THE VIRGINIA BOARD OF HEALTH PROFESSIONS
THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

Study into the Need to Regulate Art Therapists in the Commonwealth of Virginia

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Virginia Board of Health Professions
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EXECUTIVE SUMMARY

Authority & Background:

Section 54.1-2510 of the *Code of Virginia* authorizes the Virginia Board of Health Profession to advise the Governor, General Assembly, and Director of the Department of Health Professions on matters pertaining to the regulation of health professions and occupations and scope of practice issues. The Board conducted this study into the feasibility of licensing Art Therapists on behalf of the Virginia Art Therapy Association.

The review was guided by the principles, evaluative criteria, and research methods set forth in the Board's standard policies and procedures for evaluating the need for regulation of health occupations and professions. It examined Art Therapist education, training, competency examination and continuing competency requirements, typical duties and functions, regulation in other U.S. jurisdictions, available workforce data, and the potential impact on existing behavioral health professions regulated in Virginia: Licensed Professional Counselors and Licensed Marriage and Family Therapists.

Major Findings

1. Art therapy is an integrative mental health and human services profession. Art therapists are educated in psychotherapeutic principles as specifically trained in the use of art media to provide counseling to individuals, families and groups.
2. Art therapy is categorically different then "art in therapy." Art in therapy is a therapeutic modality leveraging the creative process as a growth-producing experience.
3. Art therapy practices pose an inherent risk of harm to the patient. Individuals practicing art therapy without the proper skills, level education, supervision and ethical standards pose a risk, especially to vulnerable patients who may have difficulty with verbal communication.
4. Art therapists practice autonomously as well as under supervision.
5. Art therapists are educated at the master's degree level and must sit for a national board certification exam to obtain the Registered Art Therapist (ATR) credential.
6. Seven (7) states license art therapists as a distinct profession; five (5) states provide for licensure of art therapists under a related profession's license; and four (4) state recognize art therapists to enable state hiring and/or to provide title protection.
7. The number of art therapists in Virginia is undetermined at this time.
8. There is a need for art therapists in Virginia.

Recommendation:

At its August 23, 2018 meeting, the Regulatory Research Committee recommended licensure for art therapists, citing the following rationale:

- The unregulated practice of the profession poses the potential for significant harm to the public especially in consideration of the vulnerability of the patients the profession serves.
- Specialized skills and training exist to distinguish the profession. The profession now requires master's degree level education and training through accredited programs, such as those at Eastern Virginia Medical School and George Washington University in Virginia. Art therapist required coursework includes

diagnostic as well as treatment aspects of care. Additionally, the profession has a psychometrically sound, national examination used to assess professional competency.

- Art therapists practice autonomously as well as within teams.
- The profession's scope of practice is defined with sufficient specificity even though other behavioral health professions employ some of the same tools and modalities. State licensure and regulations would assure the public of professional practice standards and a clearer understanding of what constitutes formal art therapy.
- The economic impact to the public of licensure costs will be small. The increase in Virginia's supply of art therapist practitioners would likely result from removal of the current barrier to practice which *also* requires licensure as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, or similar profession.
- Lack of standalone licensure has restricted the potential supply of these mental health professionals in Virginia. Comment revealed that students and graduates of George Washington University and Eastern Virginia Medical School art therapy programs feel driven to look to other states where art therapist licensure without the additional burden of obtaining licensure as *another* profession exists.
- No alternatives to licensure were deemed commensurate with the public's protection.

AUTHORITY

At its August 31, 2017 meeting, the full Board of Health Professions considered a request to review the need to regulate art therapists in the Commonwealth of Virginia. At this meeting, the Regulatory Research Committee (RRC) received approval to move forward with the study. At its December 7, 2017 meeting, the RRC adopted the workplan and began work on the study. The study is being conducted pursuant to the following authority:

Code of Virginia Section 54.1-2510 assigns certain powers and duties to the Board of Health Professions. Among them are the power and duty:

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations;

12. To examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts;

Pursuant to these powers and duties, the Board of Health Professions and its Regulatory Research Committee conduct a sunrise review into the need to regulate art therapists in the Commonwealth of Virginia.

THE CRITERIA AND THEIR APPLICATION

The Board of Health Professions has adopted the following criteria and guidelines to evaluate the need to regulate health professions. Additional information and background on the criteria are available in the Board of Health Professions Guidance Document 75-2 *Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupations or Professions, revised February 1998* available on the Board's website: https://www.dhp.virginia.gov/bhp/guidelines/75-2.doc

CRITERIA FOR EVALUATING THE NEED FOR REGULATION

CRITERION ONE: RISK FOR HARM TO THE CONSUMER

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

CRITERION TWO: SPECIALIZED SKILLS AND TRAINING

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

CRITERION THREE: AUTONOMOUS PRACTICE

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

CRITERION FOUR: SCOPE OF PRACTICE

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

CRITERION FIVE: ECONOMIC IMPACT

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

CRITERION SIX: ALTERNATIVES TO REGULATION

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

CRITERION SEVEN: LEAST RESTRICTIVE REGULATION

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

APPLICATION OF THE CRITERIA

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

- Licensure - Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.
    - **Risk**: High potential, attributable to the nature of the practice.
    - **Skill & Training**: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
    - **Autonomy**: Practices independently with a high degree of autonomy; little or no direct supervision.
    - **Scope of Practice**: Definable in enforceable legal terms.
    - **Cost**: High
    - **Application of the Criteria**: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

- Statutory Certification - Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.
    - **Risk**: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
    - **Skill & Training**: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
    - **Autonomy**: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
    - **Scope of Practice**: Definable, but not stipulated in law.
    - **Cost**: Variable, depending upon level of restriction of supply of practitioners.
    - **Application of Criteria**: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, & 6.

- Registration - Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.
    - **Risk**: Low potential, but consumers need to know that redress is possible.
    - **Skill & Training**: Variable, but can be differentiated for ordinary work and labor.
    - **Autonomy**: Variable.
    - **Application of Criteria**: When applying for registration, Criteria 1, 4, 5, & 6 must be met.

OVERVIEW

This preliminary document provides an overview of the profession, including recent changes affecting the profession. It also highlights some of the key areas of concern. Its purpose is to inform Committee members and the public during the public comment period. Interested parties may also review the sunrise proposal submitted by the Virginia Art Therapy Association. A full report, incorporating public comment and final recommendations, will be issued at the end of the study period.

DESCRIPTION OF THE PROFESSION

Art Therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship. (AATA)

Art Therapy, facilitated by a professional art therapist, effectively supports personal and relational treatment goals as well as community concerns. Art Therapy is used to improve cognitive and sensory-motor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change. (AATA)

Since the beginning of human history art has been an instrument for symbolism and self-expression, a medium for communicating thoughts and ideas. In the 1940s, psychologist Margaret Naumburg's work was based on the idea of using art to release the unconscious by encouraging free association. She started referring to her work as art therapy, a form of symbolic speech that the patient was encouraged to interpret and analyze. In 1944, Austrian born Edith Kramer, a student of art, painting, drawing and sculpture became a US citizen and founded the art therapy graduate program at New York University. (Art Therapy Journal)

By the middle of the 20th century, art therapy programs were in many mental health facilities and hospitals. It was observed that this form of therapy could promote emotional, developmental, and cognitive growth in children. The discipline has continued to grow, becoming an important tool for assessment, communication, and treatment of children and adults. (Art Therapy Journal)

The American Art Therapy Association (AATA) is a 501(c)(3) not-for-profit, non-partisan, professional and educational organization dedicated to the growth and development of the art therapy profession. Nearly 5,000 professional art therapists and students are part of the American Art Therapy national network. The AATA has established its own set of standards for art therapy education and practice. (AATA)

Art as therapy should not be confused with art in therapy as they are two distinct concepts. Art as therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship. Art in therapy embodies the idea that art making is, in and of itself, therapeutic and that the creative process is a growth-producing experience. (Malchiodi, 2013)

A major concern of trained art therapists is that there are therapists utilizing "art as therapy" who are not masters' level clinicians in visual art or theories and techniques of human development, psychology, and counseling. (AATA)

Art therapists are trained in the use of art media and provide these counseling and psychotherapeutic principles to individuals, groups and families. Training involves identifying and assessing each client's needs in order to implement therapeutic art interventions to meet the clients psychological, developmental, behavioral, physical and emotional functioning needs.

Scope of Practice and Overlap

In Virginia, Licensed Professional Counselors (LPCs) and Marriage and Family Therapists (MFTs) are mental health professions licensed by the Board of Counseling. These two professions have laws and regulations in place where the applicant must meet course work requirements, experience requirements and a passing grade on the licensing exam to obtain licensure. Art therapy also has private credentialing requirements in education and experience as well as passing an exam to obtain credentialing, the difference being that state licensure is currently not available for this mental health profession.

Art therapy differs from counseling and marriage and family therapy in that its practice incorporates art media and the creative process. This form of therapy involves art processes and art materials in combination with psychotherapy, engaging and promoting the use of art in the healing process. Art therapy also allows individuals who are unable to express themselves verbally with a therapeutic way to engage their mind, body and spirit, promoting healing.

Art therapists currently work in Virginia, some with a license in counseling or marriage and family therapy, with additional credentialing in art therapy. Credentialed art therapist working in Virginia work as art therapists in many settings, while others represent themselves as providing "art therapy" but do not have the education or credentials to use the title "art therapist".

The practice of art therapy is specific in its scope of practice (Appendix 2) and regulation of this profession could negatively affect individuals with licenses to practice counseling or marriage and family therapy who are utilizing "art therapy" during treatment without having the education and credentialing to do so. This would also negatively affect individuals utilizing the term "art therapy" when they do not hold the necessary credentials to do so.

Typical work settings for art therapists are similar to those they worked in while obtaining supervision hours, private practice, inpatient and outpatient mental health facilities, schools and detention centers, and other settings where mental health practitioners practice. Art therapists often work in teams and interact with social workers, physical therapists, psychologists and medical providers such as nurses and doctors. Within these settings, art therapists serve a diverse group of individuals, from all ages and populations.

Unsupervised practice depends on the level of training of the art therapist and the treatment setting they are working in. Should the art therapist have a private practice all treatment would likely be unsupervised, holding the art therapist accountable for the job they perform. However, when treating patients in a clinical environment or school setting within which they are employed, there would be some level of being both supervised and unsupervised, holding both parties accountable for the job being performed. Virginia currently cannot hold art therapists legally

liable for improper conduct or unethical practice as no standards have been established for this unlicensed profession. Art therapist currently follow the Code of Ethics (Appendix 3) established by the ATCB.

Section 1.1.6 of the Code of Ethics prohibit engaging in therapy practices or procedures beyond scope of practice[1], experience, training, and experience. Patients requiring services outside of this scope are referred out to seek the services of another provider. Referral to see an art therapist might come from another health practitioner, such as a doctor. Children's Hospital of Richmond at VCU provides art therapy to young patients as a creative outlet to help them express their emotions and cope with the pain and stress of treatment. VCU understands the healing value of art and artistic traditions and how art therapists are able to apply their special knowledge of human development and psychology, clinical practice, and spiritual and cultural customs, to help children and their families deal with the impact of complex medical conditions on their lives. (Children's Hospital, 2018)

CREDENTIALING

The ATCB develops and administers board certification exams for art therapists who have met the education and supervision requirements to become credentialed as a Registered Art Therapist (ATR). The exam covers the following domains: Administrative and Therapeutic Environments, Initial Interview and Evaluation Assessment, Art Therapy Treatment and Services, Professional Practice and Ethics, and Theory and Therapeutic Applications. This exam is psychometrically sound and administered at locations across the United States four times each year.

To maintain ATCB certification art therapists must complete a yearly minimum of 20 continuing education (CE) credits, during a five (5) year recertification cycle, equivalent to 100 hours of approved continuing education during the recertification cycle. Six of these credits must be in ethics during each cycle. CE audits are performed on 10 percent of those applying for recertification.

ATCB credentialing allows for easy recognition of individuals who are Master's degree trained and qualified to practice art therapy.

[1] "Scope of practice" is a term, which generally references specific state statutes, which describe the permissible activities of the regulated occupation or profession.

Credentials - National Level

Credential	Description
Provisional Registered Art Therapist (ATR-Provisional)	Individuals who have completed a degree (or education requirements for the ATR-Provisional) and are engaged in a supervisory relationship with a qualified supervisor(s). The ATR-Provisional is not a required credential to apply for the ATR.
Registered Art Therapist (ATR)	Individuals who meet established standards, with successful completion of advanced specific graduate-level education in art therapy and supervised, post-graduate art therapy experience.
Board Certification (ATR-BC)	Individuals who complete the highest-level art therapy credential by passing a national examination, demonstrating comprehensive knowledge of the theories and clinical skills used in art therapy.
Art Therapy Certified Supervisor (ATCS)	Experienced Board Certified Art Therapists who provide clinical supervision and have acquired specific training and skills in clinical supervision.

*AATA Credentials and Licensure

EDUCATION

Education to practice as an art therapist requires a minimum of a master's degree in a program accredited by the AATA's Educational Programs Approval Board (EPAB). After obtaining the necessary education, 1,000 hours of post-graduate clinical experience under the supervision of a credentialed art therapist is required. Private, national certification is available from an independent certification board.

Educational training in psychopathology with children, adolescents and adults provide the art therapist the ability to learn the criteria for psychiatric diagnoses, allowing them to recognize behavioral and art indicators of functional and organic disorders. Practice includes the application of art therapy principles and methods in diagnosis, prevention, treatment and amelioration of psychological problems and emotions. They often work in team settings that allow them to contribute to collective diagnosis and treatment plans. Treatment plans are designed and implemented based on the art therapists level of training and the practice setting.

Art therapists must undergo individual and group supervised training as part of their education. The ATCB requires that students complete 100 hours of supervised practicum, and 600 hours of supervised art therapy clinical internship to obtain their degree. Credentialing as a registered art therapist (ATR) requires 1,000 hours (if individual graduated from an AATA/EPAB), or 1,500 hours (if individual graduated from a non-approved art

therapy program) of direct contact practice supervised by a credentialed art therapist, another licensed mental health provider or an Art Therapy Certified Supervisor (ATCS), 100 hours of which half must be supervised by an ATCS or an ATR-BC credentialed supervisor. While under supervision, the facility in which they are obtaining supervision is legally accountable and held liable for the supervisee's actions. Supervision practice agreements follow the ATCB Code of Ethics, Conduct and Disciplinary Procedures established policy.

The American Art Therapy Association (AATA), Inc., offers program and curriculum standards for each Master's degree program. All AATA programs must be approved by the AATA Education Program Approval Board (EPAB). There are two AATA EPAB approved art therapy Master's degree programs in Virginia:

- George Washington University's Columbian College of Arts and Sciences' Art Therapy Master's Degree Program in Alexandria, Virginia offers three (3) options: a Master's in Art Therapy (with a thesis option); a Master's in Art Therapy Practice; and a combined Bachelor of Arts/Masters of Arts in Art Therapy, enrolling approximately 20 students per year (George Washington University, 2017); and
- Eastern Virginia Medical Schools Art Therapy & Counseling Program in Norfolk, Virginia, a Post Master's program (Appendix 1) 2016-2017 school year enrollment listed 34 students. (Eastern Virginia Medical School, 2018)

There is currently a five-year transition for approved EPAB programs to transition to a new program with external accreditation through the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

It is important to note that undergraduate and Doctoral degree programs in art therapy do not undergo a formal review and approval process by the EPAB. Certificate art programs are offered online but do not provide the level of education necessary to obtain credentialing as an art therapist.

There are currently 39 colleges and/or universities in the United States and Canada with AATA approved master's degree art therapy programs.

Art Therapy Programs – US and Canada

State	Master's Degree Program	Undergraduate Degree Program	Doctoral Program
California	4		1
*Canada	1		
Colorado	1		
Connecticut	1		
Florida	1	1	
Illinois	3		
Indiana	1		
Kansas	1		
Kentucky	1		
Maryland		1	
Massachusetts	2	1	1

State	Master's Degree Program	Undergraduate Degree Program	Doctoral Program
Michigan	2		
Minnesota	1		
New Jersey	1		
New Mexico	1		
New York	7	2	
North Carolina		1	
Ohio	1	2	
Oregon	1		
Pennsylvania	3	5	1
South Carolina		1	
Tennessee		6	
Virginia/Washington DC	2	1	
Washington	3		
Wisconsin	1	2	1
Total Programs	39	23	4

Source: American Art Therapy Association-Approved Programs

REGULATION

Currently seven (7) states require art therapists to be licensed as art therapists. There are five (5) states that license art therapists under a related license, and four (4) states that recognize art therapists for purposes of state hiring and/or title protection. Currently, 17 states are considering art therapist licensure. (AATA)

In Virginia, there are no laws, regulations or standards of practice that exist for the practice of art therapy. Credentialed art therapists that are employed in Virginia as counselors or marriage and family therapists would be under the laws and regulations of the Board of Counseling. Employers of art therapists have applicable standards of practice that must be followed to comply with state laws. State agencies and hospitals that employ art therapists would have an established code of conduct along with regulations that apply to that entity.

The Art Therapy Credentials Board administers the ATCB Examination (ATCBE) which is a national exam taken for Board Certification and, in some cases, needed for state licensure. The board certification proficiency exam provides credentialing for board certified art therapists (ATR-BC) and is administered yearly by paper and pencil at the AATA conference as well as computer based testing which is offered several times per year at different testing locations. Test by exception is offered for an additional fee for individuals wishing to take the exam outside the scheduled time frame.

Professional regulation may have more of an impact when it comes to disciplining impaired, unethical or incompetent art therapists, and those practicing art therapy without credentialing, removing them from practice.

Licensure by Title

State	Licensure Title
Delaware	Licensed Professional Art Therapist (LPAT) and Licensed Associate Art Therapist (LAAT)
Kentucky	Professional Art Therapy License (LPAT)
Maryland	Professional Clinical Art Therapy License (LPCAT)
Mississippi	Professional Art Therapy License (LPAT)
New Jersey	Professional Art Therapy License (LPAT)
New Mexico	Professional Art Therapist License (LPAT)
Oregon	Licensed Art Therapist (LAT) and Licensed Certified Art Therapist (LCAT)
New York	Creative Arts Therapist License (LCAT)
Pennsylvania	Art therapy defined in regulation as a qualifying "closely related field" for the professional counseling license (LPC)
Texas	Professional Counselor with Specialization in Art Therapy License (LPC-AT)
Utah	Art therapists with clinical art therapy master's degrees recognized by the Utah Division of occupational and Professional Licensing as meeting the education requirements for the Associate Clinical Mental Health Counselor license
Wisconsin	Registered Art Therapist with License to Practice Psychotherapy

*American Art Therapy Association-Credentials and Licensure

RISK OF HARM

Due to the low number of states that license or utilize title protection for art therapists, and the Art Therapy Credentials Board, Inc. (ATCB) requirement that all ATCB credential holders self-report any violations of the ATCB Code of Ethics, Conduct and Disciplinary Procedures, the level of reported cases is negligible.

Information regarding disciplinary action against art therapists was not readily accessible. Many states that license or provide title protection group these individuals under another closely related mental health category such as licensed marriage and family therapist or licensed mental health counselor. Virginia does not delineate disciplinary actions or complaints against practitioners with art therapist credentials. Since 2008, Kentucky has reported a total of six cases, five pertaining to practicing art therapy without a license. The sixth case was dismissed.

Harm may be attributed to providers practicing art therapy without the necessary skill set, master's degree education, supervision and ethical standards necessary to obtain credentialing from the ATCB. Untrained providers of art therapy can cause potential harm to their clients' emotional wellbeing, as they do not understand how to assess, diagnose and treat patients utilizing art material.

Overall, art therapists do not utilize dangerous equipment while performing within their practice guidelines. There are however, basic art tools, such as paint and glue, which contain toxic chemicals that could cause harm should they be inhaled or ingested, scissors which have sharp edges capable of causing cuts or punctures, and objects such as clay, if thrown, could be considered potentially dangers. It is the responsibility of the art therapist to understand the ability of the patient, the specific art therapy tools deemed safe to use with that patient, and the environment within which the therapy session takes place.

The potential for fraud does exist in Virginia, as there are no existing laws or regulations regarding this profession. Virginia does not acknowledge the profession of art therapy, does not codify a scope of practice, nor does it provide any form of title protection for individuals practicing as art therapists. This lack of delineation between professions creates confusion for the public at large. Consumers are not able to determine actual credentialed art therapists with academic and clinical training who are safe to practice art therapy versus those that claim to be art therapists but have no training.

Art therapists in Virginia do not qualify for direct third party payments. However, they are able to receive payment for their services under another behavioral sciences license or indirectly through their employer.

The ATCB Code of Ethics, Conduct and Disciplinary Procedures (Appendix 3) was updated in 2016 to reflect standards established by the NCCA. Compliance with these standards of ethics is required to protect the patient, the employer and the art therapist. The Code consists of 18 principles and standards of conduct and is enforced by the ATCB. All ATCB credential holders and applicants are required to self-report any violation referred to in the ATCB Code of Ethics, Conduct, and Disciplinary Procedures document. The Code is enforced through a written grievance process and reviewed by a discipline hearing panel of three members who review the matter and provide a written decision. Based on the decision there is an appeals process. If certification or registration is revoked, the individual is not eligible to apply for certification or registration for a minimum of three years.

Virginia does not have a peer review mechanism for art therapists, however, credentialed art therapists are subject to review according to the ATCB Code of Ethics, Conduct and Disciplinary Procedures as stated above. Grounds for discipline are explained in section II. Disciplinary Procedures, Item 4. Standards of Conduct, Grounds for Discipline. (Appendix 3)

Legal offenses that would preclude a practitioner from practice include: sexual offenses involving a child, homicide 1st degree, and kidnapping. Additional serious offenses are in section 5.2.12 of Appendix 3.

ECONOMIC IMPACT

WAGES & SALARIES

Profession	Median Wage
Art Therapist	*$31K-$64K
Licensed Professional Counselor	*$50K-$60K
Family & Marriage Therapist	*$50K-$60K

Source: *Bureau of Labor Statistics – 2016 Data
**DHP Healthcare Workforce Data Center – 2017 Data

Available compensation data on the profession is subsumed within broader behavioral health providers' categories. Nationally, estimates for art therapists' salaries ranged from $32,000 - $58,000 with a median income of $43,400. The U.S. Department of Labor Bureau of Labor Statistics shows that in Virginia the median salary per year is $42,410 with a salary range of $31,440 up to $64,240. Location influences pay, as Washington, DC, New York and

Philadelphia receive salaries above the national average, while Pittsburgh, Milwaukee and Denver receive salaries below the national average. Also affecting pay is the number of years of experience the individual has invested in the profession. Depending on the size of the employers' workforce, some art therapists receive benefits, such as medical and dental coverage.

Art therapist salaries appear to be lower than that of other comparable, mental health providers with a master's degree. According to the Department of Health Professions Healthcare Workforce Data Center (DHP HWDC, 2017) survey for Licensed Professional Counselors, the median income for both licensed professional counselors and marriage and family therapists for 2017 was $50,000 - $60,000. An art therapists work environment is similar to that of other therapists and counselors, so the lower than average wages are not aligned in the profession.

A national internet search for credentialed art therapists provided a varying rate of services ranging from $90 for a 50-minute session to $125 for a 55-minute session. An initial intake assessment fee ranged from $0 to $150. These prices are similar in range to those being charged by similar behavioral health specialists.

Art Therapist Session Fees

State	Session Fee	Session Length
Richmond, VA	*$95	Not available
Washington, DC	**$120	60 minutes
New Orleans, LA	***$120	60 minutes
Laramie, WY	****$125	55 minutes

Sources: *Mind-Body Art Essentials, **Work of Art Therapy, ***NOLA Art Therapy and Counseling, LLC, ****Wyoming Art Therapy and Medical Counseling, LLC

WORKFORCE ADEQUACY

According to the AATA, there are nearly 5,000 professional art therapists and students as members of the American Art Therapy national network. Virginia currently has 131 members. Of this, 91 are members at the professional level, 37 at the student level and 9 are associate members or retired. This would lead one to believe that there are at least 91 individuals credentialed to practice art therapy, with 37 students currently enrolled in an art therapy credentialed program that could be added to the workforce.

Whether there is a shortage or an oversupply of these practitioners in Virginia is unknown. The profession-distinct supply and demand data are not available to make such assessment. It can be determined however, that as a mental health provider already providing care to individuals in Virginia, that they do provide care to individuals in need of this unique type of mental health care.

Discussion of Economic Impacts

In Virginia, individuals who have dual licensure in counseling and art therapy are able to bill for their services and qualify for third-party payment as licensed professional counselors or marriage and family therapists, but are not allowed to directly bill for services otherwise.

Licensure of art therapists in Kentucky, Maryland and Mississippi allows them to receive Medicaid reimbursement for their services. Pennsylvania and Texas allow for private insurance and state program reimbursement as art therapists are licensed as professional counselors. In Maryland, art therapists are able to receive reimbursement from private insurers. One goal of licensure of art therapists in Virginia is for the profession to be able to receive third-party payment for the services they provide.

