versus entrapment.

As the previous themes addressed the potential for "charged" emotions, lack of predictability and fragmentation, the significance of containment within the therapeutic relationship followed in the discussion and the art. Both participants identified the value of using an holistic lens when approaching treatment such as, working with as many people involved to gather information and support as well as "viewing the family system as a whole" rather than focusing or "villainizing" one individual family member. This

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holistic approach may also be understood as containing the fragmentation that DCFS elicits for families. Additionally, the artwork of both participants demonstrated some form of containment. In participant S's first piece, she used white tissue paper to place over the DCFS 'map' and tissue paper structures she created. The white tissue paper appears to be holding everything in. In her second art piece, S described her blue line strokes on the "non art" side as a "diffuse" space in comparison to the art side, which displays a more condense blue surrounding. She described this as "sturdy" and "strong." Furthermore, S described the art process as "grounding" as it enables the client's feelings and shared experiences to become "concretized" and "tangible." This notion of grounding can also be viewed as containing as the client's array of feelings can come together and be processed as a whole. Participant M displayed a similar idea in her artwork, which can be seen in the scuba diver's netting. She explained that the art allows the therapist to "collect treasures" in which they are uncovering through the art process.

The participants also frequently addressed the importance of "flexibility" and "space" when working with this population to help diminish the feeling of "entrapment" that may be brought on by their DCFS involvement. This idea can be seen in participant M's artwork in which she displayed two contrasting dolphin images. The first dolphin image displays a net in which the dolphin is approaching entrapment; participant M described this image as the perspective of parents while they are in the DCFS system. The other image displayed a dolphin mid-jump from the ocean, in which she addressed as "parents feeling free" when leaving the system. Participant S also touched on this theme when reflecting on her first art piece. She described her "holding" white tissue paper to

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be representative of creating a plan based on the DCFS requirements, but ensuring the plan is more “gentle” and “open” in order to “allow for freedom and space.”

As the focus group progressed the theme of flexibility continued to be addressed in conjunction with important therapeutic qualities such as attunement, joining and countertransference. Participant M described attunement as an “engagement” or “dance” in which the therapist can follow the client to different points in time. S defined attunement as the ability to “allow space for two distinct selves to be experiencing something at the same time” while also maintaining “flexibility” in “bouncing back and forth” with the client. In contrast, the participants defined joining and countertransference to be on opposing ends of a spectrum, involving a greater potential to overwhelm the client. Participant S explained that joining differs from attunement because the therapist is becoming a part of the client’s “self” opposed to maintaining two distinct selves within the therapeutic relationship. She explained this could result in “over joining” and potentially overwhelm the client if the clinician is not careful. Countertransference however, was described in an opposing manner, where the therapist is temporarily consumed by their own experiences, which may take them away from their ability to stay present with their clients. S identified this process as “attuning to yourself instead attuning to your client.” When understanding this in terms of entrapment versus containment, countertransference and joining were described as potentially “overwhelming and flooding” which can make the client feel trapped where attunement was understood as a flexible engagement that may help provide support and ultimately containment for the client.

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Art as an equalizer

The final theme that was revealed through the data was viewing art as an equalizer in response to the various power differentials that families face when involved with DCFS. In participant S's second art piece she described the "with art" side of her drawing as a family sharing a "common space" which all members are the "same size" and "equal distance from each other." As she continued to explain, she discussed how the art allows for equal and immediate access of emotions and feelings because it is a "direct conduit" from an individual's emotional state "on to the visual image." In M's second art piece, she also described a similar experience on the "with art" side of her piece stating that she chose the words "the real knowing" to demonstrate how the art allows her to come into an understanding of her client's lived experience. This idea of emotional understanding through imagery was also illuminated through symbols of vision seen in both of the participant's art. In S's artwork she discussed the meaning of the "third eye" on all individuals on the "art side" of her drawing as an equal ability to "access" compared to her "without art" side which only displayed the therapist with a "third eye." In M's artwork a similar theme is displayed where the layers of an onion are blocking an individual's vision in the "without art" side, where in her "with art" side the two scuba divers are displayed with masks in which they are collaboratively looking and "searching" for something.

The data also exhibited the theme of art as an equalizer in relation to clients gaining empowerment and self-advocacy that may otherwise be barricaded by the various cultural implications discussed in the previous section. For example, S referenced several cases in which her clients were able to find a voice through art and find ways of

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communicating their needs not only to their family members but also to the DCFS staff. She also highlighted that the art provided a mutual curiosity within the viewers and maker, which the participants established as feeling “productive” where verbal discussion alone may feel “punitive” and “anxiety producing.” This was also demonstrated in participant M’s artwork in which she explained how the art allows the therapist and client to collaboratively “collect treasures” rather than “gather information.” Thus, the data revealed that when the client feels as though the therapist is “gathering information” the client may begin to align their therapy experience with their DCFS experience, compared to when the client feels the therapist is curious in learning the meaning behind their art, there might be less defenses and ultimately an increased willingness to explore. In addition to this, the group highlighted the value of eliciting curiosity from the art when language barriers are involved in treatment. Participant S shared her experience of witnessing parents from different cultures become active in their translation to help translators find words to describe their images, which ultimately can decrease the potential for their words to be lost in translation.

Art as an equalizer was also revealed when looking at the data involving the art therapist and the art process. The participants identified the art therapy space as a “new environment” in which the art is being provided for them, resulting in a sense of “hospitality” in the space. In addition to this the participants identified the physicality involved with preparing the art materials may further evoke this sense because the client is able to see the therapist’s body in movement and recognize that they are in fact, human. The participants identified that this process can help the client gain a social

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relatedness on a human level with the therapist, and ultimately help strengthen the relationship by decreasing the inherent power differentials.

Study Question #1

How does the DCFS involvement impact treatment? Results from the study suggest DCFS involvement amplifies various complications and challenges within the therapeutic relationship such as, distress management, building trust and empowering clients. Subsequently, clinicians must put forth extra effort when attempting to establish rapport and safe space in treatment. In addition to this, community mental health agencies may overwork and overwhelm their employees with excessive workloads and expectations. As a result, the therapist is vulnerable to internal challenges such as burn out and lack of empathy due to the minimal time and energy and in some cases vicarious trauma. The focus group identified lack of self reflection may often result in the therapist “overwhelming” or “flooding” their client through over joining or through their unidentified countertransference. The data also suggests that when this occurs, the attunement may be hindered in the therapeutic relationship

Study Question #2

How does the art impact treatment? How is the attunement enhanced by the art? The research suggests art may help diminish various power differentials families face within the DCFS system through providing a voice for families who may otherwise face many obstacles and barriers in feeling heard and understood. The art may assist the access of feelings and emotions that could help clients unravel and communicate their needs. Additionally, the research suggests self-expression through art transforms fragmented and disorganized experiences into concrete objects, which allows for both the

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client and the therapist to use in treatment at various points in time, thus enhancing the therapist's ability to understand, stay present and attune. In addition to this, art allows for flexibility and fluidity, which enables the client to express multilayered and multidimensional ideas, beliefs and feelings at once, allowing the therapist to see a more holistic and cohesive lens of the client and ultimately enhance the attunement in the relationship.

Findings

Upon the reflection and processing of the emergent themes in the data, the researcher gained a more comprehensive understanding regarding the various complications within DCFS involvement for families and clinicians as well as the role of art in treatment and attunement. Additionally, the analysis of data revealed several implications for future research and treatment. The following sections will discuss these findings, which include an examination of the interlocking flawed systems, the use of art to negate language barriers and lastly understanding art as an implicit form of knowledge.

Interlocking Flawed Systems

The research aimed to explore how the DCFS system impacts the experience of families when receiving treatment. As the answers to this inquiry were deciphered in the data, it was revealed that there are not only deficiencies within the DCFS system, but the over-arching community mental health system as a whole. This research found that there are various intersecting flaws within the larger mental health system, which further compound the dilemmas that families face within the DCFS system. For example, participant M expressed in the focus group that parents often lack the access to the