In 2014, the AATA petitioned the Standard Occupational Classification Policy Committee (SOCPC) requesting that the occupational classification for art therapy be changed from occupation code "recreational therapy" to a separate classification as a mental health profession. The Committee rejected the request siting that existing policy prevents providing a separate defined classification for any occupation or profession for which the Bureau of Labor Statistic or the Census Bureau cannot collect data. In 2018 the Standard Occupational Classification (SOC) System-Revision for 2018 announced that the federal governments revised occupational codes, including reclassification of art therapists from being classified as "recreational therapists" (under code 29-1125) will now be classified as "Therapists: All Other" (sub-code 29-1125. Effective January 1, 2018, this change in SOC code according to the AATA will: require federal and state agencies and private employers to redefine job descriptions, pay levels and hiring guidelines; require insurers to re-evaluate how art therapy services are defined and covered for individual and group insurance plans; and may open additional approaches for state licensing and regulation. (AATA)

SOURCES

American Art Therapy Association (AATA). Retrieved from https://arttherapy.org/about/

Art Therapy Credentials Board (ATCB). Code of Ethics, conduct and disciplinary procedures. Retrieved from https://www.atcb.org/Ethics/ATCBCode

Art Therapy Journal. The history of art therapy. Retrieved from http://www.arttherapyjournal.org/art-therapy-history.html

Children's Hospital of Richmond at VCU. Support service: art therapy. Retrieved from https://www.chrichmond.org/Services/Art-Therapy.htm

Commission on Accreditation of Allied Health Education Programs (CAAHEP). Retrieved from https://www.caahep.org/ACATE

Department of Health Professions: Healthcare Workforce Data Center (DHP HWDC). Profession reports – Behavioral Sciences Licensed Professional Counselor. Retrieved from https://www.dhp.virginia.gov/hwdc/docs/BehSci/0701LPC2017.pdf

Eastern Virginia Medical School (EVMS) Art Therapy Program. Retrieved from https://www.evms.edu/education/masters_programs/art_therapy_counseling_program/

George Washington University (GWU) Columbian College of Arts and Sciences. Art Therapy Program. Retrieved from https://arttherapy.columbian.gwu.edu/history

Malchiodi, J. (2013) Defining art therapy in the 21st century: seeking a picture of health for art therapy. Psychology Today. Retrieved from https://www.psychologytoday.com/blog/arts-and-health/201304/defining-art-therapy-in-the-21st-century

Mind-Body Art Essentials. Therapies. Rates. Retrieved from http://www.mindbodyartessentials.com/appointments-specials

Nola Art Therapy. Rates. Retrieved from http://nolaarttherapy.com/rates-insurance.html

U.S. Department of Labor Bureau of Labor Statistics. 2016 National occupational and wage statistics United States. Retrieved from https://www.bls.gov/oes/current/oes_nat.htm

Work of Art Therapy. Rates. Retrieved from http://www.workofarttherapy.com/rates-insurance/

Wyoming Art Therapy. Rates. Retrieved from http://nolaarttherapy.com/rates-insurance.html

APPENDIX

APPENDIX 1 - EASTERN VIRGINIA MEDICAL SCHOOL – ART THERAPY & COUNSELING PROGRAM CURRICULUM

Art Therapy & Counseling Program
Course Sequence

*Courses and sequence are subject to change

FIRST YEAR

Semester 1 - Fall
AT 516 Clinical Case Conference (1)
AT 521 Individual Counseling & Psychotherapy (3)
AT 524 Processes & Materials of Art Psychotherapy I (4)
AT 528 Theories of Human Psychological Development (3)
AT 530 Psychopathology (3)
AT 534 Introduction of the History & Theory of Art Therapy (1)
AT 548 Assessment (3)
AT 550 Practica Fieldwork (1)

Semester 2 - Spring
AT 513 Research Methods (3)
AT 520 Group Counseling & Psychotherapy (3)
AT 529 Case Presentation Skills (1)
AT 547 Individual Supervision I (1)
AT 549 Processes & Materials of Art Psychotherapy II (4)
AT 551 Practicum I (.5)
AT 555 Internship I (2.5)
AT 561 Child Counseling & Psychotherapy Skills (1) or
AT 563 Adolescent Counseling & Psychotherapy Skills (1) or
AT 565 Adult Counseling & Psychotherapy Skills (1)
AT 567 Group Supervision Counseling & Psychotherapy w/Children (1.5)or
AT 670 Group Supervision Counseling & Psychotherapy w/Adoles (1.5)or
AT 667 Group Supervision Counseling & Psychotherapy w/Adults (1.5)

Summer Semester
AT 607 Capstone I (1)

SECOND YEAR

Semester 3 - Fall
AT 607 Capstone II (1)
AT 617 Clinical Case Conference II (1.5)
AT 636 Cultural Competency (3)
AT 646 Individual Supervision II (1)
AT 650 Practicum II (.5)
AT 656 Internship II (2.5)
AT 660 Child Counseling & Psychotherapy Skills (1) or
AT 662 Adolescent Counseling & Psychotherapy Skills (1) or
AT 664 Adult Counseling & Psychotherapy Skills (1)
AT 569 Group Supervision Counseling & Psychotherapy w/Children (1.5) or
AT 672 Group Supervision Counseling & Psychotherapy w/Adoles (1.5) or
AT 669 Group Supervision Counseling & Psychotherapy w/Adults (1.5)

Semester 4 - Spring
AT 607 Capstone III (1)
AT 617 Ethics & Professionalism (3)
AT 647 Individual Supervision III (1)
AT 649 Creativity, Symbolism & Metaphor (3)
AT 651 Practicum III (.5)
AT 657 Internship III (2.5)
AT 661 Child Counseling & Psychotherapy Skills (1) or
AT 663 Adolescent Counseling & Psychotherapy Skills (1) or
AT 665 Adult Counseling & Psychotherapy Skills (1)
AT 571 Group Supervision Counseling & Psychotherapy w/Children (1.5)or
AT 674 Group Supervision Counseling & Psychotherapy w/Adoles (1.5) or
AT 673 Group Supervision Counseling & Psychotherapy w/Adults (1.5)

Electives and Specialization Courses
AT 533/633 Clinical Specialities (varies)
AT 535/635 Art Therapy in the Schools (1)
AT 562/652 Medical Art Therapy (1)
AT 615 Family Counseling & Psychotherapy (3)**
AT 638 Countertransference/Jung (1)
AT 639 Exploration of the Psyche (1)
AT 655 Trauma Informed Art Therapy (1)
AT 632 Addictions (3)**
AT 634 Career Counseling (3)**

**Optional coursework for graduation; required for licensure
***Number in parentheses designates number of credits

APPENDIX 2 - SCOPE OF PRACTICE AMERICAN ART THERAPY ASSOCIATION

Typical functions performed and services provided by art therapists according to scope of practice as defined by the American Art Therapy Association include, but are not limited to:

(a) The use of psychotherapeutic principles, art media, and the creative process to assist individuals, families, or groups in:

(1) Increasing awareness of self and others;

(2) Coping with symptoms, stress, and traumatic experiences;

(3) Enhancing cognitive abilities; and

(4) Identifying and assessing clients' needs in order to implement therapeutic intervention to meet developmental, behavioral, psychological, and emotional needs.

(b) The application of art therapy principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems and emotional or psychological conditions that include, but are not limited to:

(1) Clinical appraisal and treatment during individual, couples, family or group sessions which provide opportunities for engagement through the creative process;

(2) Using the process and products of art creation to tap into client's inner fears, conflicts and core issues with the goal of improving physical, psychological and emotional functioning and well-being; and

(3) Using art therapy assessments to determine treatment goals and implement therapeutic art interventions which meet developmental, psychological, and emotional needs; an

(c) The employment of art media, the creative process and the resulting artwork to assist clients to:

(1) Reduce psychiatric symptoms of depression, anxiety, post traumatic stress, and attachment disorders;

(2) Enhance neurological, cognitive, and verbal abilities, develop social skills, aid sensory impairments, and move developmental capabilities forward in specific areas;

(3) Cope with symptoms of stress, anxiety, traumatic experiences and grief;

(4) Explore feelings, gain insight into behaviors, and reconcile emotional conflicts;

(5) Improve or restore functioning and a sense of personal well-being;

(6) Increase coping skills, self-esteem, awareness of self and empathy for others;

(7) Healthy channeling of anger and guilt; and

(8) Improve school performance, family functioning and parent/child relationship.

ART THERAPY CREDENTIALS BOARD, INC. | ATCB

September 2016

Code of Ethics, Conduct, and Disciplinary Procedures

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PREAMBLE

The Art Therapy Credentials Board (ATCB) is a nonprofit organization that seeks to protect the public by issuing registration, board certification, and clinical supervisor credentials to practitioners in the field of art therapy who meet certain established standards. The Board is national in scope and includes academicians, practitioners, supervisors, and a public member who work to establish rigorous standards that have a basis in real world practice. The ATCB art therapy registration, board certification, and clinical supervisor credentials, hereinafter sometimes referred to as credentials, are offered to art therapists from a wide variety of practice disciplines, who meet specific professional standards for the practice of art therapy.

The Code of Ethics, Conduct, and Disciplinary Procedures is designed to provide art therapists and credential applicants with a set of Ethical Standards (Part I, Section 1) to guide them in the practice of art therapy, as well as Standards of Conduct (Part I, Section 2) to which every credentialed art therapist and credential applicant must adhere. The ATCB may decline to grant, withhold, suspend, or revoke the credentials of any person who fails to adhere to the Standards of Ethics and Conduct (Part I, Section 3). Credentialed art therapists and credential applicants are expected to comply with ATCB Standards of Ethics and Conduct.

The ATCB does not guarantee the job performance of any credential holder or applicant. The ATCB does not express an opinion regarding the competence of any registered or board certified art therapist or art therapy certified supervisor. Rather, registration, board certification or super-visor certification offered through an ATCB program constitutes recognition by the ATCB that, to its best knowledge, an art therapist or applicant meets and adheres to minimum academic preparation, professional experience, continuing education, and professional standards set by the ATCB.

I. CODE OF ETHICS AND CONDUCT

1. General Ethical Standards

The Art Therapy Credentials Board endorses the following general ethical principles, which shall guide the conduct of all art therapists who seek to obtain or maintain credentials under the authority of the ATCB.

1.1 Responsibility to Clients

1.1.1 Art therapists shall advance the welfare of all clients, respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.
1.1.2 Art therapists will not discriminate against or refuse professional services to individuals or groups based on age, gender, gender identity, gender expression, sexual orientation, ethnicity, race, national origin, culture, marital/partnership status, language preference, socioeconomic
status, citizenship or immigration status, disability, religion/spirituality, or any other basis.
1.1.3 At the outset of the client-therapist relationship, art therapists must discuss and explain to clients the rights, roles, expectations, and limitations of the art therapy process.

1.1.4 Art therapists respect the rights of clients to make decisions and assist them in understanding the consequences of these decisions. Art therapists advise their clients that decisions on whether to follow treatment recommendations are the responsibility of the client. It is the professional responsibility of the art therapist to avoid ambiguity in the therapeutic relationship and to ensure clarity of roles at all times.
1.1.5 Art therapists continue a therapeutic relationship only so long as they believe that the client is benefiting from the relationship. It is unethical to maintain a professional or therapeutic relationship for the sole purpose of financial remuneration to the art therapist or when it becomes reasonably clear that the relationship or therapy is not in the best interest of the client.
1.1.6 Art therapists must not engage in therapy practices or procedures that are beyond their scope of practice, experience, training, and education.
1.1.7 Art therapists must not abandon or neglect clients receiving services. If art therapists are unable to continue to provide professional help, they must assist the client in making reasonable alternative arrangements for continuation of services.
1.1.8 Art therapists shall ensure regular contact with clients and prompt rescheduling of missed sessions.
1.1.9 Art therapists shall make all attempts to ensure there are procedures in place or follow recommendations for a "professional will" that suggests the handling of client documentation and art, if applicable, in the event of their unexpected death or inability to continue practice. Art therapists shall recognize the harm it may cause if clients are unable to access services in such a situation and identify individuals who can assist clients with obtaining services and with appropriate transfer of records. These written procedures shall be provided to the client.
1.1.10 Art therapists shall provide clients with contact information for the Art Therapy Credentials Board.
1.1.11 Art therapists are familiar with state requirements and limitations for consent for treatment. When providing services to minors or persons unable to give voluntary consent, art therapists seek the assent of clients and/or guardians to services, and include them in decision making as much as possible. Art therapists recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.
1.1.12 Art therapists should obtain qualified medical or psychological consultation for cases when such evaluation and/or administration of medication is required. Art therapists must not provide services other than art therapy unless certified or licensed to provide such other services.
1.1.13 Practitioners of art therapy must conform to relevant federal, provincial, state, and local statutes and ordinances that pertain to the provision of independent mental health practice. Laws vary based upon the location of the practice. It is the sole responsibility of the independent practitioner to conform to these laws. Art therapists shall be knowledgeable about statutes and/or laws that pertain to art therapy and mental health practice in any jurisdiction (state, province, country) in which they practice.
1.1.14 Art therapists must seek to provide a safe, private, and functional environment in which to offer art therapy services. This includes, but is not limited to: proper ventilation, adequate lighting, access to water supply, knowledge of hazards or toxicity of art materials and the effort needed to safeguard the health of clients, storage space for client artworks and secured areas for any hazardous materials, monitored use of sharps, allowance for privacy and confidentiality, and compliance with any other health and safety requirements according to state and federal agencies that regulate comparable businesses.

1.2 Professional Competence and Integrity
1.2.1. Art therapists must maintain high standards of professional competence and integrity.
1.2.2 Art therapists must keep informed and updated with regard to developments in the field which relate to their practice by engaging in educational activities and clinical experiences. Additionally, art therapists shall seek regular consultation and/or supervision with fellow qualified professionals.
1.2.3 Art therapists shall assess, treat, or advise only in those cases in which they are competent as determined by

their education, training, and experience.
1.2.4 Art therapists shall develop and improve multicultural competence through ongoing education and training. Art therapists shall use practices in accordance with the client's or group's age, gender, gender identity, gender expression, sexual orientation, ethnicity, race, national origin, culture, marital/partnership status, language preference, socioeconomic status, immigration/citizenship status, disability, religion/spirituality, or any other identity factor.
1.2.5 Art therapists shall communicate in ways that are both developmentally and culturally sensitive and appropriate. When clients and/or art therapists have difficulty understanding each other's language, art therapists shall attempt to locate necessary translation/interpretation services.
1.2.6 Art therapists will obtain client's written consent to communicate with other health care providers for the purpose of collaborating on
client treatment.
1.2.7 Art therapists, because of their potential to influence and alter the lives of others, must exercise special care when making public their professional recommendations and opinions through testimony or other public statements.
1.2.8 Art therapists must seek appropriate professional consultation or assistance for their
personal problems or conflicts that may impair or affect work performance or clinical judgment.
1.2.9 Art therapists must not distort or misuse their clinical and research findings.
1.2.10 Art therapists shall file a complaint with the ATCB when they have reason to believe that another art therapist is or has been engaged in conduct that violates the law or the Standards of Ethics and Conduct contained in this Code. This does not apply when the belief is based upon information obtained in the course of a therapeutic relationship with a client and voluntary, written authorization for disclosure of the information has not been obtained; however, this does not relieve an art therapist from the duty to file any reports required by law.
1.2.11 Art therapists shall notify the ATCB of any disciplinary sanctions imposed upon themselves or another art therapist by another professional credentialing agency or organization, when such sanctions come to their attention.
1.2.12 Art therapists shall not knowingly make false, improper, or frivolous ethics or legal complaints against colleagues or other art therapists.

1.3 Responsibility to Students and Supervisees
1.3.1 Art therapists must instruct their students using accurate, current, and scholarly information and at all times foster the professional growth of students and advisees.
1.3.2 Art therapists as teachers, supervisors, and researchers must maintain high standards of scholarship and present accurate information.
1.3.3 Art therapists must not permit students, employees, or supervisees to perform or to represent themselves as competent to perform professional services beyond their education, training, experience, or competence, including multicultural and diversity competence.
1.3.4 Art therapists who act as supervisors are responsible for maintaining the quality of their supervision skills and obtaining consultation or supervision for their work as supervisors whenever appropriate.
1.3.5 Art therapists are aware of their influential position with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Art therapists, therefore, shall not engage in a therapeutic relationship with their students or supervisees.
1.3.6 Art therapists do not condone or engage in sexual harassment, which is defined as unwelcome comments, gestures, or physical contact of a sexual nature.
1.3.7 Art therapists who offer and/or provide supervision must:
1.3.7.1 Ensure that they have proper training and supervised experience, contemporary continuing education and/or graduate training in clinical supervision;

1.3.7.2 Ensure that supervisees are informed of the supervisor's credentials and professional status as well as all conditions of supervision as defined/outlined by the supervisor's practice, agency, group, or organization;
1.3.7.3 Ensure that supervisees are aware of the current ethical standards related to their professional practice, including the ATCB Code of Ethics, Conduct, and Disciplinary Procedures;
1.3.7.4 Ensure regular contact with supervisees and prompt rescheduling of missed supervision sessions;
1.3.7.5 Provide supervisees with adequate feedback and evaluation throughout the supervision process;
1.3.7.6 Ensure that supervisees inform their clients of their professional status, the name and contact information of their supervisors, and obtain informed consent from their clients for sharing disguised client information and artwork or reproductions as necessary with their supervisors;
1.3.7.7 Ensure that supervisees obtain client consent to share client artwork or reproductions in supervision;
1.3.7.8 Establish procedures with their supervisees for handling crisis situations.
1.3.9 Art therapy supervisors shall provide supervisees with a professional disclosure statement that advises supervisees of the supervisor's affirmation of adherence to this Code of Ethics, Con-duct, and Disciplinary Procedures, and instructions regarding how the supervisee should address any dissatisfaction with the supervision process including how to file a complaint with the ATCB, the ATCB's address, telephone number, and email address.

1.4 Responsibility to Research Participants
1.4.1 Art therapists who are researchers must respect the dignity and protect the welfare of participants in research.
1.4.2 Researchers must be aware of and comply with federal, provincial, state, and local laws and regulations, agency regulations, institutional review boards, and professional standards governing the conduct of research.
1.4.3 Researchers must make careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators must seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.
1.4.4 Researchers requesting potential participants' involvement in research must inform them of all risks and aspects of the research that might reasonably be expected to influence willingness to participate, and must obtain a written acknowledgment of informed consent, reflecting an understanding of the said risks and aspects of the research, signed by the participant or, where appropriate, by the participant's parent or legal guardian. Researchers must be especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, have impairments which limit understanding and/or communication, or when participants are children.
1.4.5 Researchers must respect participants' freedom to decline participation in or to withdraw from a research study at any time. This principle requires thoughtful consideration when investigators or other members of the research team are in positions of authority or influence over participants. Art therapists, therefore, must avoid relationships with research participants outside the scope of the research.
1.4.6 Art therapists must treat information obtained about research participants during the course of the research protocol as confidential unless the participants have previously and reasonably authorized in writing that their confidential information may be used. When there is a risk that others, including family members, may obtain access to such information, this risk, together with the plan for protecting confidentiality, must be explained to the participants as part of the above stated procedure for obtaining a written informed consent.

1.5 Responsibility to the Profession
1.5.1 Art therapists must respect the rights and responsibilities of professional colleagues and should participate in activities that advance the goals of art therapy.
1.5.2 Art therapists must adhere to the ATCB standards of the profession when acting as members or employees of third-party organizations.
1.5.3 Art therapists must attribute publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

1.5.4 Art therapists who author books or other materials that are published or distributed must cite persons to whom credit for original ideas is due.
1.5.5 Art therapists who author books or other materials published or distributed by a third party must take reasonable precautions to ensure that the third party promotes and advertises the materials accurately and factually.
1.5.6 Art therapists are encouraged, whenever possible, to recognize a responsibility to partictipate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.
1.5.7 Art therapists are encouraged, whenever possible, to assist and be involved in developing laws and regulations pertaining to the field of art therapy that serve the public interest and in changing such laws and regulations that are not in the public interest.
1.5.8 Art therapists are encouraged, whenever possible, to promote public understanding of the principles and the profession of art therapy through presentations to general audiences, mental health professionals, and students. In making such presentations, art therapists shall accurately convey to the audience members or students the expected competence and qualifications that will result from the presentations, as well as, the differences between the presentation and formal studies in art therapy.
1.5.9 Art therapists must cooperate with any ethics investigation by any professional organization or government agency, and must truthfully represent and disclose facts to such organizations or agencies when requested or when necessary to preserve the integrity of the art therapy profession.
1.5.10 Art therapists should endeavor to ensure that the benefits and limitations are correctly conveyed by any institution or agency of which they are employees.
1.5.11 Art therapists are accountable at all times for their behavior. They must be aware that all actions and behaviors of the art therapist reflect on professional integrity and, when inappropriate, can damage the public trust in the art therapy profession. To protect public confidence in the art therapy profession, art therapists avoid behavior that is clearly in violation of accepted moral and legal standards.

2. Standards of Conduct

The Art Therapy Credentials Board prescribes the following standards of conduct, which shall guide the conduct of all art therapists who seek to obtain or maintain credentials under the authority of the ATCB.

2.1 Confidentiality

2.1.1 Art therapists shall inform clients of the purpose and limitations of confidentiality.
2.1.2 Art therapists shall respect and protect confidential information obtained from clients, including, but not limited to, all verbal and/or artistic expression occurring within the client-therapist relationship.
2.1.3 Art therapists shall protect the confidentiality of the client-therapist relationship in all matters.
2.1.4 Art therapists shall not disclose confidential information without the client's explicit written consent unless mandated by law or a court order. In these cases, confidences may be disclosed only as legally and reasonably necessary in the course of that action. All disclosures of information shall be documented in the client's file, including the identity of the recipient, the basis upon which the information was disclosed, and a description of the information disclosed.
2.1.5 If there is reason to believe that the client or others are in immediate, serious danger to health or life, any such disclosure shall be made consistent with state and federal laws that pertain to the protection and welfare of the client or others. Art therapists strive to disclose information in a way that ensures respect for the client and integrity for the therapeutic relationship.
2.1.6 In the event that art therapists believe it is in the interest of a client to disclose confidential information, they shall seek and obtain written authorization from the client or the client's legal guardian, before making any disclosures, unless such disclosure is required by law.

2.1.7 For the purpose of collecting information on harm caused to clients or possible violations of ATCB rules and its Code of Ethics, Conduct, and Disciplinary Procedures by art therapists or those falsely claiming to have an ATCB credential, art therapists may disclose such information without the client's explicit written consent if the information is disguised so that the identity of the client is fully protected.
2.1.8 Art therapists shall maintain client treatment records for a reasonable period of time consistent with federal and state laws, agency regulations and sound clinical practice. Records shall be stored or disposed of in ways that maintain client confidentiality.
2.1.9 Whenever possible, a photographic representation should be maintained, in accordance with the provisions set forth in 2.2.2 of this document on consent to photograph, for all work created by the client that is relevant to document the therapy if maintaining the original artwork would be difficult.
2.1.10 When the client is a minor, any and all disclosure or consent shall be made to or obtained from the parent or legal guardian of the client, except where otherwise provided by state law. Care shall be taken to preserve confidentiality with the minor client and to refrain from disclosure of information to the parent or guardian that might adversely affect the treatment of the client, except where otherwise provided by state law or when necessary to protect the health, welfare, or safety of the minor client.
2.1.11 Client confidentiality must be maintained when clients are involved in research, according to Part I, Section 1.4 of this code of practice.
2.1.12 Independent practitioners of art therapy must sign and issue a written professional disclosure statement to a client upon the establishment of a professional relationship. Such disclosure statement must include, but need not be limited to, the following information: education, training, experience, professional affiliations, credentials, fee structure, payment schedule, session scheduling arrangements, information pertaining to the limits of confidentiality and the duty to report. The name, address, and telephone number of the ATCB should be written in this document along with the following statement, "The ATCB oversees the ethical practice of art therapists and may be contacted with client concerns." It is suggested that a copy of the statement be retained in the client's file.

2.2 Use and Reproduction of Client Art Expression and Therapy Sessions
2.2.1 Art therapists shall take into consideration the benefits and potential negative impact of photographing, videotaping, using other means to duplicate, and/or display and/or broadcast client artwork with the client's best interest in mind. Art therapists shall provide to the client and/or parent or legal guardian clear warnings about the art therapist's inability to protect against the use, misuse, and republication of the art product and/or session by others once it is displayed or posted.
2.2.2 Art therapists shall not make or permit any public use or reproduction of a client's art therapy sessions, including verbalization and art expression, without express written consent of the client or the client's parent or legal guardian.
2.2.3 Art therapists shall obtain written informed consent from a client, or when applicable, a parent or legal guardian, before photographing the client's art expressions, making video or audio recordings, otherwise duplicating, or permitting third-party observation of art therapy sessions.
2.2.4 Art therapists shall use clinical materials in teaching, writing, electronic formats and
public presentations only if a written authorization has been previously obtained from the client, client's parent, or legal guardian.
2.2.5 Art therapists shall obtain written, informed consent from a client or, when appropriate, the client's parent or legal guardian, before
displaying the client's art in galleries, healthcare facilities, schools, the Internet or other places.
2.2.6 Only the client, parent or legal guardian may give signed consent for use of client's art or information from sessions and treatment, and only for the specific uses, and in the specific communication formats, designated in the consent. Once consent has been granted, art therapists shall ensure that appropriate steps are taken to protect

client identity and disguise any part of the notes, art expression or audio or video recording that reveals client identity unless the client, parent or legal guardian specifically designates in the signed consent that the client's identity may be revealed. The signed consent form shall include conspicuous language that explains the potential that imagery and information displayed or used in any form may not be able to be permanently removed if consent is later revoked.

2.3 Professional Relationships

2.3.1 Art therapists shall not engage in any relationship, including through social media, with current or former clients, students, interns, trainees, supervisees, employees, or colleagues that is exploitative by its nature or effect.

2.3.2 Art therapists shall make their best efforts to avoid, if it is reasonably possible to do so, entering into non-therapeutic or non-professional relationships with current or former clients, students, interns, trainees, supervisees, employees, or colleagues or any family members or other persons known to have a close personal relationship with such individuals such as spouses, children, or close friends.

2.3.3 In the event that the nature of any such relationship is questioned, the burden of proof shall be on the art therapist to prove that a non-therapeutic or non-professional relationship with current or former clients, students, interns, trainees, supervisees, employees, or colleagues is not exploitative or harmful to any such individuals.

2.3.4 Exploitative relationships with clients include, but are not limited to, borrowing money from or loaning money to a client, hiring a client, engaging in a business venture with a client, engaging in a romantic relationship with a client, or engaging in sexual intimacy with a client.

2.3.5 Art therapists shall take appropriate professional precautions to ensure that their judgment is not impaired, that no exploitation occurs, and that all conduct is undertaken solely in the client's best interest.

2.3.6 Art therapists shall not use their professional relationships with clients to further their own interests.

2.3.7 Art therapists shall be aware of their influential position with respect to students and supervisees, and they shall avoid exploiting the trust and dependency of such persons. Art therapists, therefore, shall not provide therapy to students or supervisees contemporaneously with the student/supervisee relationship.