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resources and services needed for reunification with their children. According to Carolan, Burns-Jager, Bozek and Chew (2010) when caregivers lose their parental rights they are no longer eligible for social and mental health services, which leaves many stuck and unable to advocate for themselves. In addition to this, the data highlighted that DCFS cases often demand extra effort on the clinicians end, yet clinicians are often “overwhelmed” and “overworked” which prevents them from having time to check in with their own emotional needs. This was supported in the research, which highlighted a recent study in which 21%– 67% of mental health providers report experiencing burnout (Morse et al., 2012). Additionally, The Job Demands-Resources model of burnout suggests that burnout can be brought on by a compilation of expectations and demands such as interacting with patients with intensive needs, balancing priorities and working overtime (Bakker & Demerouti, 2007). This becomes additionally problematic when addressing the oppression many families in the system face due to their ethnicity, low income and trauma histories. According to Hardy and Laszloffy, (1992) the ability to recognize and accept the differences within ethnicities and class requires self-reflection about personal biases and values. Yet if clinician’s are overworked, they may not be able to fully engage in their reflective abilities due to burn out and exhaustion. Without acknowledging these differences, the clinician may be subject to adopting the predominantly white, middle-class, Eurocentric lens that the system puts forth; a lens that does not encompass the various cultural implications and experiences of the people it is intended to help.

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Art and Language Barriers

Another significant finding of this research is the empowering qualities art provides when families require translators. Participant S discussed her experience of witnessing art promote the active participation of parents when working with translators to find the appropriate description and translation. This may differ from the typical use of a translator in which, the translator may not always check in with the parent to see if they're message was understood, which may result in meaning being lost upon translation. However, when there is an art image to reference, there is a negotiation and discussion that is required in order to find the best fitting description. There is currently no literature regarding art therapy treatment in conjunction with translators, however this may be important for future research endeavors.

Building Attunement Through Art and Implicit Knowledge

An additional finding of the research is the perspective of art as an implicit form of knowledge, which may subsequently promote attunement in the therapeutic relationship. The data suggests that art permits a form of communication that is absorbed through a visceral experience, as opposed to verbal language, which is processed mainly on a cognitive level. Participant S and M pointed out that verbal communication by itself often fails in bridging internal experiences into external communication, opposed to art which S described as “a direct conduit” of a individual’s emotional state and which M depicted as “the real knowing.” The data also revealed how art has served those with strong defenses in providing them the ability to not only express their own discomfort but to also be able to absorb other’s messages about them with curiosity rather than anxiety. A possibility for this may be that the art expression is able to encompass the full depth of

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someone's experience, as opposed to verbal expression, which may be limiting due to the inherent categorical and sequential qualities of language. When the message is decoded to fit language, it may become fragmented, and thus vulnerable to misinterpretation. Art however, can be viewed as a whole, which may be helpful for populations that are facing complicated and fragmented experiences. Art is also fluid in its ability to simultaneously hold contradictory experiences and ideas that may not be able to comply with the organized nature of language. This may be significant when considering that individuals with poor attachment histories often present with dissociative shifts that are both nonlinear and difficult to follow (Hopenwasser, 2008). As a result, when working with this population, the clinician's ability to stay present and empathetically attuned may be hindered when solely using verbal communication. The participants also identified art as a continuum ranging from the ability to "protect through the images" to also being able to "expose through the images." This is significant when looking at the literature regarding attachment traumas and the tension that exists between the opposing impulses of wanting to be soothed and cared for while simultaneously seeking protection from danger (Bowlby, 1969; Liotti, 2006). Art can encompass multiple experiences at once and although the therapist is not hearing the verbal explanation, the process and the content that the client brings through the art may enable a new form of understanding for both the clinician and client and possibly sparking curiosity, collaboration and attunement.

Conclusion

The focus group research utilized the personal experiences and reflections of two art therapists to uncover the fundamental challenges of working with families involved with DCFS as well as the use of art in treatment potential impact on attunement. The study specifically examined the problematic layers that exist within DCFS and mental health system as well as the various cultural implications, which were found to contribute to the stress, chaos and confusion that both families and clinicians face. The research also highlighted the value of using art to help confront these barriers. Such findings suggest that art can promote the therapeutic relationship through offering families a sense of containment, empowerment and form of expression that is able to hold the disorganized and fragmented parts of their world. These qualities may help the therapist understand their client's needs despite the various challenges that they also face.