2.3.8 Art therapists must not knowingly misuse, or allow others to misuse, their influence when engaging in personal, social, organizational, electioneering or lobbying activities.

2.3.9 Art therapists do not condone or engage in sexual harassment, which is defined as unwelcome comments, gestures, or physical contact of a sexual nature.

2.3.10 Art therapists shall be aware of and take into account the traditions and practices of other professions with which they work and cooperate fully with them.

2.3.11 Art therapists who have a private practice, but who are also employed in an agency or group practice must abide by and inform clients of the agency's or group practice's policies regarding self-referral.

2.3.12 Any data derived from a client relationship and subsequently used in training or research shall be so disguised in such a way that the client's identity is fully protected. Any data which cannot be so disguised may be used only as expressly authorized by the client's informed and voluntary consent.

2.4 Financial Arrangements

2.4.1 Independent practitioners of art therapy shall seek to ensure that financial arrangements with clients, third party payers, and supervisees are understandable and conform to accepted professional practices.

2.4.2 If a client wishes to access insurance coverage for art therapy services out of state, art therapists shall advise clients that it is the client's responsibility to confirm coverage before beginning services.

2.4.3 Art therapists must not offer or accept payment for referrals.

2.4.4 Art therapists must not exploit their clients financially.

2.4.5 Art therapists must represent facts truthfully to clients, third party payers, and supervisees regarding services rendered and the charges thereof.

2.4.6 Art therapists who intend to use collection agencies or take legal measure to collect fees from clients who do

not pay for services as agreed upon must first inform clients in writing of such intended actions and offer clients the opportunity to make payment.
2.4.7 Art therapists may barter only if the relationship is not exploitive or harmful and does not place the art therapist in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals within the community. Art therapists should consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.
2.4.8 Art therapists shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant to the specific client. Prior to acceptance, art therapists shall consider the value of the gift and discuss the gift-giving with the client. The art therapist shall document the matter, including all consideration and the client discussion in the client's record.

2.5 Advertising
2.5.1 Art therapists shall provide sufficient and appropriate information about their professional services to help the layperson make an informed decision about contracting for those services.
2.5.2 Art therapists must accurately represent their competence, education, earned credentials, training, and experience relevant to their professional practice.
2.5.3 Art therapists must ensure that all advertisements and publications, whether in print, directories, announcement cards, newspapers, radio, television, electronic format such as the Internet, or any other media, are formulated to accurately convey, in a professional manner, information that is necessary for the public to make an informed, knowledgeable decision.
2.5.4 Art therapists must not use names or designations for their practices that are likely to confuse and/or mislead the public concerning the identity, responsibility, source, and status of those under whom they are practicing, and must not hold themselves out as being partners or associates of a firm if they are not.
2.5.5 Art therapists must not use any professional identification (such as a business card, office sign, letterhead, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading or deceptive. A statement is false, fraudulent, misleading or deceptive if it: fails to state any material fact necessary to keep the statement from being misleading; is intended to, or likely to, create an unjustified expectation; or contains a material misrepresentation of fact.
2.5.6 Art therapists must correct, whenever possible, false, misleading, or inaccurate information and representations made by others concerning the art therapist's qualifications, services, or products.
2.5.7 Art therapists must make certain that the qualifications of persons in their employ are represented in a manner that is not false, misleading, or deceptive.
2.5.8 Art therapists may represent themselves as specializing within a limited area of art therapy only if they have the education, training, and experience that meet recognized professional standards to practice in that specialty area.

2.6 Measurement and Evaluation
2.6.1 Art therapists shall use or interpret only the specific assessment instruments for which they have the required education and supervised experience.
2.6.2 Art therapists must provide instrument specific orientation or information to an examinee prior to and following the administration of assessment instruments or techniques so that the results may be placed in proper perspective with other relevant factors. The purpose of testing and the explicit use of the results must be made known to an examinee prior to testing.
2.6.3 In selecting assessment instruments or techniques for use in a given situation or with a particular client, art therapists must carefully evaluate the specific theoretical bases and characteristics, validity, reliability and appropriateness of each instrument.
2.6.4 When making statements to the public about assessment instruments or techniques, art therapists must

provide accurate information and avoid false claims or misconceptions concerning the instrument's reliability and validity.
2.6.5 Art therapists must follow all directions and researched procedures for selection, administration and interpretation of all evaluation instruments and use them only within proper contexts.
2.6.6 Art therapists must be cautious when interpreting the results of instruments that possess insufficient technical data, and must explicitly state to examinees the specific limitations and purposes for the use of such instruments.
2.6.7 Art therapists must proceed with caution when attempting to evaluate and interpret performance of any person who cannot be appropriately compared to the norms for the instrument.
2.6.8 Because prior coaching or dissemination of assessment instruments can invalidate test results, art therapists are professionally obligated to maintain test security.
2.6.9 Art therapists must consider psychometric limitations when selecting and using an instrument, and must be cognizant of the limitations when interpreting the results. When tests are used to classify clients, art therapists must ensure that periodic review and/or retesting are conducted to prevent client stereotyping.
2.6.10 Art therapists recognize that test results may become obsolete, and avoid the misuse of obsolete data.
2.6.11 Art therapists must not appropriate, reproduce, or modify published assessment instruments or parts thereof without acknowledgement and permission from the publisher, except as permitted by the fair educational use provisions of the U.S. copyright law.
2.6.12 Art therapists who develop assessment instruments for the purpose of measuring personal characteristics, diagnosing, or other clinical uses shall provide test users with a description of the benefits and limitations of the instrument, appropriate use, interpretation, and information on the importance of basing decisions on multiple sources rather than a single source.

2.7 Documentation

Art therapists must maintain records that:
2.7.1 Are in compliance with federal, provincial, state, and local regulations and any licensure requirements governing the provision of art therapy services for the location in which the art therapy services are provided.
2.7.2 Are in compliance with the standards, policies and requirements at the art therapist's place of employment.
2.7.3 Include essential content from communication with/by the client via electronic means.

2.8 Termination of Services

2.8.1 Art therapists shall terminate art therapy when the client has attained stated goals and objectives or fails to benefit from art therapy services.
2.8.2 Art therapists must communicate the termination of art therapy services to the client, client's parent or legal guardian.

2.9 Electronic Means

2.9.1 Art therapists must inform clients of the benefits, risks, and limitations of using information technology applications in the therapeutic process and in business/billing procedures. Such technologies include but are not limited to computer hardware and software, faxing, telephones, the Internet, online assessment instruments, and other technological procedures and devices. Art therapists shall utilize encryption standards within Internet communications and/or take such precautions to reasonably ensure the confidentiality of information transmitted, as in 2.9.5.6.
2.9.2 When art therapists are providing technology-assisted distance art therapy services, the art therapist shall make a reasonable effort to determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.
2.9.3 Art therapists must ensure that the use of technology in the therapeutic relationship does not violate the laws of any federal, provincial, state, local, or international entity and observe all relevant statutes.

2.9.4 Art therapists shall seek business, legal, and technical assistance when using technology applications for the purpose of providing art therapy services, particularly when the use of such applications crosses provincial, state lines or international boundaries.
2.9.5 As part of the process of establishing informed consent, art therapists shall do the following:
2.9.5.1 Inform clients of issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications, and the difficulty in removing any information or imagery that has been posted electronically if consent is later revoked.
2.9.5.2 Inform clients of all colleagues, supervisors, and employees (including Information Technology [IT] administrators) who might have authorized access to electronic transmissions.
2.9.5.3 Inform clients that, due to the nature of technology assisted art therapy, unauthorized persons may have access to information/art products that clients may share in the therapeutic process.
2.9.5.4 Inform clients of pertinent legal rights and limitations governing the practice of a profession across state/provincial lines or international boundaries.
2.9.5.5 Inform clients that Internet sites and e-mail communications will be encrypted but that there are limitations to the ability of encryption software to help ensure confidentiality.
2.9.5.6 When the use of encryption is not possible, art therapists notify clients of this fact and limit electronic transmissions to general communications that are not client specific.
2.9.5.7 Inform clients if and for how long archival storage of transaction records are maintained.
2.9.5.8 Discuss the possibility of technology failure and alternate methods of service delivery.
2.9.5.9 Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the art therapist is not available.
2.9.5.10 Discuss time zone differences, and cultural or language differences that might impact service delivery.
2.9.5.11 If a client wishes to access insurance coverage for technology-assisted distance art therapy services, art therapists shall advise clients that it is the client's responsibility to confirm coverage before beginning services.
2.9.5.12 Inform clients that communication will be included in client documentation as mentioned in 2.7.3.
2.9.6 Art therapists maintaining sites on the Internet shall do the following:
2.9.6.1 Regularly check that electronic links are working and professionally appropriate.
2.9.6.2 Provide electronic links to the ATCB and other relevant state, provincial, and or international licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
2.9.6.3 Strive to provide a site that is accessible to persons with disabilities

2.10 Social Media

2.10.1 Art therapists who maintain social media sites shall clearly distinguish between their personal and professional profiles by tailoring information specific to those uses and modifying who can access each site.
2.10.2 Art therapists do not disclose or display confidential information through social media.

3. Eligibility for Credentials

As a condition of eligibility for and continued maintenance or renewal of any ATCB credential, each applicant, registrant, certificant, or certified supervisor agrees to the following:

3.1 Compliance with ATCB Standards, Policies and Procedures

3.1.1 No person is eligible to apply for or main-tain credentials unless in compliance with all ATCB eligibility criteria as stated in the ATR, ATR-BC, and ATCS applications, as well as all other ATCB rules and standards, policies and procedures, including, but not limited to, those stated herein, and including timely payment of fees and any other requirements for renewal of credentials.
3.1.2 Each applicant, registrant, or certificant bears the burden for showing and maintaining compliance at all times.

The ATCB may deny, decline to renew, revoke, or otherwise act upon credentials when an applicant, registrant, or certificant is not in compliance with all ATCB stan-dards, policies, and procedures.

3.2 Complete Application

3.2.1 The ATCB may make administrative requests for additional information to supplement or complete any application for credentials or for renewal of existing credentials. An applicant must truthfully complete and sign an application in the form provided by the ATCB, must provide the required fees, and must provide additional information as requested.

3.2.2 The applicant, registrant, or certificant must provide written notification to the ATCB within 60 days of occurrence of any change in name, address, telephone number, and any other facts bearing on eligibility for credentials, including but not limited to: filing of any civil or criminal charge, indictment or litigation involving the applicant, registrant, or certificant; disposition of any civil or criminal charge, indictment or litigation involving the applicant, registrant, or certificant, including but not limited to, dismissal, entry of a judgment, conviction, plea of guilty, plea of nolo contendere, or disciplinary action by a licensing board or professional organization.

3.2.3 An applicant, registrant, or certificant will provide information requested by the Ethics Officer.

3.2.4 An applicant, registrant, or certificant must not make and must correct immediately any statement concerning his or her status that is or becomes inaccurate, untrue, or misleading.

3.2.5 All references to "days" in ATCB standards, policies and procedures shall mean calendar days. Communications required by the ATCB shall be transmitted by certified mail, return receipt requested, or other verifiable method of delivery.

3.2.6 The applicant, registrant, or certificant shall provide the ATCB with documentation of compliance with ATCB requirements as requested by the ATCB through its President or Executive Director.

3.3 Property of ATCB and Eligibility Determination

3.3.1 All examinations, certificates, and registration or certification cards of the ATCB, the name Art Therapy Credentials Board, all marks and terms of credentials, and all abbreviations relating thereto, are all the exclusive property of the ATCB and may not be used in any way without the express prior written consent of the ATCB.

3.3.2 ATCB applicants, registrants, or certificants who share, use, or alter ATCB examinations, certificates, and registration or certification cards of the ATCB, the name Art Therapy Credentials Board, all marks and terms of credentials, and all abbreviations relating thereto, are subject to disciplinary sanctions that may include but are not limited to denial, declined renewal, or revocation of ATCB credentials and may be subject to civil or criminal prosecution.

3.3.3 In case of suspension, limitation, relinquishment, or revocation of ATCB credentials, or as otherwise requested by the ATCB, a person previously holding an ATCB credential shall immediately relinquish, refrain from using, and correct at his or her expense any and all outdated or otherwise inaccurate business cards, stationery, advertisements, or other use of any certificate, logo, emblem, and the ATCB name and related abbreviations.

3.4 Pending Criminal or Administrative Proceedings

3.4.1 An applicant, registrant, or certificant shall provide written notification to the ATCB of the filing in any court of any information, complaint, or indictment charge of a felony or with a crime related to the practice of art therapy or the public health and safety, or the filing of any charge or action before a state or federal regulatory agency or judicial body directly relating to the practice of art therapy or related professions, or to a matter described in Part I, Section 4.1. Such notification shall be within 60 days of the filing of such charge or action, and shall provide written documentation of the resolution of such charge within 60 days of resolution.

3.5 Criminal Convictions

3.5.1 Applicants who meet all criteria as delineated in the current ATCB credential applications and who have not

had sanctions imposed by the ATCB or other governmental authority, insurance carrier, professional organization, or credentialing board, or been convicted of a serious criminal offense, or been listed on a governmental abuse

registry will be considered eligible for an ATCB credential upon submission of all application materials and fees. All other applicants will be subject to review by the ATCB and demonstration of their fitness to practice art therapy and that they do not pose a risk to the public.

II. DISCIPLINARY PROCEDURES

4. Standards Of Conduct: Discipline Process

4.1 Grounds For Discipline

4.1.1 The ATCB may deny or revoke credentials or otherwise take action with regard to credentials or an application for credentials under the following circumstances:
4.1.1.1 Failure to observe and comply with the Standards of Ethics and Conduct stated herein;
4.1.1.2 Failure to meet and maintain eligibility for ATCB credentials;
4.1.1.3 Irregularity in connection with any ATCB examination;
4.1.1.4 Failure to pay fees required by the ATCB;
4.1.1.5 Unauthorized possession of, use of, or access to ATCB examinations, certificates, registration or certification cards, logos, the name Art Therapy Credentials Board, all marks and terms of credentials, and all abbreviations relating thereto, and any variations thereof, and any other ATCB documents and materials;
4.1.1.6 Obtaining, maintaining, or attempting to obtain or maintain credentials by a false or misleading statement, failure to make a required statement, fraud, or deceit in an application, reapplication, or any other communication to the ATCB;
4.1.1.7 Misrepresentation of status of ATCB credentials;
4.1.1.8 Failure to provide any written information required by the ATCB;
Failure to cooperate with the ATCB or anybody established or convened by the ATCB at any point from the inception of an ethical or disciplinary complaint through the completion of all proceedings regarding that complaint;
4.1.1.10 Habitual use of alcohol, any drug or any substance, or any physical or mental condition, which impairs competent and objective professional performance;
4.1.1.11 Gross negligence in the practice of art therapy or other related professional work; including, but not limited to, sexual relationships with clients, and sexual, physical, social, or financial exploitation;
4.1.1.12 Limitation or sanction (including but not limited to discipline, revocation, or suspension by a regulatory board or professional organization) in a field relevant to the practice of art therapy;
4.1.1.13 ?The conviction of, or plea of guilty or plea of nolo contendere to, (i) any felony or (ii) any crime related to the practice of art therapy, the therapist's professional qualifications, or public health and safety. Convictions of this nature include but are not limited to those involving rape, sexual abuse of a patient or vulnerable person, actual or threatened use of a weapon or violence, and the prohibited sale, distribution or use of a controlled substance;
4.1.1.14 Failure to update information in a timely manner, including any violation referred to in this section, to the ATCB;
4.1.1.15 Failure to maintain confidentiality as required in the Standards of Ethics and Conduct, by any ATCB policy or procedure, or as otherwise required by law; or
4.1.1.16 Other violation of an ATCB standard, policy, or procedure stated herein or as stated in the ATCB candidate brochure or other material provided to applicants, registrants, or certificants.

4.2 Release of Information

4.2.1 Each applicant, registrant, and certificant agrees to cooperate promptly and fully in any
review of eligibility or credential status, including submitting such documents and information deemed necessary to

confirm the information in an application.
4.2.2 The individual applicant, registrant, or certificant agrees that the ATCB and its officers, directors, committee members, employees, ethics officers, and agents, may communicate any and all information relating to an ATCB application, registration or certification, and review thereof, and any imposed public disciplinary sanctions to state and federal authorities, licensing boards, and employers, and may communicate any imposed public disciplinary sanctions and the status of
a registrant's or certificant's credential to the public.

4.3 Waiver
4.3.1 An applicant, registrant, or certificant releases, discharges, exonerates, indemnifies, and holds harmless the ATCB, its officers, directors, committee members, employees, ethics officers, and agents, and any other persons from and against all claims, damages, losses, and expenses, including reasonable attorneys' fees, for actions of the ATCB arising out of applicant's application for or participation in the ATCB registration and/or certification programs and use of ATCB trademarks or other references to the ATCB registration and/or certification programs, including but not limited to the furnishing or inspection of documents, records, and other information and any investigation and review of applications or credentials by the ATCB.

4.4 Reconsideration of Eligibility and Reinstatement of Credentials
4.4.1 If eligibility or credentials are denied, revoked, or suspended for a violation of the Standards of Ethics and Conduct, eligibility for credentials may be reconsidered by the Board of Directors, upon application, on the following basis:
4.4.1.1 In the event of a felony conviction, no earlier than five years from and after the exhaustion of appeals, completion of sentence by final release from confinement, probationary or parole status, or satisfaction of fine imposed, whichever is later;
4.4.1.2 In any other event, at any time following imposition of sanctions, at the sole discretion of the Board of Directors.
4.4.2 In addition to other facts required by the ATCB, such an applicant must fully set forth the circumstances of the decision denying, revoking, or suspending eligibility or credentials as well
as all relevant facts and circumstances since the decision.
4.4.3 The applicant bears the burden of demonstrating by clear and convincing evidence of rehabilitation and absence of danger to others.

4.5 Deadlines
4.5.1 The ATCB requires its applicants, registrants, and certificants to meet all deadlines imposed by the ATCB, especially in regard to submission of fees, renewal or recertification applications, required evidence of continuing education, and sitting for its examinations. On rare occasions, circumstances beyond the control of the applicant, registrant or certificant, or other extraordinary conditions may render it difficult, if not impossible, to meet ATCB deadlines.
4.5.2 An applicant, registrant, or certificant who wishes to appeal a missed deadline must transmit a written explanation and make a request for a reasonable extension of the missed deadline along with the appropriate fees with full relevant supporting documentation, to the ATCB Executive Director, to the attention of the ATCB National Office.
4.5.3 The Board of Directors shall determine at the next meeting of the Board, in its sole discretion and on a case-by-case basis, what, if any, recourse will be afforded based on the circumstances described and the overall impact on the profession of art therapy. No other procedures shall be afforded for failure to meet ATCB deadlines.
4.5.4 The ATCB shall make every effort to follow the time requirements set forth in this document. However, the ATCB's failure to meet a time requirement shall not prohibit the final resolution of any ethics matter.

5. DISCIPLINARY PROCEDURES

5.1 Appointment of Disciplinary Hearing Panel

5.1.1 The ATCB Board of Directors may authorize an Ethics Officer and a Disciplinary Hearing Panel to investigate or consider alleged violations of the Standards of Ethics and Conduct contained in this Code or any other ATCB standard, policy or procedure. The ATCB Board of Directors shall appoint the chair of the Disciplinary Hearing Panel.
5.1.2 The Disciplinary Hearing Panel shall be composed of three members, including the chair. The membership of the Disciplinary Hearing Panel shall be drawn from ATCB registrants and certificants, except that one member of the Disciplinary Hearing Panel shall be a public member who shall not be an ATCB registrant or certificant.
5.1.3 The initial appointments to the Disciplinary Hearing Panel shall be for terms of three years as determined by the ATCB Board of Directors. Thereafter, a panel member's term of office on the panel shall run for three years and may be renewed. Once a member of the Disciplinary Hearing Panel begins to participate in the review of a matter, the panel member shall remain part of the Disciplinary Hearing Panel for that particular matter even if the review extends beyond the expiration of his or her term.
5.1.4 A Disciplinary Hearing Panel member may not serve simultaneously as Ethics Officer and may not serve on any matter wherein an actual or apparent conflict of interest or the Panel Member's impartiality might reasonably be questioned.
5.1.5 When a party to a matter before the Disciplinary Hearing Panel requests that a member of the panel, other than the chair, self-recuse, a final decision on the issue of recusal shall be made by the chair, subject to review as hereinafter provided. In the event a request is made that the chair self-recuse, the decision shall be made by the ATCB President, subject to review as hereinafter provided.
5.1.6 Panel action shall be determined by majority vote.
5.1.7 When a Panel member is unavailable to serve by resignation, disqualification, or other circumstance, the President of the ATCB shall designate another registrant or certificant, or public member, if applicable, to serve as an interim member for a particular matter or for the duration of the panel member's unexpired term whichever is appropriate.

5.2 Submission of Allegations

5.2.1 Any person concerned about a possible violation of the ATCB Standards of Ethics and Conduct, or other ATCB standard, policy or procedure, may initiate a written grievance, in as much detail and specificity as possible, including identifying the person(s) alleged to be involved and the facts concerning the alleged conduct. The written grievance should be accompanied by all available documentation. The grievance should be addressed to the Executive Director. A person initiating a grievance shall be referred to as the complainant.
5.2.2 The written grievance must identify by name, address, and telephone number of the complainant making the information known to the ATCB, and others who may have knowledge of the facts and circumstances concerning the alleged conduct. The ATCB may provide for the submission of grievances on forms to be supplied by the Executive Director.
5.2.3 The Executive Director shall forward the grievance to the Public Member of the ATCB Board of Directors (the "Public Member") for further action. The Public Member may initiate grievances that shall be handled in the manner provided hereinafter for the review and determination of all grievances.
5.2.4 The Public Member shall review the allegations and supporting information and make a determination of the merits of the allegations, after such further inquiry as considered appropriate, and after consultation with ATCB legal counsel as needed.
5.2.5 The Public Member may direct the ATCB Executive Director to assist with factual investigations or with administrative matters related to the initial review of allegations.
5.2.6 If the Public Member determines that the allegations are frivolous or fail to state a violation of the Standards of Ethics and Conduct, or that the ATCB lacks jurisdiction over the grievance or the person(s) complained about, the

ATCB shall not take further action and shall notify the complainant.
5.2.7 If the Public Member determines that probable cause may exist to deny eligibility for credential or that probable cause exists of a failure to comply with the Standards of Ethics and Conduct or any other ATCB policy or procedure, the Public Member shall forward in writing all details of the allegations to one of the Ethics Officers.
5.2.8 The Ethics Officer shall review the allegations and supporting information provided and may make such further inquiry, as deemed appropriate.
5.2.9 The Ethics Officer may seek the assistance of the Executive Director to research precedents in the ATCB's files, as reasonably determined to be necessary in making a determination regarding probable cause of a violation of the Standards of Ethics and Conduct, any other ATCB policy or procedure, or other misconduct. The Ethics Officer may direct the ATCB Executive Director to assist with factual investigations or with administrative matters related to the review of allegations.
5.2.10 If the Ethics Officer concurs that probable cause may exist to deny eligibility or that probable cause exists of a failure to comply with the Standards of Ethics and Conduct or any other ATCB policy or procedure, the Ethics Officer shall transmit written notification containing the allegations and findings to the full Disciplinary Hearing Panel, the complainant and the applicant, certificant or registrant. All written notices to the applicant, registrant or certificant shall be sent by certified mail, return receipt requested, to their addresses listed in the ATCB records. However if the Ethics Officer, in agreement with the Public Member, determines that the probable violation(s) are minor or technical in nature and have neither caused nor presented a danger of serious harm to a client or the public, the Ethics Officer may choose to resolve the complaint by the issuance of an advisory letter to the registrant or certificant setting out the identified probable violations and recommendations on corrective or preventative measures that should be implemented by the registrant or certificant in the future. All such advisory letters shall be maintained as part of the registrant's or certificant's file and may be taken into consideration of the sanctions to be assessed in connection with any future complaints brought against the registrant or certificant. Advisory letters shall not be made public.
5.2.11 If the Ethics Officer determines that probable cause does not exist to deny eligibility or that that probable cause does not exist of a failure to comply with the Standards of Ethics and Conduct or any other ATCB policy or procedure, or that the ATCB lacks jurisdiction over the complaint or the person(s) against whom the complaint was made, the Ethics Officer shall direct ATCB to take no further action and shall notify in writing the Board, the applicant, registrant, or certificant, and complainant, if any.
5.2.12 If upon referral of a grievance from the Public Member the Ethics Officer determines that reasonable cause exists that a registrant or certificant has had a license or certification revoked or suspended or has been charged, indicted, placed on deferred adjudication, community supervision, probation, or convicted of an offense listed below or determines that there is a serious concern for the protection and safety of the public, the Ethics Officer shall present to the Disciplinary Hearing Panel a recommendation for summary suspension of the registrant's or certificant's registration or certification. If approved by a majority vote of the Disciplinary Hearing Panel, the Ethics Officer shall notify the registrant or certificant in writing by certified mail, return receipt requested, of the summary suspension at the registrant's or certificant's address listed in the ATCB records. The suspension shall be effective three (3) days after the date of mailing.
Summary suspension shall be considered for all serious offenses including but not limited to the following:
(A) capital offenses;
(B) sexual offenses involving a child victim;
(C) felony sexual offenses involving an adult victim who is a client (one or more counts);
(D) multiple counts of felony sexual offenses involving any adult victim;
(E) homicide 1st degree;
(F) kidnapping;
(G) arson;
(H) homicide of lesser degrees;

(I) felony sexual offenses involving an adult victim who is not a client (single count);
(J) attempting to commit listed crimes;
(K) any felony or misdemeanor offenses potential physical harm to others and/or animals;
(L) felony or misdemeanor alcohol and drug offenses;
(M) all other felony offenses not listed.
A registration or certification summarily suspended shall remain suspended until final resolution of all criminal charges and a final decision of all complaints by the ATCB.
5.2.13 The ability of a complainant to withdraw a complaint shall be governed by the following standards:
(A) The complaint may be withdrawn in the initial stage of the examination by the Public Member Director; however, the Public Member Director or the ATCB reserves the right to refile the complaint if, in his or her judgment, there is concern for the protection of the public.
(B) Once the complaint has moved to an Ethics Officer for review, it cannot be withdrawn; however, the complainant cannot be forced to assist further.

5.3 Procedures of the Disciplinary HearingPanel

5.3.1 Upon receipt of notice from the Ethics Officer containing a statement of the complaint allegations and the finding(s) that probable cause may exist to deny eligibility for credential or question compliance with the Standards of Conduct or any other ATCB policy or procedure, the applicant, registrant, or certificant shall have thirty (30) days after receipt of the notice to notify the Ethics Officer in writing that the applicant, registrant, or certificant disputes the allegations of the complaint and to request review by written submissions to the Disciplinary Hearing Panel, a telephone conference with the Disciplinary Hearing Panel, or an in-person hearing (held at a time and place to be determined by the panel), with the respondent bearing the respondent's own ex-penses for such hearing.
5.3.2 If the applicant, registrant, or certificant (respondent) does not contest the allegations of the complaint, the respondent may still request review by written submissions to the Disciplinary Hearing Panel, a telephone conference with the Disciplinary Hearing Panel, or an in-person hearing (held at a time and place to be determined by the panel), with the applicant, registrant, or certificant bearing the respondent's own expenses for such hearing, concerning the appropriate sanction(s) to be applied in the case.
5.3.3 If the applicant, registrant, or certificant does not submit a written statement contesting
the allegations or notify the board of a request for review by written submission, telephone conference or in-person hearing as set forth in this paragraph, then the Disciplinary Hearing Panel shall render a decision based on the evidence available and apply sanctions as it deems appropriate.
5.3.4 If the applicant, registrant, or certificant requests a review, telephone conference, or hearing, the following procedures shall apply:
5.3.4.1 The Ethics Officer shall forward the allegations and any written statement from the applicant, registrant, or certificant to the Disciplinary Hearing Panel, and shall present the allegations and any substantiating evidence, examine and cross-examine witnesses, and otherwise present the matter during any hearing of the Disciplinary Hearing Panel.
5.3.4.2 The Disciplinary Hearing Panel shall then schedule a written review, or telephone or in-person hearing as requested by the applicant, registrant, or certificant, allowing for an adequate period of time for preparation, and shall send by certified mail, return receipt requested, a notice to the applicant, registrant, or certificant and the complainant. The notice shall include a statement of the standards allegedly violated, the procedures to be followed, and the date for submission of materials for written review, or the time and place of any hearing, as determined by the Disciplinary Hearing Panel. The applicant, registrant, or certifi-cant and the complainant may request a change in the date of any hearing for good cause, which shall not unreasonably be denied.
5.3.4.3 The Disciplinary Hearing Panel shall maintain a verbatim audio, video, or written transcript of any telephone or in-person hearing.
5.3.4.4 During any proceeding before the Disciplinary Hearing Panel, all parties may consult with and be

represented by counsel at their own expense. At any hearing, all parties or their counsel may make opening statements, present relevant documents or other evidence and relevant testimony, examine and cross-examine witnesses under oath, make closing statements, and present written briefs as scheduled by the Disciplinary Hearing Panel.

5.3.4.5 The Disciplinary Hearing Panel shall determine all evidentiary and procedural matters relating to any hearing or written review. Formal rules of evidence shall not apply. Relevant evidence may be admitted. The chair, subject to the majority vote of the full panel, shall determine disputed questions regarding procedures or the admission of evidence. All decisions shall be made on the record.

5.3.4.6 The burden shall be upon the ATCB to demonstrate a violation by preponderance of the evidence.

5.3.4.7 Whenever there is a reasonable concern that the mental or behavioral abilities of the applicant, registrant, or certificant may be impaired, calling into question the ability to competently, safely and professionally provide art therapy services, the respondent may be required to undergo a mental or behavioral health examination at the respondent's own expense. The report of such an examination shall become part of the evidence considered.

5.3.4.8 The Disciplinary Hearing Panel shall issue a written decision following any telephone or in-person hearing or written review and any submission of briefs. The decision shall contain findings of fact, a finding as to the truth of the allegations, and any sanctions applied. It shall be mailed by certified mail, return receipt requested, to the applicant, registrant, or certificant and complainant.

5.3.4.9 If the Disciplinary Hearing Panel finds that the allegations have not been proven by a preponderance of the evidence, no further action shall be taken, and the applicant, registrant, or certificant, and the complainant, if any, shall be notified by certified mail.

5.3.4.10 If the Disciplinary Hearing Panel finds that the allegations have been proven by a preponderance of the evidence it shall assess one or more appropriate public sanctions as set forth below:

(1) deny, refuse to issue, or refuse to renew a registration or certification;
(2) revoke or suspend a registration or certification;
(3) probate a suspension of a registration or certification;
(4) issue a reprimand.
(5) publish the rule violation and the sanction imposed;
(6) require mandatory remediation through specific education, treatment, and/or supervision;
(7) require that the registrant or certificant take appropriate corrective action(s);
(8) provide referral or notice to governmental bodies of any final determination made by the ATCB; or
(9) other corrective action.

The Disciplinary Hearing Panel will determine the length of the probation or suspension. If the Disciplinary Hearing Panel probates the suspension of a registration or certification, it may require the registrant or certificant to:

(1) report regularly to the Ethics Officer on matters that are conditions of the probation;
(2) limit practice to the areas prescribed by the Disciplinary Hearing Panel; or
(3) complete additional educational requirements, as required by the Disciplinary Hearing Panel to address the areas of concern that are the basis of the probation.
(4) provide periodic progress reports from the registrant's or certificant's health care providers.
(5) provide periodic supervision reports from the registrant's or certificant's supervisor.

All public sanctions shall be listed on the ATCB's website and accessible to the general public and/or published in the ATCB's official publication.

5.3.4.11 An individual whose registration or certification is revoked is not eligible to apply for a registration or certification for a minimum of three years after the date of revocation. The ATCB may consider the findings that resulted in revocation and any other relevant facts in determining whether to deny the application if an otherwise complete and sufficient application for a registration, or certification is submitted after three years have elapsed since revocation.

5.3.4.12 A voluntary surrender of a registration or certification accepted by the ATCB in response to a grievance or complaint shall be deemed to be an admission to the alleged violations and may be considered as such by the Disciplinary Hearing Panel in rendering its decision.

5.4 Appeal Procedures

5.4.1 If the decision rendered by the Disciplinary Hearing Panel is not favorable to the applicant, registrant, or certificant (respondent), the respondent may appeal the decision to the ATCB Board of Appeals by submitting to the Executive Director a written appeal statement within thirty (30) days following receipt of the decision of the Disciplinary Hearing Panel. The Disciplinary Hearing Panel shall grant any reasonable requests for extensions.

5.4.2 The Disciplinary Hearing Panel may file a written response to the appeal with the Executive Director.

5.4.3 The Executive Director shall immediately forward any appeal documents to the ATCB Board of Appeals.

5.4.4 The ATCB Board of Appeals by majority vote shall render a decision on the record without further hearing, although written briefs may be submitted on a schedule reasonably determined by the Board of Appeals. On matters on which the ATCB Public Member has initiated a complaint or performed the initial review, the Public Member shall not be part of the ATCB Board of Appeals.

5.4.5 The decision of the ATCB Board of Appeals shall be rendered in writing following receipt and review of briefs. The decision shall contain findings of fact, findings as to the truth of the allegations, and any sanctions applied and the decision shall be final.

5.4.6 The decision of the ATCB Board of Appeals shall be communicated to the applicant, registrant, or certificant by certified mail, return receipt requested. The complainant, if any, shall be notified of the Board of Appeals' final decision.

5.5 Bias, Prejudice, Impartiality

5.5.1 At all times during the ATCB's handling of any matter, the ATCB shall extend impartial review. If at any time during the ATCB's review of a matter an applicant, registrant, certificant, or any other person identifies a situation where the judgment of a reviewer may be biased or prejudiced or impartiality may be compromised (including employment with a competing organization), such person shall immediately report such matter to the Executive Director or President of the ATCB.

5.5.2 In matters where impartiality may be compromised, the reviewer shall self-recuse.

APPENDIX 4 – PUBLIC COMMENT

NOTE: The next section of the report will incorporate oral comments received during the Public Hearing held on June 26, 2018 and a summary of written comments received until 5:00 p.m. on July 27, 2018. The Regulatory Research Committee's next meeting is scheduled for August 23, 2018 where it will consider recommendations to the full Board.

VIRGINIA:

BOARD OF HEALTH PROFESSIONS

Regulatory Research Committee Meeting & Public Hearing

PUBLIC HEARING:

Invitation for Public Comment on the Review of the Need for Regulation of the Practice of Art Therapy in Virginia

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The matter in the above-titled hearing came on for hearing on Tuesday, June 26, 2018, at the U.S. Department of Health Professions Office, Perimeter Center, 9960 Mayland Drive, Boardroom 4, Henrico, Virginia, 23233, before Denise M. Holt, VCR No. 0315066.

Board of Health Profession Board Members:

James Wells, Chairperson
Elizabeth Carter
Jacquelyn M. Tyler
Martha S. Rackets
Lisette P. Carbajal
Maribel Ramos
Kevin P. O'Connor
Yvonne Haynes

MR. WELLS: Good morning. My name is Jim Wells, and I am the Chair of the Regulatory Research Committee, and this is a public hearing to receive public comment on the Board's review of the need for regulation for the practice of art therapy in Virginia. The Code of Virginia authorizes the Board of Health Professions to advise the Governor, the General Assembly and Department of Health Professions' Director on matters related to health care professions, occupations, and professions.

Accordingly, the Board is conducting this review and will provide recommendation on the competency of Virginia art therapists to practice art therapy. At this time, I will call on persons who signed up to comment. As you come up, please, as I call your name, come forward, tell us your name and where you are from. And in the interest of time, we do have a meeting after this.

We want to hear from all of you. We definitely do. If there are similar comments, or if there's a spokesman for a particular setup, if you could maybe limit it to that. So I will call on the first person, and is it Kendra Orr?

MS. ORR: Yes.

MR. WELLS: Yes, ma'am. If you would state your name and affiliation please.

MS. ORR: My name is Kendra Orr. I'm from Spotsylvania, Virginia. I'm a board certified art therapist.

I feel very strongly that our therapists need to be licensed in order to address the current mental health crisis. According to the CDC, since 1999, the suicide rate in the U.S. has gone up across all racial and ethnic groups, in both men and women, in both cities and rural areas and across all age groups.

Overall, the suicide rate has increased nearly 30 percent. Twenty-five states have suicide rate increases of more than 30 percent, and suicide is one of the leading causes of death and is on the rise. Among adolescents, suicide is the third leading cause of death and has been rising. Depression and anxiety is affecting college students at alarming rates.

As noted in Collegiate Center of Mental Health, anxiety and depression are the top reasons that college students seek counseling, and nearly one in five university students are affected with anxiety and depression. Youth mental health is worsening. Rates of youth with severe depression increased from nearly 6 percent in 2012 to over 8 percent in 2015. And even with severe depression, 63 percent of youth are left with no or insufficient treatment.

In Virginia alone, the suicide rate among children has increased 29 percent in 2016, the highest it's been in 18 years. In adults, one in five adults have a mental health condition, which is over 40 million Americans. There's a

serious mental health workforce shortage. In states with the lowest work force, there's up to six times the individuals to only one mental heath professional, which includes psychiatrists, psychiatrists, social workers, counselors and psychiatric nurses. The agency that I work with in the Stafford-Fredricksburg area, there's currently a two-month waiting list for people who need mental health support.

Licensing our therapists would provide another tier of healers to address the mental health crisis. Also, these statistics are imposing an increasing burden on children's hospitals and pediatricians. As suicide rates have risen in Virginia, Governor Northam has signed legislation calling on state officials to report how they're addressing the problem.

On a personal level, as a registered art therapist, when I moved to Virginia 22 years ago, the lack of licensing made our therapy positions difficult to find. In desperation, I began teaching public high school instead. If I had a license as an art therapist at the time, I could have found work and maybe helped hundreds of people. Art therapy work was hard to find, still is, largely due to the fact that mental health agencies in Virginia are reticent to hire art therapists because of the lack of licensing.

Given the increasing rate of anxiety, depression, trauma, and suicide nationwide and in Virginia, I think licensing our therapists in Virginia would provide

substantially more mental health professionals and better access to mental health treatment for adults, children, and adolescents. Thank you.

MR. WELLS: I apologize. We were running a little bit late, and we have one piece of business we have to take care of. Ms. Carter?

MS. CARTER: In the event of an emergency in which we have to evacuate the building, you can go out that door right there or this door right here, make an immediate right, go across the parking lot into the fence and stand. Sorry. It has happened. We have had calls. This is so you know what to do. Thank you.

MR. WELLS: One other thing that I didn't say is that this is a formal public hearing, but it's also informal. If any members have any questions that they would like to ask any of the speakers as we go, please feel free, and hopefully you all are willing to answer some back-and-forth questions that we might have questions about. Okay. Our second speaker is Gretchen Graves.

MS. GRAVES: Good morning, good morning. I'm Gretchen Graves. I am a credentialed art therapist who lives here in Richmond. I work at the Children's Hospital at MCV. I have been driving this study for a while. I went through and I did find a few inaccuracies in this, and I would like to address a couple of them now, and I will send all of the

inaccuracies that I saw to Miss Lawrence; is that okay?

Okay. Thank you. One of the most important ones that I did notice is on page 8, under credentialing. Can you all hear me? The second paragraph, it states to maintain ATCB certification, art therapists must complete a yearly minimum of six continuing credits. We wish it was 20 per year, which comes out to be a hundred continuing education credits for every five years. And we have to renew our credentialing every five years, and so that is how that worked. And I felt like that was a pretty important piece, because that speaks to how we are monitored under our credentialing.

On page 9, under education, the first paragraph, I think there was a typo or a misunderstanding. The first sentence says education to practice as an art therapist requires a minimum of a master's degree in a program accredited by the Art Therapy Credentials Board. And actually, the programs are accredited by the Education Program Approval Board, which currently is in a five-year transition to have accrediting going external with CAAHEP.

And I apologize, but I don't remember what that acronym stands for. But it is an external accrediting board for educational programs. There were a few other minor details. I will forward those to Miss Lawrence, but those didn't seem quite as important to me as the other thing.

I also want to point out a few facts that recently were uncovered that speaks to art therapists and public protection. In Psychology Today, for example, there are 232 clinicians advertising that they provide art therapy in Virginia. However, only 29 of them, like a tenth almost, were actually credentialed art therapists. So there is a lot of people going out there and expressing that they're doing art therapy, and they're not.

And the thing that is very important about that is that we are trained with certain modalities to use with certain populations. We understand that we're not gonna go use specific materials with, for example, substance abuse people. There's just some materials you don't want to use with certain populations. And if you are not a trained art therapist, you may not understand that, and you could cause a lot more harm than good for your client in the end.

So it's very important, and there was another statistic. Recently, the Virginia Art Therapy Association just did a study of graduates or students -- graduate student survey, and it had 23 participants in it. So one of the questions they said -- that they asked was does the lack of licensure in Virginia pose a barrier in staying in Virginia once you graduate.

Well, out of all those people, 18 of them said yes, they were gonna move out of Virginia to seek states that have

license -- for example -- Maryland has licensure. Washington, D.C. is moving forward with art therapy licensure. North Carolina is moving forward with art therapy licensure. These are pulling very viable, very trained mental health service people out of our state. We need good mental health people in our state. And I think that's all I have to say right now. Thank you.

MS. ORR: CAAHEP is the Commission on Accreditation of Allied Health Education Programs. It's CAAHEP.

MS. CARTER: We're familiar with that organization.

MS. ORR: Great. Thank you.

MR. WELLS: The next speaker is Carol Olson.

MS. OLSON: Hi, I'm Carol Olson. I'm a board certified art therapist and a certified art therapy supervisor as well as several other credentials. And I am also the president of the Virginia Art Therapy Association. There are a lot of people working on this issue to get art therapy licensing in Virginia. I agreed with everything my peers have said. I have been working in this field for a long time.

Right now, very recently, there are concerns that we are trying to get people credentialed, finish their educations, go into practice, provide ethical services that we face in an unregulated field. I think it's time for us to be regulated. We seek that as a group of people, which is

why several of our members are here with us. We want to be engaged more formally in the mental health system. There are a lot of us who have been in practice for a long time.

We face people out there with absolutely no education and no degrees, marketing themselves as art therapists and calling themselves counselors who don't know what they're doing. And we, as a profession, end up then seeing these people afterward, and we have to kind of undo potential damage to the clients. We feel that the popularity of art therapy is rising right now. We hear about it in the news.

It's effective in multiple treatment issues, especially trauma, and we are trying to ensure that the best trained people are providing competent services in particular modalities, and we hope that you will take our application seriously and work with us on this. Any questions?

MR. WELLS: Ms. Olson, walk me through. You said that you were board certified, and you said that you were credentialed; what are you able to do now? What can you do now that differentiates you from me? What is available to you now?

MS. OLSON: Well, in Virginia nothing, that's why we're here. Right. So the National Art Therapy Association, in an effort to help art therapists practice in their states, you know, now offer a national test in what we call board

certification. So we spend, as outlined in our application, hours, just like any other mental health professional.

So I've done the same thing twice. So I've gone through practice for two years under the supervision of an art therapist, and I took a national exam. And I do a hundred hours every five years, 20 hours a years, of additional certification classes to maintain my board certification to allow me to call myself an art therapist.

But in Virginia, actually you could call yourself an art therapist and charge money and see people and do counseling without any education at all, and that's the difference. We would like Virginia to recognize us as a health profession and have title protection, and we could be regulated and address issues of fraud and protect the public.

I would like there to be a difference between us. And I'm an artist too, but I had never called myself a therapist before I went through the extensive degrees and training that I did.

MR. WELLS: So currently there is a national board exam?

MS. OLSON: The Art Therapy Credentials Board does a national test that people take to call themselves art therapists.

MR. WELLS: Are there programs in Virginia?

MS. OLSON: There's Eastern Virginia Medical School

that has an art therapy program, and George Washington University has their art therapy program within Virginia, northern Virginia. We have a few undergraduate programs as well in Virginia. Our field considers entry into the field as a professional after the completion of a master's degree and after supervision.

MR. WELLS: Thank you.

MS. RACKETS: I was curious -- my name is Martha Rackets. I work at a licensed substance abuse agency in Virginia, and I'm curious about what the previous speaker and also what you were speaking to around adding art therapists into the work force in Virginia, and what some of the experience barriers are by your profession in becoming employed in Virginia in agencies, in licensed agencies for mental health or substance abuse or facilities; given that they are licensed facilities and sometimes the requirement is that they're hiring licensed mental health practitioners, and you know, if that is an experience or something that is brought up in your meetings or your profession.

I'm just curious to hear some of the concerns. I know that at the agency that I work at, it is a barrier. We're looking for licensed mental health practitioners, and art therapists don't qualify, unless they have a dual license in something else. So I was just curious if you could speak to that.

MS. OLSON: Definitely. As Gretchen said, you can join me for a few questions. We spend a lot of time as professionals, spend a lot of time mentoring people and supervising them, just to have to watch them move to another state in order to practice. So it is something that we talk about in meetings all the time, is how to keep people in Virginia. For me, when I moved here, I knew I was gonna stay here. I mean, I had to go the extra effort to get another degree and another licensure just to maintain employment here.

So it is a huge factor. We have to have a licensed person. We want art, so they will call and hire a non-licensed person and allow them to do art therapy and, you know, they get around the regulation that way. They still call it art therapy all the time. They can hire that person much cheaper. They have very little training, and generally they don't realize that the staff is gonna have to come in and help that person when you have clients in crisis.

I mean, many factors can happen. Their behavior is not regulated, so they have dual relationships with clients and other inappropriate behavior. They are not regulated. We can't do anything about that, but we have to repair the damage. So we do face losing the work force. I work at an agency now and have a hard time finding counselors for these reasons.

There's a whole slew of counselors in Virginia that would love to work, and they have the appropriate training, and they're under supervision, and they maintain themselves under supervision. We behave like licensed professional counselors. We are seeking education, staying in supervision, and are engaging in supervision as well, and maintaining all of the education requirements that we have.

So we would like to be formalized. We would like to have title protection as part of that. We sent you a list of all the private practitioners who are not art therapists who set up private practice in Virginia, who call themselves art therapists, and we feel they are defrauding the public.

MR. WELLS: Comment or questions?

MR. O'CONNOR: Hi. I am Kevin O'Connor with the Board of Medicine. I am sort of new to this process. So, how many states license art therapists currently?

UNIDENTIFIED SPEAKER: We have the same licenses in seven states, and three states have our license under counseling specialization in art therapy, and then we have title protection, which has been an additional. It's growing.

MR. O'CONNOR: Also, help me understand the intersection or the spectrum between art therapy, music therapy, counseling occupational therapy and physical therapy; tell me how those all intersect. Many people would

say music therapy falls into that as counseling or physical therapy or occupational therapy. So help me understand. If we're going to be licensing art therapists, the next people to be here would be music therapists.

MS. ORR: Well, other than separate lobbying efforts, we see ourselves distinctly. We started distinctly. So we can sometimes be lumped under the realm of what might include art and us, music, dance, theater. So a lot of it is because they are growing out in separate fields, because they are not being regulated. People start associations because states would not listen to us when we're saying like, these particular modalities are extremely effective with working with clients across the range of mental health issues, across the range of ages, across the range of ethnicities.

And so we're watching, you know, just really who creates a lobbying group to push their field forward, and we started as art therapy, and it certainly is a very defined field, and certainly other people are using creative means.

MR. O'CONNOR: I guess that is my point. We are talking about expressive therapy and seeing how that is used for mental health counseling. It's also used, to some extent, for rehabilitation, stroke rehab, that sort of thing. That group is also served by other expressive therapists, and so, why you and why not everyone else?

MS. GRAVES: Well, music therapists are trained and

credentialed differently than art therapists. Music therapists graduate from, I think, even undergraduate degrees. They can sit credentially for a music therapy credential; that is not the same as art therapists.

MR. O'CONNOR: I don't mean to interrupt, but the population we serve is the same. It can be the same.

MS. GRAVES: Yes.

MR. WELLS: So if the purpose is to regulate the service provided to a population, where does that line stop? Where does dance therapy stop? And it could be said that next year we will be regulating dance therapists because they serve a similar population with similar goals.

MS. OLSON: Well, we serve all populations, and we work with many other medical and psychiatric professionals when working with a client. I guess I'm not sure why we would have to be lumped in with them.

MR. O'CONNOR: Well, I'm not putting you on the hot seat here.

MS. OLSON: That's okay, I understand.

MR. O'CONNOR: You lump this all together and call it expressive therapists, and so I have had some experience in northern Virginia where we have a very active art therapy population and a very active music therapy population, and they serve the same population. They do it as inpatient and outpatient. So I'm just trying to wrap my head around why we

should regulate one group that provides this bundle of services and not regulate another or a third.

MS. GRAVES: Well, counselors and OTS and PTs are regulated, am I not correct?

MS. OLSON: They are regulated. So, I mean, we are fine if you regulate music therapists.

MS. GRAVES: Yeah, we're good with that.

MS. OLSON: We're not saying you shouldn't actually. I mean, like she said, it's really different training. We see ourselves different, much like, you know, there are different levels of other types of therapists out there. You know, substance abuse is regulated separately than mental health counseling in that they overlap and tend to, you know, really cross realms sometimes.

We would support music therapy being regulated as well. We're advocating right now within our own. So we don't see it as competitive or different. We see it as complementary.

MS. RAMOS: A quick question. If art therapists were regulated, what is the impact on the work force, and do you have specific numbers? How would that help meet the demand?

MS. GRAVES: I don't know if we have specific numbers at this time. But as I stated earlier about, you know, the projection of students coming out of the two very

large graduate programs that we have in the state, I think that we would retain more licensed therapists in our state than if we didn't regulate. Like I said, deregulate it, they will leave.

MS. OLSON: So you look at these graduating classes, on average, between 25 to 30 people graduate from each school in Virginia. So on average, that's 50 to 60 art therapists graduating each year from schools, as well as the potential of people who go to other art schools -- art therapy schools outside of Virginia that want to come back to practice.

So when we state it that way, you have a force of people who would come out looking for jobs that would go elsewhere, because we don't have the ability to provide them what they need or salary stability. You know, in this realm, it's a mixed bag of what people can expect to earn as well.

MS. CARBAJAL: Speaking about the population that art therapy serves, can you talk to me a little bit about how it serves our seniors, especially those with cognitive impairment. Are there programs that would benefit this certain population?

MS. OLSON: Yeah. Actually that was one of my specialty areas was working with the elderly and dementia. And there have been a couple of times I've been able to work on special grants within the population, and I would love to really formalize that service for the various agencies.

Art therapy is a great way of working with those with dementia and other aging-process issues. Actually, I made a small film about it. I will send it to you. Because it can help with orientation. It can help with different family issues. I have done a mix of different ways of using art in helping the elderly.

And, you know, I have worked in programs outside of Virginia as well in rehabilitation. So it's a very effective means with other modalities as well. So it would be a great way to, you know, expand the ability of working with the elderly in a very broad population. It is a very effective means of working with them.

MR. CARBAJAL: So you view yourself as working in nursing homes?

MS. OLSON: Yes.

MS. SAADEH: Hi. My name is Leila Saadeh. I am the vice president of the Virginia Art Therapy Association. I just wanted to speak with you, Dr. O'Connor; is that okay? I would just hate for art therapy to be bundled up into dance therapy, music therapy, because we are, in fact, very different. The only thread of similarity is that we come from an art space practice. So art therapists are trained as psychotherapists. We have the same training as LPC counselors -- anyone who wants to be a psychotherapist.

In my experience in working with music therapists,

we are very different. They don't have the counseling in the psychotherapy, psychopathology, training, and education.

MS. OLSON: They have a bachelor's degree, is that correct?