Although the amount of participants in the focus group enabled a thorough and in-depth exploration of the research questions, the data is only based on two participants' experiences, which may be a limitation of this study. A possible suggestion for future research may be including subjects from entire agencies such as administration, clients, and children. Expanding the participant group to encompass all possible perspectives may help facilitate a more reliable and holistic examination of the interlocking systems. Lastly, this research specifically looked at the experiences of art therapists, which may result in biased perspectives regarding the art and the beneficial qualities. For more a more comprehensive examination, future research may involve focus groups for families with experience in art therapy and DCFS.

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Appendix A: Email to Participants

Dear Participant, I hope you are doing well. I'm contacting you with a request to participate in a second year research project focus group on how art therapy can enhance the attunement within the therapeutic relationship, specifically when treating parents with child welfare involvement and a history of trauma. Should you decide to participate in this research you will be contacted by Amanda Gonzalez with instructions information about the focus group. The focus group should take about two hours in the art therapy studio at Loyola Marymount University.

Please reply to this email and let me know if you can participate and with any questions you may have.

Appendix B: Informed Consent

LOYOLA MARYMOUNT UNIVERSITY

Date of Preparation _____

Loyola Marymount University

(Title in Lay Language)

- 1) I hereby authorize Amanda Gonzalez MFT/ATR Trainee to include me in the following research study: An Exploration of Attunement in Art Therapy With Parents and Caregivers
- 2) I have been asked to participate on a research project, which is designed to explore the relationship of art therapy and attunement in the therapeutic relationship when working with parents with trauma histories who are involved with DCFS. The research will last for approximately two hours.
- 3) It has been explained to me that the reason for my inclusion in this project is due to my past or current experience as an art therapist in working with parents involved with DCFS.
- 4) I understand that if I am a subject, I will be asked to engage in art making as a reflection my overall experience when working with parents with trauma histories involved with DCFS, and that I will be asked to provide feedback on the meaning of my art piece and participate in a group discussion regarding common themes and/or experiences and/or lack thereof. I understand that I will be asked to complete a second piece of art as a reflection on how art therapy has played a role in the therapeutic relationship when working with parents with trauma histories and involvement with DCFS.

The investigator(s) will provide all art materials, facilitate discussion, take photography of my art.

These procedures have been explained to me by Dr. Paige Asawa, PhD, MFT, ATR-BC.

- 5) I understand that I will be videotaped, audiotaped and/or photographed in the process of these research procedures. It has been explained to me that these tapes will be used for teaching and/or research purposes only and that my identity will not be disclosed. I have been assured that the tapes will be destroyed after their use in this research project is completed. I understand that I have the right to review the tapes made as part of the study to determine whether they should be edited or erased in whole or in part.

I understand that the artwork I make during the focus group will be photographed in the process of these research procedures. It has been explained to me that these photographs will be used for research purposes only and that my identity will not be disclosed. I have been assured that the photographs will be destroyed after their use in this research project is completed. I understand that I have the right to

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review the photographs made as part of the study to determine whether they should be edited or erased in whole or in part.

- 6) I understand that there are no foreseeable risks in the study described above. The PI will ensure confidentiality of all subjects involved, obtain full consent and provide detailed explanation of research purpose. Research mentor and PI will remind participants of the importance of maintaining confidentiality in order to ensure boundaries of confidentiality are not breached.
- 7) I also understand that potential benefits may include an opportunity for self-reflection as it relates to art therapy, attachment focused treatment and trauma with parents and or caregivers impacted by DCFS.
- 8) I understand that Amanda Gonzalez MFT/ATR Trainee who can be reached at (631)335-6875 and the research mentor Dr. Paige Asawa who can be reached at (310) 338-4562 will answer any questions I may have at any time concerning details of the procedures performed as part of this study.
- 10) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.
- 11) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to (e.g., my future medical care at LMU.)
- 12) I understand that circumstances may arise which might cause the investigator to terminate my participation before the completion of the study.
- 13) I understand that no information that identifies me will be released without my separate consent except as specifically required by law.
- 14) I understand that I have the right to refuse to answer any question that I may not wish to answer.

Subject's Signature _____ Date

Witness _____ Date

Appendix C:

Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.
2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.
3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.
4. I will be given an explanation of any benefits to be expected from the study, if applicable.
5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.
6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.
7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.
8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.
9. I will be given a copy of the signed and dated written consent form.
10. I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.

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