MS. SAADEH: Which is different. So I just want to make that clear with you. I know that dance, music, art is very expressive, but we are actually very different. And that also ties in with the populations that we serve. We can serve anyone who has a mental health diagnosis, a chronic illness diagnosis. Autism is extremely valuable, which as we all know, is increasing in numbers, and there's a huge need for professionals who serve that population.

So I won't keep talking about all the people that we can serve, because we can really serve anyone who needs any sort of help. As where other expressive therapies are a little bit more limited, but I can't speak to you on that. I appreciate it.

MR. WELLS: Is there anyone else who wishes to speak who is not on the list? Yes, ma'am.

MS. MILLS: Good morning. My name is Ann Mills, and I am a registered and board certified art therapist. I work in Alexandria, Virginia. I am licensed in the District of Columbia, Maryland, and New York. I am the former chair of the Research Committee, former chair of the Nominating Committee, the former director of the graduate program in Art

Therapy at George Washington University.

I am unable to work in Virginia. I am a proud Virginian, and I would like to work in Virginia. I have an example of harm done to a patient by a non-art therapist, an example that has been repeated any number of times over the 30 years of my career. I am a trauma therapist. I specialize in trauma therapy.

I have been approached by allied mental health professionals who will say well, I had this or that clinical challenge with a client, and I didn't know what else to do. So I got out some letterhead and gave them a pen and asked them to draw what happened, draw some horrible, traumatic event.

So a specific of one of those was a survivor of severe trauma became mute and unable to speak. She then drew it for her therapist, not an art therapist, on letterhead. And then the mental professional showed me a picture and asked for sort of a curbside consult on it. And then after she drew this, she withdrew and hid in a corner and started banging her head. The patient started banging her head against the wall and seemed not to hear me when I begged her to stop.

So eventually, I put a pillow between her head and the wall, and that is how the session ended. And what would you have done as an art therapist that would have been

different? So I find this appalling. I am very concerned that this kind of thing happens to clinicians when they get stuck, and this is where we would hold as art therapists that we would receive appropriate referrals due to practices that are inherent in our profession and the characteristics of the clients we serve as outlined on page 8 of the report.

This is the kind of thing where we feel we have something special. We know we have something special to offer in our hands, our skilled hands. We can help people. It's a powerful tool, visual arts. As you know, it can retraumatize people in untrained hands. Sometimes people work beyond their areas of competence and their scope of practice. We don't want them hurting people.

My private practice is in the District of Columbia. I was grandfathered in as an LPC. But then just for fun, I took the national counseling exam, just to kind of have that legitimacy as well and passed that. Two-thirds of my practice is people who live in Virginia. People seeking referrals to art therapists call me weekly because they want help for daughters who are dieting themselves to death, or husbands whose explosive anger has caused them to be fired.

In Virginia, a licensed art therapist should be able to help with support, and with your support, we will. I wanted to also mention that I am also a researcher as well as a clinician.

I am the director of the archive of the International Collection of Drawings, standardized drawings. Our policy is that only mental health professionals and art therapy students may administer this particular assessment. We do not allow artists and lay people to administer this assessment.

I would like to say a word about CAAHEP. CAAHEP for me personally would impose the impossible. It's already an impossible standard for me to become an LPC in Virginia. CAAHEP would make it that much more difficult. Thanks very much. Any questions for me? Thank you.

MR. WELLS: Is there anyone else who would like to speak or respeak?

MS. GRAVES: We're all art therapists. We come from all over the state, and this is a small, small spattering of what we have. Last time, the American Art Therapy Association put together our numbers, we estimate there's at least 300 or greater art therapists in our Commonwealth that we know of. Only that we know. There's probably many out there. But without things like licensure and stuff, they may not come out of the woodwork and join the associations and things like that.

MR. WELLS: Thank you.

MS. GRAVES: Thank you.

MR. WELLS: Okay. I want to thank all of who came

today and took time to comment. We will consider all of the comments prior to submitting any recommendations. Written comment will be accepted until 5 p.m. on July 27, and this concludes our hearing this morning.

HEARING CONCLUDED

CERTIFICATE OF COURT REPORTER

I, DENISE HOLT, hereby certify that the foregoing hearing was taken down by me in stenotype and therefore reduced to typewriting; that I am neither related to, nor employed by any of the parties to which this public hearing was taken; and further, than I am not a relative or employee or employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

Given under my hand this 26th day of June, 2018.

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Denise Holt

0315066

Art Therapist Study - Public Comment Summary

	Credentials	Resides In	Works In	State License	Decision - In Favor or Opposed	Summary
1	Gioia Chilton, ATR-BC, PhD, LCPAT (MD), CSAC (VA)	Fairfax County, VA	Maryland	MD	In Favor	Has worked in DC for 25 years with people with mental health needs. Over the past 18 years has seen harm to the public due to lack of licensure in VA. Is licensed and works in MD as a LCPAT, unable to serve Virginia residents due to lack of license.
2	Emery Mikel, ATR-BC, LCAT, LCPAT	New York City	NY	NY, MD	In Favor	Licensure will safeguard against potential harm to clients by untrained clinicians. Founded creative arts therapy company in NY. Would like to expand to VA, creating employment opportunities and access to therapy, lack of licensure in VA for art therapists prohibits this.
3	Darlene Green, ATR-BC		Charlottesville, VA		In Favor	Works as an art therapist for a children's grief program and with hospice patients; paid by community donations. Licensure would allow art therapists to be reimbursed by Medicaid, Medicare or private insurance.
4	Kacie Karafa, Board Certified, Master's Level Art Therapist				In Favor	Works at a hospice with grieving children. To open up a private practice would need to go back to school and get a LCSW or LPC. Lack of licensure limits where and how to practice art therapy since unable to be reimbursed by private insurance, Medicaid or Medicare, limiting clientele to those who could afford to pay out of pocket.
5	Abby Calisch, ATR-BC, PsyD, LPC	Norfolk, VA	Virginia Beach, VA		In Favor	Licensed counselor and registered board certified art therapist in a group private practice, also teaches graduate art therapy classes at ODU and in Indiana. Graduates leave Virginia due to difficulty in finding employment as unlicensed graduate trained therapists. Licensure would allow graduates to stay, expanding the profession, providing more access to care and affordable services.
6	Cheryl Shiflett, ATR-BC, PhD, PPC-ACS, ATCS	Virginia Beach, VA	Virginia Beach, VA		In Favor	As an art therapy instructor, highly trained art therapy students are able to provide ethical, professional and effective mental health services to Virginia's vulnerable populations. Licensure will allow them the opportunity to so serve those in need.
7	Monika Burkholder, MS, Resident in Counseling, Art Therapist	Shenandoah Valley, VA	Shenandoah Valley, VA		In Favor	Employed at a private art therapy practice, working with people dealing with trauma. Clients frequently unable to access services or stop treatment early due to inability to get reimbursement for services. Without licensure, cannot provide art therapy to people who need it the most.

Art Therapist Study - Public Comment Summary

8	Kendra Orr, ATR-BC, MS	Spotsylvania, VA	Virginia		In Favor	Moved to Virginia 22 years ago as a registered art therapist, lack of licensure made art therapy positions difficult to find so went into teaching. At present, only part time art therapy work is available due to reluctance of mental health agencies to hire unlicensed art therapists. Licensure would provide more mental health professionals, better access to mental health treatment, and protect careers of current art therapists.
9	Lisa Garlock, ATR-BC, MS, LCPAT, ATCS	Maryland	Virginia	MD	In Favor	Working in Virginia, lives in Maryland and holds a Maryland art therapy license. Licensure in Virginia would ensure that qualified, licensed art therapists will be able to work with Virginia residents, particularly trauma survivors, in need of mental health services.
10	Rebecca Tom, PMHNP-BC		Virginia		In Favor	As a psychiatric nurse practitioner who works with an art therapist believes licensure for these essential clinicians would improve patient safety and outcomes.
11	Jorge Grandela, LPC, PsyD		Stafford, VA		In Favor	Licensure of art therapists will provide an opportunity to measure the benefits of art therapy and help meet the need for trained mental health.
12	Sonia Castro-Castillo, Candidate, Master of Arts in Art Therapy		Fairfax County, VA		In Favor	Recent graduate of a credentialed art therapy program. Mental health profession employers are looking for licensed individuals. Without licensure for art therapists anyone can provide therapeutic art services, increasing risk of harm to the client. Licensure will allow those in need of art therapy to be reached.
13	Catherine Rubin, ART-BC, MPS				In Favor	Licensing art therapy would allow people to receive the services they need and protect both potential clients and art therapists from the harms of unqualified people presenting themselves as art therapists and qualified mental health professionals.
14	Terri Giller, ATR-BC, MeD; Secretary of VATA		Fredericksburg, VA		In Favor	Has practiced art therapy for 11 years and worked in four (4) states. Licensure is necessary to define appropriate standards for the practice of art therapy and ensure that the public has access to art therapy services provided by a trained and licensed art therapist. Licensure would help Virginia build and maintain a viable mental health workforce by recognizing, attracting, and retaining these highly trained health professionals.

Art Therapist Study - Public Comment Summary

15	Holly Waide, 2nd Year Student at EVMS, Graduate Art Therapy and Counseling Program	Virginia			In Favor	2nd year student at EVMS in the Graduate Art Therapy and Counseling program. Licensure will be a huge benefit to Virginia and the field of art therapy in establishing guidelines and ensuring that the power of creative expression is being used properly with the knowledge of a trained professional, elevating credibility and spreading awareness.
16	Peggy Healy, ATR-BC	Midlothian, VA			In Favor	Licensure will help protect art therapists and educate other health professions as to what art therapists do as a credible, valuable member of the Virginia mental health workforce. *Reported by a psychologist to the regulatory board, accused of doing the job of a psychologist when using projectives as a testing tool. Case was dropped.
17	Crista Kostenko, ATR-BC, LCPAT	Arlington, VA	Arlington, VA	MD	In Favor	Licensed in Maryland as a Licensed Clinical Professional Art Therapist, works in Virginia. It is vital that any individuals representing themselves as art therapists have the knowledge and understanding of how art making and processing affects individuals with a variety of issues. Seeking out art therapy for mental illness should be supported and individuals should be able to submit to insurance art therapy received by a professional art therapist.
18	Adele Stuckey, ATR-BC, MA, LPC		Alexandria, VA		In Favor	Art therapists are clinically trained to work with clients of all ages and work in community, medical and private settings throughout the state. Art therapy goals range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities to relieving stress and anxiety.
19	Janna Kilkki, ATR-BC, MA	Haymarket, VA			In Favor	Art therapy licensure in Virginia would ensure that more qualified mental health services would be available for Virginians. Art Therapists have difficulty establishing careers and contributing to communities equally due to lack of licensure. The scope of practice and usage of the term "art therapy" is ambiguous and sometimes used by people who do not have qualifications, due to not having art therapy specific licensure.
20	Kristin Gartner, LPC		Stafford, VA		In Favor	Art therapy has shown to offer not only an effective avenue for emotional expression but a healing that talk therapy cannot always achieve. All licensed practitioners at this location are at full capacity caseloads and the ability to hire more licensed mental health professionals would be beneficial to a multitude of clients.

Art Therapist Study - Public Comment Summary

21	Anne Walpole, MSN, NP		Virginia		In Favor	A nurse practitioner with over 30 years experience sees many patients with mental health issues, both chronic and acute. Art therapists should be licensed to clarify to both insurance companies and potential clients that they are fully trained counselors worthy of professional respect and reimbursement.
22	Stephanie Houpt, Assistant Program Director, Insight Memory Care Center		Fairfax, VA		In Favor	Art therapy at Insight has been an important part of offering holistic and person-centered care. Individuals with depression, anxiety, or who are socially withdrawn benefit from art therapy sessions. The intentional goals of the art therapist is to enhance the participants quality of life.
23	Emmy Lou Glassman, ATR-BC, MA		Fairfax, VA		In Favor	The unique field of art therapy requires completion of a highly rigorous academic program which includes a comprehensive internship experience spanning a variety of settings. The field is unique because it combines the properties of both creating art as well as the rich and layered therapeutic process. Using art as a tool for communication and expression provides healing for many who may need a bridge to their unconscious or traumatized minds. The art can become the clients dialogue. By offering licensure to trained and attained art therapists the public will be able to be made aware of their qualifications.
24	Sarah Deaver, ATR-BC, PhD, HLM		Norfolk, VA		In Favor	Has worked as an art therapist for 37 years, first as faculty at EVMS with the graduate art therapy and counseling program and now in private practice. Testified in 1990 to the Board of Counseling for the need for a standalone professional art therapist license, Board determined that art therapist could obtain LPC, therefore no need for a separate license. Art therapists are not counselors as art therapy is a distinct profession with its own unique scope of practice, education and credentialing. There is a great need in Virginia for more qualified mental health professionals and art therapists are qualified to address these needs. *Attachments - 2
25	Christina Hagemeier, Graduate of GWU Art Therapy Program		Fairfax County, VA		In Favor	Recent graduate of GWU art therapy program, with a one year internship with and now working in Fairfax County public schools. Art therapy provides cognitive growth, emotional support and behavioral regulation to help a student participate, thrive and excel in the classroom. Many students respond well to this form of therapy as they do not need to talk or possess the words needed to describe what they are experiencing.

Art Therapist Study - Public Comment Summary

26	Lacy Mucklow, ATR-BC, MA, LPAT, LCPAT, ATCS	Springfield, VA	MD	MD	In Favor	Had to look for work in another state that had a clinical art therapy license, which is miles away from home and takes away from seeing Virginia clientele. The Virginia art therapy license needs to be a clinical license with the ability to diagnose and bill for insurance, like that of other master's-level mental health providers, protecting the public and retaining art therapists who live in Virginia.
27	Donna Betts, ATR-BC, PhD; Immediate Past President of AATA; Adjunct Associate Professor GWU Graduate Art Therapy Program	Virginia			In Favor	As Board Chair and President of the AATA from 2015-2017, the AATA worked closely with the British Association of Art Therapy (BAAT) where art therapy is nationally recognized through the National Health Service. In Virginia, graduates of GWU graduate art therapy program often move to Maryland, or another state that offers licensure, after degree completion. *Attached is relevant resource information from BAAT regarding harm.
28	Janet Johnson, Retired Principal, Fairfax County Public School	Fairfax Station, VA			In Favor	The licensure of art therapists will ensure that individuals in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational and credentialing requirements. Disciplinary action could be taken against an art therapist for failure to adhere to the professional ethics in art therapy settings. Provisions allowing for licensing reciprocity between states could encourage qualified art therapists to work in VA.
29	Anne Mills, ATR-BC, MA, LPC, LCPAT; Former Chair of AATA Research Committee and former Director of a university Master's program in Art Therapy	Virginia	DC	DC, MD, NY	In Favor	Licensed counselor in DC private practice for 3 decades, unable to work in Virginia as an art therapist due to lack of licensure. More than two-thirds of clients live in Virginia. Would move practice to Virginia if licensure were available. Harm is being done to clients as a consequence of someone introducing art into their treatment without proper training.

Art Therapist Study - Public Comment Summary

30	Carol Olson, ATR-BC, MA, LPC; President VATA; Crisis and Clinical Director of the James House; Clinical Supervisor in Richmond, VA; Certified Substance Abuse Counselor	Virginia	Richmond, VA		In Favor	Manages agencies that hire therapists. Has a hard time retaining art therapists due to lack of licensure and lack of consistent pay-scales appropriate for their level of education that result in lack of opportunities for professional growth. It is time for Virginia to join the 12 other states that currently provide an avenue for art therapists to pursue a license specific to their qualifications, scope of practice, standards of practice and ethical code.
31	Karen Montgomery, MSW, LCSW		Winchester, VA		In Favor	As an LCSW has worked in the past with an excellent art therapist LPC candidate whose ability to have less verbal children and teens express themselves openly through various art mediums was amazing and extremely helpful in her therapy work with them. Hopes the Board will do what is needed to see that these creative and valuable clinicians are able to continue to work to benefit the public in a wide variety of settings, such as the Integrative Care Program at Shenandoah Oncology that offers art therapy as part of patient services.
32	Mary Ellen Ruff, ATR-BC, MS, LPC, ACS	Alexandria, VA			In Favor	Serves as an Approved Clinical Supervisor for the LPC. Some supervisee's have a Master's in art therapy and some with a Master's in Counseling. At times Residents have been part of a group supervision format and have mutually benefited from their diverse training and educational experiences, creating a richer, more meaningful experience. In a recent supervision group, someone from a counseling background talked about how much she learned from being in a group with art therapists and that she had incorporated art techniques into her work with clients. While counselors may incorporate creative or expressive arts into their work, this supervisee was operating outside her scope of any training she had received. State licensure for Art Therapists would prevent situations such as this from arising because it would support independent practice, title protection, and protect the public from those practicing outside their scope.

Art Therapist Study - Public Comment Summary

33	Sangeeta Prasad, ATR-BC		Fairfax, VA		In Favor	Has worked in the field for 33 years. Currently in private practice and feels there is a need for art therapists to be licensed. Art therapy is a useful tool for PTSD and during disaster relief. Clients need to be protected from persons claiming to provide art therapy when they do not have the required training or skills to offer such services. Art therapy is not covered by Medicare, Medicaid or other insurances.
34	Jordan Potash, ATR-BC, PhD, LCPAT (MD), LCAT (NY)		Alexandria, VA	MD, NY	In Favor	Has been serving Virginia residents as an art therapist since 1998. Currently an Assistant Professor in Art Therapy at GWU. Art therapy offers a unique combination of psychology with the arts that promotes imaginative expression and metaphoric perspective. With the increased need for licensure, it has become more difficult to make sure that clients are able to partake in the full benefits that art therapy has to offer.
35	Elizabeth Hlavek, ATR-BC, LCPAT	MD	MD	MD	In Favor	In 2012, led the initiative to develop an art therapy license in Maryland, which was signed into law later that year. Sits on Maryland's Board of Professional Counselors and Therapists as an art therapy representative. Art therapy has proven to be a valuable treatment option for veterans, individuals struggling with PTSD, eating disorders, and myriad other medical and behavioral health concerns. These populations exist in Virginia and deserve evidence based treatments such as art therapy. Considered relocating to Northern Virginia for a full time position, but is not licensed in Virginia. Had there been an equivalent license in Virginia would have happily moved. Perhaps EVMS art therapy graduates would stay if they were able to be licensed.
36	Lindsay Downs, In residence towards ATR-BC	Manassas, VA	Manassas, VA		In Favor	Currently in residence towards ATR-BC and works as an in-home clinician to prevent out-of-home placement and psychiatric hospitalization. Has found that non-art therapists are ill-informed about the creative process, how and what materials are used in session and are unaware of ethical considerations when engaging with clients on sensitive subject matter incorporated with art making and the creative process.

Art Therapist Study - Public Comment Summary

37	Michelle Vaughan, ATR-BC		Leesburg, VA		In Favor	Is a registered board certified art therapist working in Virginia, undergoing the supervision process for LPC licensure. Without the education, experience and knowledge, regular clinicians who are not art therapists attempting to provide "art therapy" may try to analyze an individuals artwork and project their own identity or feelings into the piece or conduct an assessment that's not appropriate for the individual and could lead to the resurfacing of traumatic flashbacks, negative feelings or cause them to develop a sense of low self-esteem. There are so many potentially harmful responses that its obvious why art therapy needs to be a regulated and licensed profession in Virginia.
38	Gretchen Graves, ATR-BC, MS, CDATA; Immediate Past President of VATA	Richmond, VA	Richmond, VA		In Favor	There are many professionals that are claiming to also practice art therapy without proper training, which can be detrimental to clients. Mental health is such a serious issue in our country and state. Lack of qualified health professionals should never be the reason someone suffers. Help us create more opportunities for client safety and jobs in our state. *8 attachments
39	Paul Eldridge, Technical Program Manager		Herndon, VA		In Favor	Art therapy is a distinct mental health profession and needs its own license as a distinct field from the general LPC path. It takes years of unique study and can have negative consequences if employed halfheartedly or incorrectly, without proper training and ethics. A license provides the necessary minimum bar and rigor to prove to a layperson that Art Therapist's competency, just as the LPC provides.
40	Heather Stemas, ATR-BC, MEd, LCPAT	Arlington, VA		?	In Favor	Has been an art therapist in a large metropolitan medical center for over 15 years and has seen the multitude of benefits of art therapy for children and teens with chronic illness and/or facing invasive and painful procedures. Many clients want to continue with art therapy services after discharge but there are few options as they have to deal with prohibitive costs (and no reimbursement) and a paucity of qualified and licensed providers.

Art Therapist Study - Public Comment Summary

41	Joyne Vaughan, Retired Teacher, Fairfax County	Fairfax County, VA			In Favor	Daughter is an art therapist who clinically assesses a client's mental health needs and determines which art media to use in order to support mental, emotional, physical and spiritual goals for them. Daughter assisted in designing and implementing a program where she works with veterans, active duty military and their families who experienced PTSD among other mental health issues. The art therapists goal is not to create a famous artist, rather they implement different media of studio art, psychotherapy and counseling to guide their client toward a healthier view of life. Urges for a state art therapy license to be required in Virginia for quality treatment.
42	Heather Montgomery, Library/Community Service Manager		Richmond, VA		In Favor	Has worked with art therapists at various agencies, most recently in the juvenile justice system. A state art therapy license is needed to protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational and credentialing requirements.
43	Erica Wang	Former VA resident			In Favor	Pursuing a Masters of Art Therapy and Counseling at the School of the Art Institute of Chicago. Upon completion of degree plans on returning to VA in order to serve the citizens of the state.
44	Kimberly Faulkner, ATR-BC, LCAT(NY)	Prince William County, VA	Prince William County, VA	NY	In Favor	Has over 13 years experience as a licensed art therapist in NY. Relocated to Virginia and is struggling to re-establish professional life as clinics and other mental health agencies will not hire her due to lack of license in Virginia. With appropriate state licensure in place her service and expertise would compliment many forms of treatment and countless people would have access to the care they deserve and are asking to receive.
45	Karen Montgomery, MS-ATR	Richmond, VA	Richmond, VA		In Favor	Received Masters in Counseling in 2003 in NY and returned to VA. Often regrets leaving NY due to recognition of art therapy as a distinct mental health profession with licensure status. Currently working for Henrico County Public School system in Henrico Juvenile Detention Home, as well as with other clients. Wants to stress that trauma-focused interventions present an area of therapy in particular need of non-verbal approaches to both accessing and treating deep psychic pain and managing new and healthier life skills. Has been concerned about the appropriateness of art therapy techniques used by those untrained to handle and unforeseen responses to the approach with a struggling client.

Art Therapist Study - Public Comment Summary

46	Leila Saadeh, ATR-BC, LPC; Vice President of VATA	Richmond, VA	Richmond, VA		In Favor	Believes title protection is most necessary reason for art therapists to obtain their own licensure. There are a great number of mental health professionals and artists in VA that claim they are doing "art therapy" recklessly and unethically without any proper training and education. This causes significant risk of harm to the population that need mental health treatment. Just because people can make art does not mean they can administer art therapy. As education and internship requirements are equal to LPC education and internship requirements, this is no reason why art therapists should not be able to be considered to obtain their own license under the Board of Counseling.
47	Christianne Strang, ATR-BC, PhD, CEDCAT-S; President, American Art Therapy Association				In Favor	Writing on behalf of the AATA to express the Association's strong support for regulation and licensure of art therapists in VA. Licensure can provide a reasonable and cost-effective approach for increasing the number of qualified and licensed professionals needed to meet Virginia's growing need for mental health and substance abuse services, benefiting consumers by promoting competent and safe practice of art therapy, and providing assurance that persons in need of art therapy services will be able to receive them from appropriately trained and credentialed mental health professionals.
48	Laura Dobbs, Credentialed Art Therapist		Virginia Beach, VA		In Favor	Has been working in Virginia in the mental health field for 16 years since graduating with a master's degree in art therapy and counseling from EVMS in 2002. Has struggled to gain respect as a professional art therapist as well as find another job due to lack of licensure as an art therapist and therefore not billable for insurance companies. Is continuing to pursue counseling licensure as an LPC in Virginia. A state art therapy license means employment opportunities would improve as well as the retention of qualified art therapy professionals in Virginia.

Art Therapist Study - Public Comment Summary

49	Sarah Balascio, Board Certified, Registered Art Therapist		Williamsburg, VA		In Favor	Board certified art therapist working in Virginia. Worked in private practice as an art therapist until a complaint was filed by another therapist alleging that she was working as a counselor without a license. This caused a hardship for her family as well as her clients. Showed that there is a need in VA as clients chose not to continue with traditional therapy and there were minimal registered art therapists to refer them to. Has seen proof from this experience that there is a clear distinction between traditional therapy and art therapy which needs to be clairified in Virginia, as other states have, through
50	Eileen Douglas, ATR-BC, MS, LPC	Norfolk, VA			In Favor	Has practiced art therapy for eight years and is currently teaching in the Graduate Art Therapy and Counseling Program at EVMS. As a practitioner has witnessed the benefits of art therapy in engaging and supporting positive growth among adolescents in juvenile detention as well as a quasi-military type program for at-risk youth. Has also provided art therapy services to students in a college counseling center. The citizens of Virginia would benefit greatly from the establishment of a state license for professional art therapists.
51	Laura Tuomisto, ATR-BC, CTT; Delegate to the Assembly of Chapters on the Board of the VATA	Virginia	Virginia		In Favor	Founded and manages a 2-art therapist private practice, which has stayed active despite the limitations of clients not being able to use their insurance (due to lack of licensure). Without title protection or a license, anyone can open a practice and claim to be providing art therapy services without the proper training, education and supervision. This, by default, puts the responsibility on clients to research and identify if their therapist is properly trained and credentialed, which is not fair to a population that may be vulnerable due to their mental or physical health and may not have the resources to protect themselves in this way. *2 attachments

Gioia Chilton, PhD, ATR-BC, LCPAT, CSAC
9314 Fairfax Street
Alexandria, VA 22309

Laura L. Jackson
Virginia Board of Health Professions
9960 Mayland Drive, Suite 300
Richmond VA 23233-1463

Dear Laura L. Jackson and the Virginia Board of Health Professions,

I am writing in my capacity as a Virginia resident and art therapist to support the effort to create licensure in Virginia for art therapists. I am a registered and board certified art therapist who has worked with people with mental health needs throughout the metro DC area for twenty five years. I hold a Ph.D. in Creative Art Therapy and recently co-authored a book on art therapy.

In my 18 years of living in Fairfax County, Virginia, I have seen harm happening to the public in several ways due to the lack of art therapy licensure. For example, I worked in Fairfax County Public Schools under a provisional teaching license with children with emotional disabilities but had to leave after 3 years because they would only employ those with teaching licensure. Teachers are not art therapists, art therapists have a specialized and unique skill set. Children with mental health needs who could benefit from art therapy services therefore do not often receive it due to the lack of art therapy licensure.

More recently, I worked for a substance abuse residential teaching facility providing art therapy. I was on the front lines of the battle against the deadly disease of opiate addiction. Several young clients told me they found that art therapy was one of the most powerful modalities they experienced in fighting addiction. Older clients with alcoholism said that it surprised them but they too found art therapy effective in breaking through denial. I saw many instances of clients creating artwork indicating a breakthrough in their treatment or indicating they were at risk for relapse. This vital clinical information could not be conveyed to the treatment team without an art therapist on staff.

Clinicians unskilled in art therapy can try to provide art activities to clients, but will miss this additional critical clinical information that only those with advanced training in art therapy notice. There is a difference between art for recreation and art in the context of therapy. It's not the same. In addition, clients can actually be triggered to use illegal substances through the unskilled use of art materials (such collage images which show people drinking alcohol). However, often treatment centers, hospitals, and mental health clinics employ only licensed professionals due to insurance requirements and regulatory limitations. Therefore licensure for art therapy is needed.

Often my Virginia friends and neighbors ask me to refer them to an art therapist for their or their children's mental health needs. Due to the lack of licensure, when I do so implore them to confirm the person has a master's degree in art therapy, and has national board certification, as I

have heard of people who are not art therapists using and mis-using art making in therapy with negative effects. However, while a master's degree in art therapy and national board certification are some indicators of competence, they do not regulate practice like an actual license.

Finally, I personally have been unable to find work in Virginia relative to my skills in the area due to lack of licensure. Obviously, I would rather use my skills in my own state so I spent time, money, and effort to cross-train to achieve some sort of licensure in Virginia. I now hold a CSAC, Certified Substance Abuse Counselor license, however this turns out to be very unsatisfactory because it can be achieved without a Master's degree and thus has limited earning potential. I am overqualified for any CSAC job. When I was offered a counseling job at Prince George's Community College in Maryland due to my Maryland licensure as a LCPAT, Licensed Professional Clinical Art Therapist, I was able to earn over $70,000 and so I now work in Maryland. I hold considerable skills in a unique skill set as an art therapist trained in substance abuse treatment so this is a loss for Virginia citizens I no longer serve.

For these reasons, I urge the Virginia Board of Health Professions to enact an art therapy license.

Sincerely,

Gioia Chilton, PhD, ATR-BC, LCPAT, CSAC

Water & Stone
A Creative Arts Therapy PLLC

Dear Laura L. Jackson and the Virginia Board of Health Professions,

I am writing today to highlight the importance of having licensed professional art therapists in Virginia. Creating this license will safeguard against potential harm done to clients by untrained clinicians, claiming to be art therapists and regulate the use of art therapy for the better throughout the state.

Personally, I have been an art therapist for over 10 years and grew up in Virginia. My parents and friends are still in the state and I am connected to George Washington University's graduate art therapy program as a guest lecturer, so return to the area multiple times a year. Currently, I reside in New York City and 3 years ago, I founded a creative arts therapy company that now has 3 locations throughout NYC with plans for an extension up in Rochester within the next year. We serve hundreds of clients annually and that number is growing. Some of the areas we focus on include dementia, Alzheimer's, anxiety disorders, grief/loss, hospice/end-of-life, adults with developmental disabilities, cancer, and more.

Over the past 3 years my dream has always been to expand my company and all its services to my home state of Virginia, creating employment opportunities and access to therapy for many people. However, every time I evaluate how this could be accomplished, the lack of licensure in Virginia, specifically for art therapists, stops me. Since I am currently licensed in both New York and Maryland it always ends up making much more sense that I expand to Maryland instead of Virginia, where my profession is not recognized or protected.

I would jump at a chance to be licensed in Virginia and know many others who would as well. While this profession overlaps in some areas with professionals who get their LPC, there are many unique aspects that require a different set of regulations, knowledge, and understanding.

Thank you for the opportunity to share my perspective and please be in touch if there is anything further I can offer.

Sincerely,

Emery Mikel
Water & Stone, Founder and Director

www.creativelyhealing.com (703) 402-4515 info@creativelyhealing.com

Office Locations
Lower East Side, NYC Union Square, NYC Dumbo, Brooklyn

From: Darlene Green [mailto:bd2green@gmail.com]
Sent: Friday, July 6, 2018 8:59 AM
To: laura.jackson@dhp.virginia.gov
Subject: comments on art therapy licensure

July 6, 2018

Dear Virginia Board of Health Professions:

I decided to become an art therapist in my 50's as a second career after spending the first 30 years working as a programmer/analyst. I spent over three years getting my masters in this field and when I got close to graduation I began looking for a job in the Shenandoah Valley area. I was dismayed to find out that our state did not provide licensure for art therapists. When I spoke to the Community Services Board, I was told that they could hire me if I had my LPC, but they could not hire me as a master's level therapist because I was not licensed and therefore they could not be reimbursed by Medicaid. The only option if I wanted to work there was to take a job that only required a bachelor's degree and obviously the pay for that job was greatly reduced and that made it unsatisfactory, especially considering the great cost it took to get this education.

A second employment opportunity I sought was at the Commonwealth Center for Children and Adolescents. I had worked there as a volunteer and did some of my art therapy practicum hours there while in the art therapy program. I was told a similar story, I could be hired as part of the recreational team, but it was a job only requiring a bachelor's degree.

Thankfully, a job opened up at Hospice of the Piedmont where I had done some of my internship work. I am now one of three art therapists working with children who are grieving a loss of a loved one. All of our work is paid for by donations from the community, therefore it was not a problem that Medicaid would not reimburse our time. We also work with those hospice patients who are interested in spending some time doing art. With our children's grief program, we serve all children in the community, whether or not their loved one was one of our hospice patients. There are other children outside of our community who are not getting services because we are one of the few hospices in our area that provide art therapy to grieving children. If art therapists are able to become licensed, this would open up art therapists being able to work in any psychology/counseling group and they could then provide services to children (as well as grieving adults). Right now, art therapists would not likely find employment as a therapist in one of these groups because without a license they cannot be reimbursed by Medicaid, Medicare or private insurance.

I hope the board sees the importance of recognizing art therapists as a separate therapeutic modality and allow them to become licensed. There are other reasons why licensure is important but I wanted to share those that have personally affected me. Thank you for your consideration.

Sincerely,
Darlene C. Green, ATR-BC
Darlene Green
540.885.7585

Laura Jackson

From: Kacie L. Karafa
Sent: Monday, July 9, 2018 3:20 PM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapy License

To whom it may concern:

I am a board certified master's level art therapist and have been practicing for 17 years with grieving children. I work at a hospice and am able to do my work without a license without any difficulty from my employer. However, if I wanted to start my own private practice, I wouldn't be able to be reimbursed by private insurance, Medicaid, or Medicare therefore limiting the clientele to only those who could afford to pay out of pocket. The only way around this would be to go back to school to get a LCSW or a LPC which I am in no place in my life to do, or pair up in a practice with a licensed clinician.

Because there is no art therapy license, I am limited in where and how I can practice.

Please support the bill to allow art therapists to be licensed like any other health care or counseling professional.

Thank you,
Kacie

Kacie Karafa
Journeys Art Therapist
Hospice of the Piedmont
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Connect with us on Facebook!

To Whom it may Concern,

My name is Abby Calisch Psy.D, LPC, ATR-BC and I am a licensed counselor and registered board - certified art therapist in a group private practice located in Virginia Beach, Virginia. I also teach graduate art therapy classes at ODU and a college in Indiana. I moved to Norfolk 10 years ago as the Director of the Graduate Art Therapy & Counseling Program at EVMS. Due to the excellent reputation of the Art Therapy program and its lengthy existence, in Virginia, I had assumed there would be many art therapy graduates who had employment and experience since their graduation and thus be able to offer internships or supervision. Unfortunately, many grads have left the area due to difficulty finding employment as an unlicensed graduate trained therapist. I know that some have moved to Maryland, Kentucky, Texas, New Mexico, or NY, PA. to get licensed. It is unusual for a region that has 2 **well known** graduate art therapy programs (EVMS & GW) to not have perpetuated employment and integration of their graduates more into the fabric of Va. healthcare. Other states that have graduate programs tend to proliferate jobs and opportunities as the graduates move into their professional status.

In the past 10 years some grads have been able to get their license LPC as a counselor in VA which has opened many varied employment opportunities. However, recent changes in LPC requirements now makes that license no longer available for an art therapist who has graduated since 2016. Art Therapists must meet the same types of educational criteria, standards, ethics, training and supervision as other mental health professionals such as social workers, counselors, and mental health practitioners and as such should be regulated for the public.

I fully support the licensure efforts of art therapists in Virginia and advocate for the safety of Virginians by establishing a state art therapy license. As a mental health professional, I am dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Experiences with <u>non-art therapists</u> who do not have the same training and knowledge to do what an art therapist does --- such as knowing about toxic supplies or cross contamination of material

An incident at a children's hospital unit where a child life employee was using art materials with a child at bedside. The child had severe respiratory issues and the therapist was using chalk pastels which would be contra indicated for ANY respiratory problems. Another incident where a pt. was on high infection precautions and the "art person" was bringing in used materials and taking those out to reuse.

Many times, military & families want to work with an art therapist because they had the services while in the psych hospital, but it is not available to them because it is not covered. Art therapy research and services are showing that it is uniquely effective with PTSD and the types of cumulative trauma that are rampant in our neighborhoods and society but the services. Yet art therapy as a stand-alone service is not frequently available.

As stated before, many art therapy grads leave the state to get licensure for their work. If they could acquire a license here, then more would stay, and the profession would expand and provide more access to care and affordable services.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. I look forward to being in touch.

Sincerely,
Abby Calisch, Psy.D, LPC, ATR-BC
Professor/Private Practitioner
abbycalisch@gmail.com 757-739-0926

To Whom it May Concern,

My name is Cheryl Shiflett and I am writing to you as a resident and art therapist in Virginia Beach, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

There is a growing mental health crisis in America, particularly among children and adolescents. As an art therapy instructor, it is imperative that my highly trained graduate art therapy students be able to provide ethical, professional, and effective mental health services to these most vulnerable populations. With roads to licensure to practice as an LPC due to CACREP rules begin to close for those training to be art therapists, a viable means must be created to offer them the opportunity to serve those in need in Virginia.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for *(but not limited to)*:

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Cheryl L. Shiflett, PhD, LPC-ACS, ATR-BC, ATCS
Shiflett.cheryl@gmail.com

Laura Jackson

From: Monika Burkholder
Sent: Friday, July 13, 2018 10:22 AM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapy licensure

To Laura Jackson,

My name is Monika Burkholder and I am writing to you as a resident and native of the Shenandoah Valley, VA who works in Staunton, VA as a board-certified art therapist. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

As an art therapist of three years, I am just entering the profession. I am already directly affected by the lack of art therapy licensure in the state of Virginia, as well as I have already witnessed the impact of the lack of licensure on my clients and the public.

Personally, as a native of the Shenandoah Valley, I chose to go to a Virginia school, Eastern Virginia Medical School, for their Masters of Science degree in Art Therapy in Counseling. The education I received there is respected by art therapists as one of the top art therapy schools in the country. At my first job after graduate school at an in-home agency, my employer started me at a higher pay and gave me more responsibility than other therapists my level due to the quality education and unique skills that I had upon entering the field.

Although I enjoyed many aspects about my job, I recognized that as an art therapist, I had skills in treating trauma that were not utilized to their fullest in an agency that provided crisis stabilization and community level care. When I became an employee of a private art therapy practice, I recognized the impact of our lack of licensure on our clients immediately. We have clients seeking out our services due to trauma from childhood and domestic sexual abuse, physical abuse, and violence; immigrants coping with adjustment and trauma; people experiencing grief and loss; people diagnosed with or managing dissociative disorders (including dissociative identity disorder), depression, Bipolar, Borderline Personality Disorder, suicidality, self-harm, anxiety, attachment disorders and more.

These populations are people who are dealing with trauma and looking for an effective therapy. I have had clients come to me saying that they are frustrated with talk therapy, after half a dozen to a dozen therapists, attempts at medication, and multiple hospitalizations, they have not found their treatment successful. These clients have told me after just a few sessions, that art therapy was more effective at treating their symptoms and healing their trauma than anything else they had tried. This is because of the uniqueness to art therapy in accessing and externalizing the unconscious in a safe way, when facilitated by a trained art therapist. When attempted by a therapist who is not trained in art therapy, the risks are magnanimous.

The difficulty is, that clients are frequently unable to access our services, or have to stop before they have fully achieved their treatment goals due to the inability to get reimbursement for our services. Although we stay busy and offer reduced rate services to a limited number of people, without a license, we cannot provide the unique services of art therapy to the people who need us the most in settings where in-depth trauma therapy is possible.

Another important issue in the lack of art therapy licensure relates to the risk of harm to the public. A school in my area with a Masters of Arts in Counseling program offers their students an expressive therapies track, in which they introduce "art therapy" to their students. They do not have an art therapist on staff and based on my interactions with students and graduates from this program, it seems that misinformation is spread to the students about what art therapy is and who can ethically practice art therapy. Multiple students have reached out to me, expressing interest in art therapy or saying that they have been practicing art therapy. Right now, there are no boundaries protecting the public from these graduate counseling students and new professionals (as well as from their supervisors) who are doing "art therapy" without the appropriate education, supervision, and certification. One of these students had an internship in a partial hospitalization program where she reportedly facilitated an art intervention and a process that trained art therapists know to be frequently triggering to people who have experienced trauma. An art therapist with the appropriate training would know how to use the materials to provide a safe, structured group and to facilitate processing that was appropriate for the level of care, as well as choosing materials that would prevent re-traumatization.

Art therapists are also trained in how to prescribe art materials and psychotherapeutic processes to help a client to improve their sense of groundedness, and thereby engaging their client's prefrontal cortex and improving their in-the-moment cognition skills. A therapist not trained in art therapy and attempting to facilitate art therapy interventions may not recognize if the art process left their client in a dissociative or dysregulated inner state (which can be indicated through the art process). Due to this, a therapist not trained in art therapy may further the risk to their client by not having the training to use the appropriate art materials and processes to help ground their client before they leave their office. Art processes and materials are not all equal in creating a sense of, or actual, emotional and physical safety. Only a trained art therapist can prescribe the appropriate materials, like a doctor prescribing the appropriate medication, to guide their client in a safe externalization of their inner experience and to facilitate their sense of groundedness.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:
• Protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
• Increase affordable access to mental health services by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
• Attract and retain qualified art therapy professionals and art therapy students in Virginia.
• Contribute to the economy of the state through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.
State licensure of professional art therapists will also support assessment and treatment for (but not limited to):
• Veterans, active duty military, and their families who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
• The growing numbers of older adults suffering with dementia and depression.
• People of all ages with cancer who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
• Individuals with developmental disabilities (i.e., autism) who need specially trained, qualified therapists.
• Those experiencing trauma from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,

Monika Burkholder, MS, Resident in Counseling
Art Therapist
Shenandoah Art Therapy, LLC

540.466.0139.c
540.255.1458.w
Greenbrier Office Park
1600 N Coalter Street, Suite 8
Staunton, VA 24401
Fax: 571-482-6060
monika@shenarttherapy.com
www.shenarttherapy.com

Kandra Orr
PO Box 1292
Spotsylvania VA 22553

July 10, 2018

Ms. Laura Jackson
Virginia Board of Health Professions
9960 Mayland Drive, Suite 300
Richmond VA 23233-1463

Re: Licensing Art Therapists in VA

Dear Ms. Jackson:

I am currently a Board Certified Art Therapist. I graduated with my Master's in Art Therapy in 1994. I am requesting that serious consideration be given to licensing Art Therapists in Virginia.

The primary concern is that there are not enough mental health professionals available to attend to the current groundswell of people needing therapy. The agency I work for has a two-month waiting period for new clients. This is undesirable given that many of those clients may be suicidal or in intense emotional pain. Here are some of the statistics regarding our current mental health crisis;

- According to the CDC, since 1999, the suicide rate in the U.S. has gone up across all racial and ethnic groups, in both men and women, in both cities and rural areas, and across all age groups below 75. Overall, the suicide rate has increased nearly 30 percent. 25 states had suicide rate increases of more than 30 percent. Suicide is one of the leading causes of death and is on the rise.

- Depression and anxiety have afflicted college students at alarming rates. As noted in the latest Center for Collegiate Mental Health report, anxiety and depression are the top reasons that college students seek counseling. Research shows that nearly 1 in 5 university students are affected with anxiety or depression.

- Among adolescents, suicide is the third leading cause of death and has been rising.

- Youth mental health is worsening. Rates of youth with severe depression increased from 5.9% in 2012 to 8.2% in 2015. Even with severe depression, 63% of youth are left with no or insufficient treatment

- In Virginia alone the suicide rate among children increased 29% in 2016--the highest it has been in 18 years.

- Children's hospitals are seeing steady increases in suicide thoughts and attempts according to a new study (Plemmons, Pediatrics May 2018).

- In adults, 1 in 5 adults have a mental health condition. That is over 40 million Americans.

- There is a serious mental health workforce shortage. In states with the lowest workforce, there is up 6 times the individuals to only 1 mental health professional. This includes psychiatrists, psychologists, social workers, counselors, and psychiatric nurses combined.

These statistics are imposing an increasing burden on children's hospitals and pediatricians. As suicide rates have risen in Virginia, Governor Northam has signed legislation calling on state officials to report how they are addressing the problem (House Bill 569). Licensing Art Therapists would provide another tier of effective healers to an overburdened mental health system. We are all painfully aware of the school shooting tragedies that have occurred in recent years due to the lack of identification and mental health support for the perpetrators of the violence.

Another concern is that many mental health technicians and therapists are claiming to be doing art therapy but are not trained and may in fact be doing harm. To practice as an Art Therapist one must hold a Master's degree in Art Therapy. Art Therapists do talk counseling in addition to utilizing artwork to help clients express what sometimes cannot be expressed in words. Art Therapy is particularly effective with children who frequently cannot find words to explain their experiences and feelings.

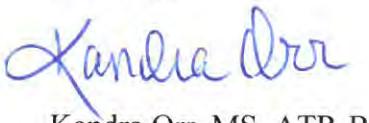
As a Registered Art Therapist when I moved to Virginia 22 years ago, the lack of licensing made art therapy positions difficult to find, in desperation I had to go into teaching instead. If I had had a license as an Art Therapist at that time, I could have found work and could have helped hundreds of people in those years. At present, I can only find part time Art therapy work, largely due to the fact that mental health agencies in Virginia are reticent to hire Art Therapists because of the lack of licensing. This is a concern to me because I want to stay in Virginia. The Commonwealth of Virginia graduates several hundred art therapy students each year, many of these graduates will be forced to find work out of state.

Given the increasing rates of anxiety, depression, trauma and suicide, licensing Art Therapists in Virginia would provide substantially more mental health professionals and thus better access to mental health treatment for adults, children and adolescents. Licensing would also protect the careers of current Art Therapists who are passed over for employment in many hospitals that are using untrained technicians as Art Therapists.

I feel Art Therapists offer a valuable extra aspect to mental health counseling. The states of New York, Pennsylvania and Maryland (among several others) have already provided licensure to Art Therapists. Our training is stringent and requires a Master's Degree. Board Certification requires a three hour exam and to remain board certified we have to take 100 continuing education credits every five years.

For all of the above reasons, it is my hope that the Virginia Board of Mental Health Professions will give the go ahead to licensing Art Therapists in the near future. Thank you for your consideration.

Sincerely,



Kandra Orr, MS, ATR-BC

Laura Jackson

From: Lisa Garlock
Sent: Monday, July 16, 2018 1:17 PM
To: laura.jackson@dhp.virginia.gov
Subject: Public comment: Art Therapy state license needed!

Ms. Jackson,

I am writing to you to advocate for the establishment of a state art therapy license in Virginia. A state art therapy license will help close the current gap between mental health diagnoses and affordable, quality treatment in VA.

Art therapy
"is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety." **As a distinct profession, it needs it's own license.**

Other reasons art therapy licensure is needed:

- ***To protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, or other mental health problems in the general population.
- **People who are experiencing homelessness, drug dependency, incarceration or other barriers to a productive life** will benefit from art therapy by learning skills, frustration tolerance, problem-solving and developing hope.

I am an art therapist living in Maryland, and working in Virginia. I have a Maryland State Art Therapy license, but it would make more sense to have a Virginia license if I'm working there. The field of art

therapy is growing, and licensure will ensure that qualified, licensed art therapists will be working with Virginia residents in need of mental health services. Art therapy is particularly effective when working with trauma survivors, as often survivors are unable to articulate their experiences verbally, and use art therapy to tell their stories.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state. Thank you for your time, energy, and service to the residents of VA.

Yours truly,

Lisa Raye Garlock MS, LCPAT, ATR-BC, ATCS
Clinical Placement Coordinator/Assistant Professor
The George Washington University Art Therapy Program
Alexandria Graduate Education Center
1925 Ballenger Ave., Suite 250 (mailing address)
413 John Carlyle Ave. (walk-in address)
Alexandria, VA 22314
703-299-4171
703-299-4142 (FAX)
lgarlock@email.gwu.edu
http://arttherapy.columbian.gwu.edu/

Laura Jackson

From: Tom, Rebecca W CIV DHA FBCH (US)
Sent: Monday, July 16, 2018 2:41 PM
To: laura.jackson@dhp.virginia.gov
Subject: art therapy licensure in VA
Attachments: arttherapist.licensure.docx

To Ms. Jackson,

My name is Rebecca Tom and I am Psychiatric Nurse practitioner in Fort Belvoir, Virginia. I work with an art therapist at Fort Belvoir Community Hospital. I fully support the licensure efforts of art therapists in Virginia and advocate for the safety of Virginians by establishing a state art therapy license. As a mental health professional, I am dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA - and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

My belief is that licensure of these essential clinicians would improve patient safety and outcomes. I have worked with an art therapist in the inpatient psychiatric unit of our military treatment facility. Time after time, the patients have attributed their biggest improvements in symptoms and general functioning to the interventions and care provided by the art therapist. Please vote to support licensure for art therapists in Virginia!

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

* Protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
* Increase affordable access to mental health services by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
* Attract and retain qualified art therapy professionals and art therapy students in Virginia.
* Contribute to the economy of the state through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (but not limited to):

* Veterans, active duty military, and their families who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
* The growing numbers of older adults suffering with dementia and depression.
* People of all ages with cancer who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
* Individuals with developmental disabilities (i.e., autism) who need specially trained, qualified therapists.
* Those experiencing trauma from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. I look forward to being in touch.

Sincerely,
Rebecca Tom, PMHNP-BC
Rtom675@gmail.com / 302-841-0089

Dr. Jorge Grandela
Bright Horizons Counseling
556 Garriosnville Road
Stafford VA 22554

July 11, 2018

Ms. Laura Jackson
Virginia Board of Health Professions
9960 Mayland Drive, Suite 300
Richmond VA 23233-1463

Re: Licensing Art Therapists in VA

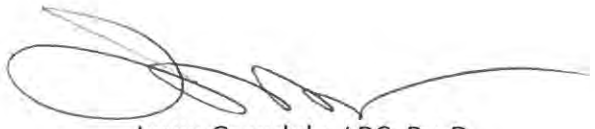
Dear Ms. Jackson:

Art therapy is a medium of expression, healing and therapeutic relief. It often provides an effective form of therapy modality after other, more traditional methods, have failed. It is particularly useful for individuals who may struggle to communicate verbally to express their feelings and confront difficult emotional issues. Art Therapy encourages people to express and understand emotions through artistic expression and through the creative process. This adjunctive therapy promotes self-awareness, allows individuals to explore emotions in a creative way and also addresses unresolved emotional conflicts. This is modality is vital in preventing further trauma with client who have been diagnosed with PTSD. Art therapists have a comprehensive understanding of the powerful effect that the creative process can have on those in therapy. Through the use of psychological, spiritual, and artistic theories in conjunction with clinical techniques Art Therapist can help clients in achieving a positive therapeutic outcome.

In my opinion, Art Therapists, like other mental health providers, occupy a special position with their clients. They often serve young children, emotionally fragile clients, and an overall population that can be seen as especially vulnerable. The client population whom art therapists serve may be seen by clinical mental health counselors, marriage and family therapists, clinical social workers, drug and alcohol counselors, psychologists, psychiatrists, speech language pathologists, and school teachers. Each one of these professions brings its own distinct philosophy, approach to treatment, and its own licensing or registration requirements and standards of practice. Members of other professions may use artist media as one therapeutic tool within their practices. Art therapy as practiced by trained art therapists is seen by the applicants as a distinct discipline.

The educational requirements for art therapists appear substantially equivalent to those required for clinical mental health counselors, marriage and family therapists, social workers or psychologists licensed at the master's level. Licensure of art therapists will provide an opportunity to measure the benefits of art therapy and help meet the need for trained mental health.

Sincerely,



Jorge Grandela, LPC, PsyD

To Whom it May Concern,

My name is Sonia Castro and I am writing to you as an individual that works in Fairfax County, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

As a recent graduate from a credentialed art therapy program in Virginia, I am in the process of looking for employment in the mental health profession. Thus far it has been my experience that employers are looking for individuals that have a license or are working towards licensure. In an effort to meet this requirement, many art therapists become Licensed Professional Counselors, which is rather limiting when taking into consideration the rigor and depth behind our art therapy training. Credentialed art therapy programs across the nation have carefully crafted an academic course load that promotes psychological knowledge and therapeutic skills with an understanding of art media, the creative process, and the neurobiological implications of art making. These courses equip art therapists with the skills needed to best serve clients presenting with a variety of emotional, mental, and physical needs. Without proper licensure for art therapists, anyone can provide therapeutic arts services, which only further increases the risk of harming the client. As art therapists, a Code of Ethics specific binds us to our profession that requires us to do no harm to the people we serve. In fact, ensuring our client's safety is at the forefront of our practice. It is my highest hope that we will be recognized as a licensed profession so that we are able to reach those that are in need of art therapy.

There is certainly a need to expand the mental health field to reach individuals that are in

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
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- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Sonia Castro, Art Therapist
scastro1@gwu.edu / (571) 241-3915

Laura Jackson

From: Catherine Rubin
Sent: Thursday, July 19, 2018 3:58 PM
To: laura.jackson@dhp.virginia.gov
Subject: Licensure for art therapy

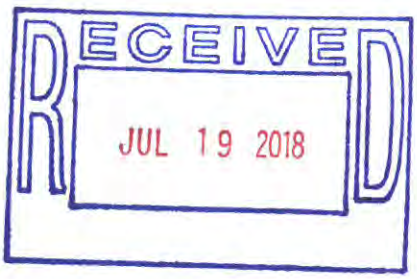
Licensure for Art Therapy in Virginia

There is a great deal of need for art therapy to be licensed in the state of Virginia. The Art Therapy Credentialing Board requires that art therapists possess a master's degree, perform a certain number of hours of supervised training, and pass an exam to become registered and board certified as art therapists (ATR-BC). Art therapists with a master's degree and an ATR-BC have training in an arts discipline as well as extensive training in psychotherapy and human development. Unfortunately, these strict standards are not recognized and do not grant title protection in Virginia. Anyone can call themselves an "art therapist" in Virginia. This lack of regulation is dangerous to potential clients and it hinders the growth of the art therapy profession.

Art therapists with a master's degree have undergone advanced studies and received rigorous training to ensure that they are competent mental health professionals. A license would allow art therapists to bill insurance as licensed professionals and give more people access to services. Many people and populations would benefit from art therapy but cannot afford to pay for services out of pocket. Currently, art therapists have to pursue an LPC in Virginia in order to be able to bill insurance. Although there is a great deal of overlap between counselors and the art therapy profession, we wish to be able to present ourselves as a distinct discipline. Many people present themselves as art therapists when in fact they have no training or education on the subject. Art therapy has been proven to an incredibly useful treatment for veterans, children with autism, trauma survivors, people suffering medical crisis, and people with mental health issues. Licensing art therapy would allow people to receive the services that they need and protect them from people who are not qualified professionals. Licensure would also expand job opportunities for true art therapists in the field.

The state of New York has created a license for creative arts therapists called the LCAT. This license has proven to be quite successful in regulating the art therapy profession and having art therapists be recognized as the professionals that they are. I believe a similar license is necessary in Virginia to protect both potential clients and art therapists from the harms of unqualified people presenting themselves as art therapists and qualified mental health professionals.

Catherine Rubin, MPS ATR-BC



To Whom it May Concern,

My name is Terri Giller and I am writing to you as a credentialed art therapist that works in Fredericksburg, VA. I am also a member and Secretary of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

I have practiced as an art therapist for 11 years and have worked in 4 states, Kentucky, Illinois, Tennessee, & now Virginia. In all states, I have advocated for licensure for art therapists, as title protection, as a way to protect the public from individuals who advertise art therapy services, but do not have the approved training and credentials, and as a way to enhance and improve mental health services for residents across the state. Currently, only one of those states has a state license for art therapists (Kentucky) and Tennessee expects to have licensure approved within the next year and Illinois continues to have active licensure efforts.

Art therapy services are distinct from those of other mental health professionals. Art therapists are specialized health professionals with an art therapy master's degree who are trained and have extensive clinical experience in both the therapeutic use of art ***and*** psychology. They use art and the creative process in assessment and treatment of clients who may lack the ability to communicate their thoughts and emotions to other health professionals due to trauma, abuse, accidents, severe illness, substance abuse, autism, dementia, or other disorders. Art therapists offer their services individually and also as part of teams of clinical health care professionals. There is increasing evidence that individuals who lack art therapy master's level education are using art techniques in their work with clients and calling it "art therapy." **These individuals are misleading the public and may be placing the people they work with at risk by evoking emotional or traumatic experiences which they are not trained to safely address.**

The Virginia Art Therapy Association continually receives and addresses reports of unethical practice of art therapy and use of the art therapist title by individuals living and working in Virginia who have not completed the aforementioned education, training, and credentialing process. A search on a popular therapist locator website indicates over 300 Virginia professionals claiming to offer art therapy to the public, and only 10% of those individuals have the credentials and education required for art therapists. In my own experience of working in a variety of inpatient psychiatric facilities, I have witnessed well- intentioned, but untrained recreational staff provide "art therapy" groups. These professionals are wonderful recreational therapists, and I do not believe art therapists "own" the use of art in therapy, but as professionals, one must remember to work within their scope of practice. When art is used irresponsibly or without caution, the results are an increase in negative symptoms, regression, and emotional pain that can contribute to dissociation, frustration, and destabilization of vulnerable patients. I have worked closely with other professionals as a consultant regarding the therapeutic use of art, and my experience is that professionals are simply unaware. Licensure of art therapists is necessary to define appropriate standards for the practice of art therapy and to ensure that the public has access to art therapy services provided by a master's level trained and licensed art therapist.

There is an increasing need for trained and experienced mental health professionals to provide assessment and treatment services for important segments of the state's population: for children and young adults experiencing behavior problems and mental health conditions; for military personnel and their families who have experienced a decade of war deployments and are experiencing mental health problems, including posttraumatic stress, traumatic brain injury, depression, and increasing rates of suicide; for the growing numbers of older persons suffering with dementia, depression, and other mental health conditions; and for

those experiencing trauma from natural disasters, abuse, drug dependency, or other mental health problems in the general population. Clearly access to quality and affordable mental health services is a great need for the residents of Virginia. Fortunately, art therapists are helping to meet this need in schools, hospitals, senior communities, crisis centers, and other settings across Virginia. This specialized therapeutic practice, when properly used by trained and experienced art therapists, employs the clinical application of the process of art making to unlock behavioral and mental conditions that adversely affect normal functioning and to help restore or improve individuals' ability to function.

Art therapy is a unique profession with educational and clinical practice requirements that equal or exceed those of other mental health professionals that are currently licensed by the state of Virginia, such as licensed professional counselors and licensed clinical social workers. National requirements for professional entry into the practice of art therapy include, at minimum, a master's degree from institutions of higher education accredited by one of the regional or national institutional bodies recognized by the Council for Higher Education Accreditation (CHEA), adherence to the rigorous educational standards established by the American Art Therapy Association and independently reviewed by the Education Program Approval Board, and extensive post-graduate clinical experience under the supervision of a credentialed art therapist. The Art Therapy Credentials Board also oversees the continuing education and experience of master's level art therapists in the United States by providing professional credentials, and by requiring continuing education to maintain credentials. Licensure of art therapists would help Virginia build and maintain a viable mental health workforce by recognizing, attracting, and retaining these highly trained health professionals.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

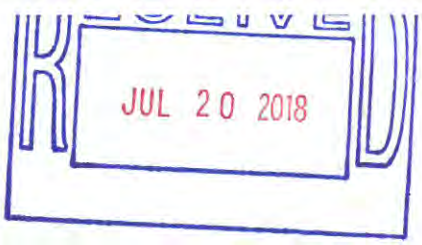
Sincerely,
Terri Giller, ATR-BC
Art Therapist/ Clinical Services Coordinator at the Rappahannock Council Against Sexual Assault
terri@rcasa.org , 540-479-3571

Laura Jackson

From: Waide, Holly M.
Sent: Friday, July 20, 2018 1:09 PM
To: laura.jackson@dhp.virginia.gov
Subject: VATA Licensure Comments

Good afternoon,
My name is Holly Waide and I am a second year student in the Graduate Art Therapy and Counseling Program at Eastern Virginia Medical School. Below are my comments that I would like to submit for the discussion on Licensure:

Being a current second year graduate student in the field of art therapy I find that I am constantly immersed in thoughts about the future and what it holds for my career in art therapy. I was born and raised in Virginia and have every hope and intention on staying here to work as an art therapist, and it is the addition of licensure specific to art therapists that will help get me to that goal. I have been pursuing my dream of being an art therapist in a children's hospital since I was in the tenth grade. It is now seven years that I have been working towards this goal and with graduation next year I am excited by the opportunity for art therapy licensure in Virginia and the new possibilities for a job that could be created. Licensure will be a huge benefit to the state of Virginia and the field of art therapy as it will help us establish guidelines and ensure that the power of creative expression is being used properly and with the knowledge of a trained professional. Licensure specific to art therapists would help elevate credibility, spread awareness, and create an environment rooted in professionalism and the ethical use of creative expression in a therapy setting. For these reasons I believe that the creation of a licensure specific to art therapists can only better the practice of art therapists, and in turn benefit the service provided to the state of Virginia.



To Whom it May Concern,

My name is Peggy Healy and I am writing to you as a resident of Midlothian , VA and a Registered Art Therapist in Virginia. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Licensure will also help Protect Art Therapist working in the field as well as educate other health professions as to what we do and how we are an important and valuable member of the Virginia Mental Health work force. Years ago , I was accused of doing the job of a psychologists when using projectives as a testing tool. This psychologist had never heard of Art Therapy and was not interested in finding out anything about my profession or listening to the Doctors, Psychiatrists , and Psychologists working with me . These Doctors stated that they were well aware of the difference between an Art Therapist and a Psychologist and almost always ordered a separate evaluation from each of us. We all reached out to this individual but he still reported me to the Health Regulatory Board and disrupted almost a full year of my career .
The case was dropped but it caused a lot of unnecessary stress, time and money for everyone involved. Licensing Art Therapists will add another level of credibility to our profession and will help protect Art Therapists from those who are not familiar with our practice.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Peggy Healy, ATR-BC
peggy1440@gmail.com/ 804-350-9175

Laura Jackson

From: Crista Linn Kostenko
Sent: Friday, July 20, 2018 2:31 PM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapy licensure

Hello, Ms. Laura L. Jackson.

My name is Crista L. Kostenko and I am writing to you as a resident who lives & an individual that works in Arlington, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

It is vital that any individuals representing themselves as art therapists have the knowledge and understanding of how art making and processing affects individuals with a variety of issues. In my work with seniors with dementia and Alzheimer's, I need to make sure I use materials that are safe for the individuals, that I set up the materials in a way to support their mastery, and that I assist them through the process in a way that empowers them and allows them to express themselves as individuals. I am not a person creating arts or crafts for these seniors, as some activities are more focused on the product made. I am a therapist working towards goals such as self-expression, coping skills, problem solving, socializing, etc.
I also work in people's homes facilitating art therapy with families and individuals. I am able to come to people who might not necessarily make it a priority to get to an office for another appointment. I offer a sliding scale for clients based on income; however, I would be more accessible to individuals if more insurance companies included art therapy along with other mental health therapies with the same or similar educational and professional requirements.
Recently I had to pause services for an adult who wanted to obtain services because she was having trouble getting reimbursement for art therapy through her healthcare provider. Seeking out art therapy for mental illness should be supported and individuals should be able to submit to insurance art therapy received by a professional art therapist.
In Maryland, I sat for and passed the test to become a Licensed Clinical Professional Art Therapist.

<u>Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:</u>

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.

- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Crista L. Kostenko, Art Therapist (ATR-BC, LCPAT)
zateshno@gmail.com / 703-861-5550

Laura Jackson

From: Adele Stuckey
Sent: Friday, July 20, 2018 3:01 PM
To: laura.jackson@dhp.virginia.gov
Subject: Virginia Art Therapy Licensure: Letter of Support

Hi Ms. Jackson,

I am a Board Certified Art Therapist working in Alexandria, Virginia and am writing in support of a state art therapy license in Virginia. As an advocate in the field and member of the Virginia Art Therapy Association (VATA), I feel it is essential to speak up about the need for licensure and continue to raise awareness for the services we art therapists provide.

We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in Virginia. We believe a state licensure will help achieve this goal.

Art therapists are clinically trained to work with clients of all ages and are working in a many settings, including community, medical, and private settings throughout the state. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities while relieving stress and anxiety.

I believe that state licensure is urgently needed for the following reasons:

- Protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, education, and credentialing requirements. Far too often I hear of counselors providing "art therapy" and the risk of emotional damage is too high. Those who are not trained in art therapy theory and technique may accidentally trigger emotional stress without understanding the catalyst.
- Increase accessible access to mental health services. I am required to bill under my LPC to ensure that individuals can access art therapy services.
- Contribute to the economy of the state through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

I appreciate your time and I welcome your thoughts.
Very respectfully,
Adele

Adele Stuckey, MA, LPC, ATR-BC
Alexandria Art Therapy, LLC

Board Certified Art Therapist
Licensed Professional Counselor

129 South Royal Street, Suite 6
Alexandria, VA 22314
(703) 596-9557

To Whom it May Concern,

My name is Jaana Kilkki and I am writing to you as a resident in Haymarket, VA and a practicing art therapist. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Art therapy licensure in Virginia would ensure that more qualified mental health services would be available for Virginians. As art therapists we receive a Masters level mental health education, but have difficulty establishing careers and contributing to our communities equally due to the lack of licensure. I personally had difficulty finding a job after I moved to Virginia. Also, it's important to understand that due to not having art therapy specific licensure, the scope of practice and even the usage of the term "art therapy" is ambiguous and sometimes used by people who don't have qualifications. Art therapy licensure would remedy these issues and ensure protection and qualified mental health services to the public. I have personally seen the healing that art therapy has brought to varying populations including military members, children, adolescents and adults.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Jaana Kilkki, MA, ATR-BC
Board Certified Art Therapist
Jkilk6@gmail.com
516-884-3749

Kristin Gartner
Bright Horizons Counseling, LLC
556 Garrisonville Road
Stafford VA 22554

July 13, 2018

Ms. Laura Jackson
Virginia Board of Health Professions
9960 Mayland Drive, Suite 300
Richmond VA 23233-1463

Re: Licensing Art Therapists in VA

Dear Ms. Jackson:

I am writing to you to express my hope that the Virginia Board of Health Professions will consider licensing Art Therapists. As an LPC I have referred numerous people to our Art Therapist. Art therapy has shown to offer not only an effective avenue for emotional expression but a healing that talk therapy cannot always achieve. I have had success with sending clients to the Art Therapist who have difficulty expressing their emotions in words, yet their trapped emotions are causing severe anxiety and/or depression. Through the guided art therapy process the Art Therapist is able to get them to open up and release some of these pent up emotions that are causing them distress. Not only can they release these emotions but clients have explained to me that our Art Therapist creates a safe space for them through their art to process and learn valuable coping skills to deal with extreme emotions. I have found that my clients can be referred to the Art Therapist for art therapy as either a separate therapy when talk therapy is not effective or as a conjunctive therapy for clients who need more than just talk therapy.

At this time my practice has a deluge of clients on the waiting list. All licensed practitioners are at full capacity caseloads and the more licensed mental health professionals we can get would be beneficial to the multitude of clients we have.

Sincerely,

Kristin Gartner, LPC, NCC

Kristin Gartner, LPC

HENRICO COUNTY HEALTH DEPARTMENT
EAST CLINIC
1400 N. LABURNUM AVE.
RICHMOND, VIRGINIA 23223-1521

In cooperation with the
State Department of Health

July 22, 2018

3531 Bittersweet Road
Richmond, VA, 23235

Ms. Laura L. Jackson
Va. Board of Health Professions
9960 Mayland Drive, Suite 300
Richmond, VA, 23233

Dear Ms. Jackson,

I am writing in support of legislation requiring all art therapists practicing in Virginia to be licensed. As a Nurse Practitioner for the Virginia Department of Health with over 30 years' experience, I see many patients with mental health issues, both chronic and acute. These vulnerable people can be helped greatly by appropriately trained and licensed professionals, but can also be deeply wounded by poorly trained, unlicensed "counselors." That is why the Commonwealth of Virginia has laws that require mental health professionals to be licensed after proving they have graduated from an approved program and successfully completed many hours of supervision. To ensure high-quality treatment, insurance companies only reimburse licensed professionals.

Many people who seek mental health treatment choose traditional "talk therapy." Others may prefer an art therapist. Art therapists generally complete a 3-year graduate degree, receiving education and supervision very similar to traditional counselors. In addition, they incorporate art into the therapeutic process. Art therapy can be a good fit for many people, including youth whose verbal skills are not yet fully developed as well as many adults who prefer to communicate through avenues other than only speech. With the opioid epidemic and other pressing mental health issues affecting Virginians, it is imperative to have more available, competent, licensed counselors to provide treatment and minimize delays in accessing care.

Unfortunately, in Virginia, potential clients do not have the opportunity of choosing to seek care from a licensed art therapist because Virginia (unlike many other states) does not yet require licensure for that profession. When I applied for my Nurse Practitioner license, Virginia's Board of Nursing required me to demonstrate completion of an accredited program including clinical hours supervised by an already-licensed clinician. Because I am licensed, insurance companies reimburse for my services. Art therapists should be licensed as well, to clarify to both insurance companies and potential clients that they are full trained counselors worthy of professional respect and reimbursement.

Sincerely,

Anne Walpole, NP

Anne Walpole, MSN, NP

To Whom it may Concern,

My name is Stephanie Houpt and I am the Assistant Program Director at Insight Memory Care Center in Fairfax, Virginia. I work with an art therapist at Insight. I fully support the licensure efforts of art therapists in Virginia and advocate for the safety of Virginians by establishing a state art therapy license. As a mental health professional, I am dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

We have a long-standing relationship with an art therapist who comes to Insight to work with small groups of our program participants once a week. We serve individuals diagnosed with dementia, and art therapy has consistently been an important part of offering holistic and person-centered care at Insight. Participants look forward to this time of safe self-expression, and we have seen individuals with depression, anxiety, or who are socially withdrawn benefit from art therapy sessions. What trained art therapists are able to accomplish with their specialized education is above and beyond what we are able to offer in traditional arts and crafts programming. The intentional goals of the art therapist enhance our participants' quality of life.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. I look forward to being in touch.

Sincerely,
Stephanie Houpt, Assistant Program Director
Stephanie.Houpt@InsightMCC.org / 703-204-4664

To Whom it May Concern:

I am writing to share pertinent information that may help legislators in better understanding the position of art therapists who work, or would like to work, under licensure in the Commonwealth of Virginia.

Although these comments are the point of view of one Virginia Art Therapist, I believe my thoughts and perceptions are shared by numerous colleagues in the field.

The unique field of art therapy requires completion of a highly rigorous academic program which includes a comprehensive internship experience spanning a variety of settings.

The field is unique because it combines the properties of both creating art (and all that that involves), as well as the rich and layered therapeutic process. Using art as a tool for communication and expression provides healing for many who may need a bridge to their unconscious or traumatized minds. (Trauma is stored in the part of the brain where art originates.) The art can become the client's dialogue.

By offering licensure to trained and attained art therapists, the public will be made aware of our qualifications. This will raise awareness of the special skills possessed by art therapists, and elevate the credentials of ATR-BC (Registered and Board Certified Art Therapist) in the eyes of the public, as well as our colleagues in both the medical and mental health fields.

Personally, I have experienced a trivialization of the Art Therapy field when, for example, others who are therapists, counselors, doctors, feel that it is ethical to use art materials when working with clients/patients, and call it art therapy, without the extensive and specialized training. Having earned a graduate degree in the field of Art Therapy, having earned the designations of Board Certified (BC), and ATR (Registered Art Therapist), and having worked in the field for over 33 years, it is shocking to note how this powerful and unparalleled field has not yet been acknowledged in the enlightened Commonwealth of Virginia with the formalization of licensure.

Invariably, working with each client brings new challenges, which in turn continues to confirm in me the power of the tool that art offers when using Art Therapy.

Thank you very much for considering these thoughts when formulating the new licensure designation for those in the field of Art Therapy.

Respectfully submitted,

Emmy Lou Glassman, MA, ATR-BC
Registered and Board Certified Art Therapist
9653 Fairfax Boulevard, Suite 211
Fairfax, VA 22031

Sarah P. Deaver, PhD, ATR-BC, HLM
234 North Blake Road
Norfolk, VA 23505

July 25, 2018

To Whom it May Concern,

I am writing to you as an art therapist who has worked for many years in Norfolk, first on the faculty of Eastern Virginia Medical School's Graduate Art Therapy and Counseling Program for 37 years, and now in private practice. I am also a member of the Virginia Art Therapy Association, with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a professional art therapist license in Virginia. We are dedicated to closing the current gap between those struggling with mental illness and affordable, quality mental health care in Virginia, and I believe a regulated, professional art therapist license will help achieve this goal.

According to the American Art Therapy Association, art therapy is a distinct mental health profession in which clients, facilitated by masters-level art therapists, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range, for example, from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Because there has been no art therapy license in the state, in 1992 I obtained a license as a professional counselor. In the late 1990s, I testified to the Board of Counseling regarding the need for a standalone professional art therapist license. The board determined that since art therapists could obtain the LPC, there was no need to establish a separate license for art therapists. The problem with that determination is that art therapists are not counselors. As someone who earned two masters degrees, one in art therapy and one in counseling as well as a doctorate in counselor education, I am in a position clarify that art therapy is a distinct profession with its own unique scope of practice, its own education program accreditation through CAAHEP, its own professional credentialing through the Art Therapy Credentials Board, and philosophical and theoretical underpinnings that combine psychoanalysis and psychology; humanism; art history, art, and aesthetics; and neuroscience. Art therapy practice is informed by these underpinnings as well as by application of the Expressive Therapies Continuum (Hinz, 2009). These facts differentiate art therapy from other professions, and point to the need for a distinct standalone professional art therapist license.

Protecting the public from practitioners who purport to provide art therapy treatment but who are not qualified to do so through a masters degree from an approved or accredited art therapy program and post graduation supervised experience is essential. I refer the Board to two scholarly articles that make the case that unqualified practitioners delivering what they call "art therapy" are unethical by practicing beyond their scope of practice and constitute a threat of harm to the public. These sources are listed below.

There is a great need in our state for more qualified mental health professionals to address the needs of veterans, active duty military, and their families who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide; growing numbers of older adults suffering with dementia and depression; and people of all ages with cancer and other medical illnesses who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment; Individuals with developmental disabilities who need specially trained, qualified therapists; and those experiencing trauma from natural disasters, abuse, drug dependency, or other mental health problems in the general population. Research suggests the efficacy of art therapy in addressing these and other issues and concerns. Art therapists are qualified to address these concerns, and due to their unique education and training, deserve professional art therapist licensure regulated through the state.

Your support and attention to the professional art therapist license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state. Thank you for your time, energy, and service to the residents of Virginia.

Sincerely,

Sarah Deaver
Sarah P. Deaver, PhD, ATR-BC, HLM

References:

Hammond, L., & Gantt, L. (1998). Using art in counseling: Ethical considerations. *Journal of Counseling & Development, 76,* 271-276.

Hinz, L. (2009). *Expressive Therapies Continuum: A framework for using art in therapy.* New York, NY: Routledge.

Springham, N. (2008). Through the eyes of the law: What is it about art that can harm people? *International Journal of Art Therapy, 13*(2), 65-73.

Using Art in Counseling: Ethical Considerations

Lynn C. Hammond and Linda Gantt

Various mental health professionals use, on occasion, drawings and other types of art in therapy, but relatively little has been written on the ethics surrounding this technique. The authors take the position that artwork should be viewed as equivalent to verbal communication. Such equivalency gives rise to a variety of ethical issues that encompass confidentiality, documentation, ownership, research, publication, and display of artwork.

In our work as art therapists, we have faced some dilemmas about specific ethical issues regarding the art created by our clients. Particularly vexing are questions about ownership and documentation of the work. When thinking about these difficult issues we began to realize that many of the issues we were struggling with also applied to other mental health practitioners. The purpose of this article is to examine potential ethical problems and to suggest some principles a counselor might consider when dealing with artwork not only as physical objects (e.g., drawings, paintings, sculptures) but also in the form of descriptions entered in progress reports and medical records.

Art therapists, by virtue of their own experience in creating art, are attuned to the layered symbolic aspects of art. We will use this perspective to make suggestions that better allow others to make appropriate ethical and informed decisions when their clients use art as a therapeutic avenue of expression. A brief introduction to the use of artwork in psychotherapy is presented, followed by discussions of six major ethical areas: (a) relationship between artwork and verbal communication; (b) confidentiality; (c) documentation; (d) ownership; (e) use of art in research, publication, and displays; and (f) use of art by therapists who do not specialize in art therapy.

ARTWORK AND THERAPY

For many years, psychotherapists have been interested in the relationship between artwork and unconscious material such as that which is revealed in a client's dreams. Freud touched on this relationship in his writings, and Jung explored it directly by asking his patients to paint their dreams. Mental health professionals have used visual imagery in many ways, such as in psychological tests like the Human Figure Drawing (Koppitz, 1968; Machover, 1949) and the House-Tree-Person Test (Buck, 1948; Hammer, 1958). Those who work with children find art a useful tool when verbal communication is difficult. The profession of art therapy has grown into an accepted form of therapy for both children and adults (Kramer, 1958, 1971, 1979; McNiff, 1981, 1988; Rubin, 1978, 1984, 1987; Wadeson, 1980, 1987). Samuel Gladding (1992) has brought attention to the use of art as a counseling tool, exploring such areas as music, dance, visual art, literature, and drama. However, few mental health professionals other than art therapists have addressed ethical questions about how the art and its accompanying associations should be treated with children or adults.

IS ARTWORK DONE IN COUNSELING EQUIVALENT TO VERBAL COMMUNICATION?

The historical rationale for producing art in therapy relates to the psychoanalytic view of the dynamic unconscious because, like free associations, art originates in the unconscious. As Wadeson (1987) stated: "Expression in art stimulates fantasy, creativity, spontaneous unconscious imagery. It offers the possibility of creating a self-reflection, an image of oneself and one's world, from which it is possible to separate and gain distance" (p. 1).

Psychoanalytic writers have used words to describe the symbolic images of a dream, fantasy, or daydream, while art therapy encourages the direct projection of this material into drawing, painting, or sculpture. In discussing dreams, Freud stated, "Part of the difficulty of giving an account of dreams is due to our having to translate these images into

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words. 'I could draw it' a dreamer would often say to us, 'but I don't know how to say it'" (Freud, 1922/1966, p. 90). Despite his recognition of the problems that verbally describing images could entail, Freud did not encourage his patients to illustrate their dreams. In the article "Freud on the Nature of Art," Halsey (1977) presented a discussion of Freud's relationship to art and psychological processes. Halsey stated, "Freud praised artists for their insights into human nature and on occasion went so far as to give them credit for seeing psychological factors before they had become evident to himself or other scientists" (p. 99). However, Jung not only encouraged patients to actually draw and paint their dreams but he sculpted (Jung, 1963) and painted mandalas as a way of observing his own psychological changes (Jung, 1950/1969). Jung saw artwork as "doorways into the unconscious" (Singer, 1972, p. 312). For example, a dream could be examined on a different level of awareness if it was translated into a picture(Singer, 1972). When verbal expression is difficult, the art materials can provide a vehicle for self-expression. Cane (1951) wrote, "For through art expression man finds his own pattern within himself and subsequently his pattern in relation to his fellow men" (p. 365).

Another example of the use of visual imagery in counseling is the use of psychological projective techniques in which the client actually draws a picture or reacts to a visual image. Human figure drawings and kinetic family drawings (Burns, 1982, 1989; Burns & Kaufman, 1970, 1972) are two examples of assessments in which the client must actually produce drawings. The Rorschach Inkblot Technique and the Thematic Apperception Test have been available for decades and are assessments in which the client responds to visual images (Anastasi, 1968). These ambiguous visual images stimulate emotional responses from the clients when they try to structure visual perceptions (McNiff, 1981). In these instances, the client's responses to the Rorschach Inkblot Technique or Thematic Apperception Test are part of the assessment process and are treated with the same consideration as the client's other verbal comments. They are considered part of the client's record for the assessment and, in a sense, are out of the client's control. The test administrator makes a written evaluation based on the assessment process, which is confidential; the client's actual products and responses are not included with the written summary.

The artwork done in therapy can sometimes trigger unexpected emotional responses. Just as the trained mental health professional can gain an understanding of what is going on at an unconscious or preconscious level when observing emotional responses or listening to client comments, the counselor can gain a similar understanding from artwork. But an important distinction must be made. As noted earlier, Freud's patients said they could draw their dreams. Spence (1982), a psychoanalyst, expanded on Freud's report by building the case that memories and dreams are primarily visual events. Therefore, their premature translation into verbal terms has some inherent risks. Language, according to Spence is unable "to capture certain visual truths" (p. 76). Although the process of creating art also introduces some distortions of the visual experiences (chiefly through limitations of skill and materials), we believe that the art provides a better (and closer) replication of crucial experience. Naumburg (1950) wrote,

> Does not art therapy . . . in emphasizing the projection of the patient's inner experience into outward image, only follow the universal process of communication validated by the unconscious projections of man throughout his existence; for always, in all aspects of ritual, dream, and artistic expression man continues to speak in nonverbal symbols that are more universal than communication in words. (p. 35)

Therefore, we take the position that artwork (an "unfiltered" form of communication) should be treated as "symbolic speech" (Naumburg, 1958) and given all due consideration and protection as that of any other form of speech. This raises concerns regarding confidentiality and its application to client's artwork.

CONFIDENTIALITY

Inherent in the therapeutic relationship is the reasonable assumption of confidentiality and respect for the individual's privacy. The different disciplines in the mental health field have ethical codes that are intended, in part, to define the responsibilities of the professional to the client. There are limits to confidentiality that are outlined in these ethical codes. We have chosen to focus on codes from the American Counseling Association, the American Psychological Association, and the American Art Therapy Association and discuss how they relate to artwork.

When a person enters a therapeutic relationship, he or she not only shares intimate thoughts and feelings with the counselor but may also reveal material that has never been told to anyone else. According to Smith-Bell and Winslade (1995), a client gives up personal privacy to gain therapeutic understanding and assistance. When clients reveal private information, they typically assume this material will not be shared with others. This assumption of confidentiality helps establish a trusting relationship. However, in recent years, the limits on confidentiality have grown. There are now situations in which a counselor is faced with breaking confidentiality to comply with the law (Herlihy & Corey, 1996; Scalise & Ginter, 1989). This is the case not only for verbal communication, but for a client's artwork as well. The "Ethical Principles and Code of Conduct" (American Psychological Association, 1992) specifically addresses the issues of privacy and confidentiality. The code states the following:

> Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances warrant. . . .
> Psychologists have a primary obligation and take reasonable precautions to respect the confidentiality rights of those with whom they work or consult, recognizing that confidentiality may be established by law, institutional rules, or professional or scientific relationships. . . .

> In order to minimize intrusions on privacy, psychologists include written and oral reports, consultations, and the like, only information germane to the purpose for which the communication is made. (p. 17)

In the *Code of Ethics and Standards of Practice* of the American Counseling Association (1995) there are similar caveats about keeping specific material confidential. The Code states:

> Counselors ordinarily release data (e.g., protocols, counseling or interview notes, or questionnaires) in which the client is identified only with the consent of the client or the client's legal representative. Such data are usually released only to persons recognized by counselors as competent to interpret the data. (p. 12)

Only the *Ethical Standards of Art Therapists* (American Art Therapy Association, 1995) addresses the specific issue of the artwork and confidentiality. The Standards state: "Art Therapists shall respect and protect confidential information obtained from patients in conversation and/or through artistic expression" (p. 1).

The right to privacy is laid out by the Fourth Amendment to the Constitution. However, there are certain limits to this right, and cases have been taken before the Supreme Court on several occasions for clarification. (See, for example, Morrissey, 1996). There are certain circumstances in which the counselor has an obligation to break confidentiality. According to Smith-Bell and Winslade (1995), "Therapists' general obligation to protect clients' confidential information is overridden by specific obligations to disclose information at the client's request, when the law requires it, or when ethics demand it" (p. 147).

Everstine and colleagues (Everstine et al., 1980) asked who should have access to confidential information and what would happen to that information if it was revealed. These questions are important to consider when one is thinking about including actual artwork or photographs of artwork in a client's record. Placing artwork that may include very primitive emotions into a record may violate a client's right to privacy. Lowental (1974) addressed the issue of discretion in psychotherapy. He stated, "The patient believes that all his productions, ranging from harmless childhood memories and 'innocent' dreams to the most bizarre sexual or aggressive contents of his psychic experiences, will be kept confidential by the therapist" (p. 235). Because artwork done in the therapeutic setting often depicts childhood memories, dreams, and expressions of sexual and aggressive content, the counselor has a particular responsibility to decide which of the pieces are seen by others, even those who are part of a treatment team. Spaniol (1994) gave an option for such instances when she suggested that

> the art therapist is in a position analogous to that of a verbal therapist who must paraphrase sessions instead of presenting verbatim process notes or audio recordings. Similarly, art therapists are always free to describe artwork verbally and to base impressions and assessments of clients on their own viewing of a client's art. (p. 73)

We can think of specific instances, however, in which showing particular artwork to the treatment team may be vital. For example, in cases such as severe psychotic regression, suicidal intent, or potentially violent behavior, artwork may make the point more vividly than a verbal description (see, for example, Morrissey, 1996).

Roback and Shelton (1995) reported findings that when a client expresses strong sexual or aggressive feelings, or the client is particularly difficult, the counselor is more likely to breach confidentiality and discuss the client with an outside person. This happens more frequently to novice rather than to experienced clinicians.

If therapeutic material can be difficult to contain, as stated previously, what are the implications for artwork placed in a record that may depict strong sexual or aggressive feelings? Again, one needs to be cautious about what enters the record.

DOCUMENTATION

Documentation is an especially vexing issue. The type of setting usually dictates how documentation is done. Certain institutional policies and procedures may present problems as to how one records a client's artwork. The type of agency also raises the issue of ownership of the artwork, which we will address later. In many cases, the counselor is expected to provide a written summary that includes a description of the artwork and the process the client went through to complete it. Some settings may require that the artwork itself be part of the client's record. This presents problems when a variety of art media (including three-dimensional materials) are used in the therapeutic setting. Some counselors may decide to photograph the client's artwork and place that photograph in the client's record. Not only is this process time-consuming and expensive, but we believe it could violate confidentiality. If a photograph of artwork is included in the client's record, anyone with access to the record can see it. Someone reading the record may have a strong reaction to a client's artwork and as a result discuss it with (or show it to) someone else. (When artwork is not perceived as being equivalent to verbal communication it becomes very susceptible to inappropriate exposure.) Simply stated, artwork done in counseling is not the same as artwork done outside of therapy, which might have been intended for a more general audience.

Spring (1994) drew a parallel to other professionals and their documentation. She stated the following:

> Each profession has specific materials that are deemed part of the clinical record (i.e., x-rays, photographs of injuries or damage, test results, etc.). What makes art therapists different in terms of clinical materials and records if the treatment is based on the art product of the patient? (p. 27)

We strongly disagree with the view that all art should go in the record. We believe when all art is placed in a client's record, the client's right to privacy may be compromised. In all situations, regardless of training, the person who is directly working with the art should give careful thought as to which artworks are shown or entered into the record so that they are given the proper context and that the possibilities for others' projections are minimized.

Photographing a client's artwork also raises the issue of informed consent. We believe a client must give written consent to having his or her artwork photographed. Obtaining consent to photograph a client's artwork may provoke unpredictable reactions that may have an unexpected or adverse impact on the therapeutic relationship. Some may be delighted and others may feel threatened. One of our clients said he thought that photographing his art would "take the magic out of it." (Again, in this case, creating the possibility of misinterpretation). Also, when a client refuses to grant permission to photograph his or her work, the counselor may feel distrusted or rejected.

OWNERSHIP

The type of setting in which the counselor works may dictate ownership of the artwork. The agency or institution may require that visual documentation be maintained as a part of the client's record. Policy may state that this is to be accomplished through photographs, slides, or by keeping the actual drawings or paintings in the client's record. Policy may also state that it is important to keep records of the client's work, both verbal and artistic expression. However, is the client's right to privacy threatened? We do not record everything the client verbally tells us both for practical reasons and because some comments are more open to multiple interpretations once taken out of the context of a therapy session (or even in the context of a therapy session). Should not the same consideration be applied to the client's artwork?

Spring (1994) addressed some of the issues surrounding the question of who owns the artwork. She stated that ownership of the artwork "can be settled at the beginning of treatment when the consent form is signed" (p. 26). She continued: "It seems more realistic to define who owns what part of the artwork and to explicitly define and ramify the legal aspects of this question" (p. 26).

Another aspect of ownership is determining who should keep the artwork. This is a controversial subject with many factors to consider and few obvious answers. For example, one factor is the type of agency. Another is how the art is used in counseling.

Should artwork done in a studio or group setting be given different treatment from artwork done in individual counseling sessions? Should the clients be allowed to keep the artwork they produced? Can this be harmful or helpful? Should it be decided on a case-by-case basis?

Ownership and documentation intertwine in complicated ways. Although many art therapists endorse the idea that the client owns the art and should be permitted to make a decision about the ultimate fate of the work, there exist implications concerning liability. Braverman (1995) stated

> medical records and hospital records, which most states require be maintained by the physician, clinic, or hospital for a period of seven years or longer ensure access in the future should the patient or any tribunal, governmental authority or other body require same. (p. 15)

If the counselor needs to defend himself or herself from charges of malpractice, a record is vital, even if some pieces have been destroyed. Therefore, it could be argued that a prudent course for those conducting intensive psychotherapy would be to keep a photographic record of all art and treat it like any other documentation. In agencies where the therapeutic emphasis is not on psychotherapy per se, one may follow more relaxed procedures. Each agency or program should make a thorough review of its own policies and procedures with its legal counsel to help employees and contractors make rational decisions on these matters.

ETHICAL ISSUES IN RESEARCH, PUBLICATIONS, AND DISPLAYS

Another area involves the use of client's artwork in displays, research, and publications and poses another problem. How does one adequately disguise the identity of a client? (This problem is particularly difficult for art therapists.) One can hide the client's name by covering up the signature, but how does one disguise a distinct artistic style? For a profession to grow and expand, the profession must conduct research and must publish and share material gained in the therapeutic setting—can this be achieved while still maintaining a client's rights to privacy and confidentiality?

In discussing the demands of professional growth through research and publications versus client confidentiality, Lowental (1974) referred to Freud's writing. In writing "A Case of Hysteria," Freud weighed publishing his discoveries for the sake of scientific discovery versus protecting the patient's confidentiality. For Freud, promoting the growth of science outweighed the patient's right to privacy (Lowental, 1974). To present another side of this dilemma, Levy (1986) stated, "Since our professional ethics are that the patient's healing comes first, then the patient is most important. Our publishing articles using our patient's work is next" (p. 89). Levy reminded the reader of the importance of the artist's vulnerability and the implication of the public viewing the artwork before the creator is ready. Wilson (1987) also cautioned therapists to "weigh carefully the costs and the benefits of any projected actions that entail a conflict between the rights of patients to privacy and the therapist's desire to contribute to the development of their field" (p. 79).

Displays, whether they are held in an agency or placed in a public venue, pose special problems. Because the art is created for therapeutic rather than aesthetic purposes, we believe that it should not be automatically treated the same as that made in an art class or created expressly for an audience. However, the way sessions are perceived by the participants can vary a great deal depending on the type of agency involved. Those facilities such as adult day programs and rehabilitation agencies put less emphasis on psychotherapeutic approaches. In such settings the art programs may be conducted by a trained art therapist or other professional with art-making skills. In adult treatment programs, participants are benefiting from "insightless change" (which focuses on catharsis and emotional reeducation) through art-making (Ulman, 1992). As a result, participants may be more interested in a public display of their work.

Pointing out the temptation for displaying art, Knowles (1996) said that in the case of children's art it is "often exciting and provocative, and it frequently cries out to be hung on the wall for others to enjoy" (p. 205). However, she also warned that when "clients' art is used for case presentations, supervision, and education, the [therapeutic] boundaries may also become unclear" (p. 205).

In setting up any public display, one must give careful thought to the goal of the event. In some agencies the art program is an important draw for future participants and supporters. However, there may be a strong temptation to publicly display art that reveals diagnostic information. We urge that such art be used only in professional presentations so that the appearance of a kind of "sideshow" is avoided. Instead, the art destined for public viewing should be selected for its aesthetic qualities and the artists should be in control of the descriptions for any catalog or picture captions (see Spaniol, 1990).

USE OF ART BY OTHER THERAPISTS

The final ethical issue we discuss is that of other therapists using art in therapy. All three ethical codes we consulted stressed that no mental health professional should practice beyond that which he or she was trained to do. We believe that any well-trained counselor should be able to talk with a client about a piece of art brought into the session. In such a case, the work should be treated as one would any dream or other reported experience. Also, other therapists should be able to prompt a client to draw or paint an image when talking becomes difficult or the client is blocked in describing something. However, many therapists may be unprepared for the strong affect often evoked by art (or even certain art materials) and unsure of how to use artistic processes to bring such affect under control. Other therapists challenge ethical and legal boundaries when they attempt to make an interpretation to the client or to make a generalization about the meaning of the art to others (e.g., to members of an agency's treatment team or as part of an assessment). Such translations require not only training in therapeutic interventions but also extensive familiarity with artistic processes, art history, and graphic symbolism.

Olivera (1997) acknowledged that there will never be enough art therapists to work with all those who could benefit from art-based interventions. She offered some "guidelines that other conscientious therapists may find useful in determining the limits of their ability to use art in therapy" (p. 17). Olivera also offered a helpful list of the situations in which one should consult with or refer to an art therapist.

CONCLUSION

The use of artwork in the counseling setting raises many unexpected ethical issues. We believe that if artwork is given the same consideration as verbal communication then the implications for confidentiality are essentially the same. Mental health professionals must take precautions to protect the confidentiality and privacy of their clients. They must be aware of the implications of including artwork in documentation as part of the client's record and be sensitive to that material. They must consider both the legal and the therapeutic implications of ownership of the artwork and weigh the benefits and potential harm that could occur from including client's artwork in research or published material.

We have raised these issues surrounding the use of artwork in the therapeutic setting hoping that other mental health professionals will write about their experiences and enter a dialogue about these complex issues. Such a discussion will help all professionals craft better answers to the various issues and concerns raised in this article.

REFERENCES

American Art Therapy Association. (1995). *Ethical standards for art therapists*. Mundelein, IL: Author.

American Counseling Association. (1995). *Code of ethics and standards of practice*. Alexandria, VA: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. In D. Bersoff (Ed.), *Ethical conflicts in psychology* (pp. 6–24). Washington, DC: Author.

Anastasi, A. (1968). *Psychological testing* (3rd ed.). Toronto, Ontario: Collier-Macmillian Canada.

Braverman, J. (1995, Winter). Retention of treatment records under the new AATA ethical standards. *American Art Therapy Association Newsletter, 28*,15, 24.

Buck, J. (1948). The H-T-P test. *Journal of Clinical Psychology, 4*, 151–159.

Burns, R. (1982). *Self-growth in families: Kinetic family drawings (K-F-D) research and application*. New York: Brunner/Mazel.

Burns, R. (1989). *The kinetic house-tree-person drawing*. New York: Brunner/Mazel.

Burns, R., & Kaufman, S. (1970). *Kinetic family drawings*. New York: Brunner/Mazel.

Burns, R., & Kaufman, S. (1972). *Actions, styles and symbols in kinetic family drawings*. New York: Brunner/Mazel.

Cane, F. (1951). *The artist in each of us*. Craftsbury Common, VT: Art Therapy Publications.

Everstine, L., Everstine, D. S., Haymann, G., True, R., Frey, D., Johnson, H., & Seidan, R. (1980). Privacy and confidentiality in psychotherapy. *American Psychologist, 35*, 828–840.

Freud, S. (1966). Difficulties and first approaches. In J. Strachey (Ed. and Trans.), *New introductory lectures on psychoanalysis* (Vol. 15, pp. 83–99). London: The Hogarth Press. (Original work published 1922)

Gladding, S. T. (1992). *Counseling as an art: The creative arts in counseling*. Alexandria, VA: American Association for Counseling and Development.

Halsey, B. (1977). Freud on the nature of art. In E. Ulman & C. Levy (Eds.), *Art therapy viewpoints* (pp. 99–103). New York: Schocken.

Hammer, E. (1958). *The clinical application of projective drawings*. Springfield, IL: Thomas.

Herlihy, B., & Corey, G. (1996). *ACA ethical standards casebook*. Alexandria, VA: American Counseling Association.

Jung, C. (1963). *Memories, dreams, reflections*. (A. Jaffé, Ed.; R. Winston & C. Winston, Trans.). New York: Pantheon.

Jung, C. (1969). *Mandala symbolism*. R. F. C. Hull, (Trans.). Princeton, NJ: Princeton University Press and the Bollingen Foundation. (Original work published 1950)

Knowles, L. (1996). Art therapists exhibiting children's art: When, where, and why. *Art Therapy: The Journal of the American Art Therapy Association, 13*, 205–207.

Koppitz, E. (1968). *Psychological evaluations of children's human figure drawings*. New York: Grune & Stratton.

Kramer, E. (1958). *Art therapy in a children's community*. Springfield, IL: Thomas.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken.
Kramer, E. (1979). *Childhood and art therapy: Notes on theory and application*. New York: Schocken.
Levy, C. (1986). Writing for publication in art therapy. *Art Therapy: Journal of the Art Therapy Association, 3*, 89.
Lowental, U. (1974). The vicissitudes of discretion in psychotherapy. *American Journal of Psychotherapy, 28*, 235–242.
Machover, K. (1949). *Personality projection in the drawing of the human figure*. Springfield, IL: Thomas.
McNiff, S. (1981). *The arts and psychotherapy*. Springfield, IL: Thomas.
McNiff, S. (1988). *Fundamentals of art therapy*. Springfield, IL: Thomas.
Morrissey, M. (1996, July). Supreme Court extends confidentiality privilege. *Counseling Today*, pp. 1, 6, 10.
Naumburg, M. (1950). *Schizophrenic art: Its meaning in psychotherapy*. New York: Grune & Stratton.
Naumburg, M. (1958). Art therapy: Its scope and function. In E. F. Hammer (Ed.), *The clinical application of projective drawings* (pp. 511–517). Springfield, IL: Thomas.
Olivera, B. (1997, Winter). Responding to other disciplines using art therapy. *American Art Therapy Association Newsletter, 30*, 17.
Roback, H., & Shelton, M. (1995). Effects of confidentiality limitations on the psychotherapeutic process. *The Journal of Psychotherapy Practice and Research, 4*, 185–193.
Rubin, J. (1978). *Child art therapy: Understanding and helping children grow through art*. New York: Van Nostrand Reinhold.
Rubin, J. (1984). *The art of art therapy*. New York: Brunner/Mazel.
Rubin, J. (Ed.). (1987). *Approaches to art therapy: Theory and technique*. New York: Brunner/Mazel.
Scalise, J. J., & Ginter, E. J. (1989). Confidentiality and privileged communication. *The Professional Reader, 1*, 37.
Singer, J. (1972). *Boundaries of the soul*. New York: Doubleday.
Smith-Bell, M., & Winslade, W. (1995). Privacy, confidentiality, and privilege in psychotherapeutic relationships. In D. Bersoff (Ed.), *Ethical conflicts in psychology* (pp. 145–150). Washington, DC: American Psychological Association.
Spaniol, S. (1990). Exhibiting art by people with mental illness: Issues, process and principles. *Art Therapy: The Journal of the American Art Therapy Association, 7*, 70–78.
Spaniol, S. (1994). Confidentiality reexamined: Negotiating use of art by clients. *American Journal of Art Therapy, 32*, 69–74.
Spence, D. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: Norton.
Spring, D. (1994, Fall). Who owns the artwork? *American Art Therapy Association Newsletter, 27*, 26–28.
Ulman, E. (1992). Therapy is not enough: The contribution of art to general hospital psychiatry. *American Journal of Art Therapy, 30*, 89–97.
Wadeson, H. (1980). *Art psychotherapy*. New York: Wiley.
Wadeson, H. (1987). *The dynamics of art psychotherapy*. New York: Wiley.
Wilson, L. (1987). Confidentiality in art therapy: An ethical dilemma. *The American Journal of Art Therapy, 25*, 75–80.

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ORIGINAL ARTICLE

Through the eyes of the law: What is it about art that can harm people?

NEIL SPRINGHAM

Abstract
The notion of arts-based risk is rarely acknowledged outside of art therapy. This paper describes an injury sustained as a result of art activity. The case was subject to legal proceedings which established arts practitioner and organisational negligence. The case was consequently settled out of court for a large sum. The paper reports the legal argument and explores what the process tells us about how art can both help and harm participants. This specifically concerns the power of art to make the subjective seem real and the need for practitioners to able to competently assess participants' psychological vulnerability to this. The case represents an important milestone in the current arts and health debate, particularly with regard to the protection of the public. Lessons to be learnt for organisations seeking to deliver arts and health projects to vulnerable people are discussed.

Keywords: *Arts and health risk, injury, law, evidence*

Introduction

In March 2008 Lord Howarth of Newport launched a debate in the House of Lords asking Her Majesty's Government how they intend to develop their policies to link the arts with healthcare (Hansard, 2008). Positive examples of the arts helping with a range of physical and mental health conditions were offered and the need for research and coordination was highlighted. Whilst the debate represents a welcome recognition of the power of art to help people, the notable lack of any reference at all to risk was typical of how the subject is currently construed by many. This is a worrying naivety. In what other area of health would we describe an agent having power but not risk?

Arts therapists attempted to raise the issue of arts-based safety and risk when the arts and health prospectus was being developed, but achieved only one referenced title to it (Sandford, 2007). Admittedly, such risk will vary greatly because the arts and health is not a single homogenous practice but a range of very different interventions. Unfortunately, the current language is very poor at differentiating practice elements across the range of creative and psychological interventions. Because of this I have attempted to identify a subset of arts and health practices by deliberately employing the term art as therapy in the paper[1] which I define as having three key elements:

1. A participant who is vulnerable
2. An art activity
3. Some kind of linkage between the art and the participant's personal material.

This linkage to personal material may still vary greatly from being asked to choose images which have individnal significance in an art group to a full psychotherapeutic process.

This definition of art as therapy would not then include a range of excellent practice such as art classes, attending galleries or participating in mural projects etc. I mnst also emphasise that I make no differentiation abont whether art as therapy interventions are run by art therapists or non therapy trained artists because in practice training does not determine who delivers what type of intervention. Many arts and health practitioners deliver art as therapy and many art therapists deliver recreational or wellbeing interventions as part of their wider roles. I also think it is very important to highlight that this description shows some arts and health activities exist in a grey area where creative projects which involve linkage to personal material can become art as therapy interventions by default. This should be a concern.

In terms of managing risk in art as therapy, the British Association of Art Therapists (BAAT) position has been that it is practitioner training and professional structures add the essential value. Our experience at arts and health conferences and meetings has been that some (but not all) continue to

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criticise the professional body for this. The allegation is that this is self-interested professional protectionism, an attitude which risks narrowing the arts and health field and its benefit to so many. This opinion has not yet been pnt in writing but it seems to pervade as some kind of received wisdom. Actnally, it seems to me there is some validity in all these points individually but the meta-problem here is that the debate is rather stuck in a polarised stalemate between practitioners. It misses the more important question about the experience of the participant. It is of course important to acknowledge that many people engage in art and improve their wellbeing significantly without harm ensuing. But whilst many benefit it is a fact, inconvenient or otherwise, that causalities do occur in this process and particularly so in the grey areas around art as therapy. For instance, I recently worked as an expert witness on a legal case involving a serious injury sustained as a result of art as therapy delivered by a non art therapist in an addictions treatment centre. I wish to report this case and to look at the issues it raises for the field.

The fact of the case makes the question of *if* harm can happen in arts and health redundant. The more pressing question is now *what* it is that can harm people and this is the focus of this paper.

I have written this paper in collaboration with the individual who suffered this injury. My co-author wishes this story to be told because he hopes the lessons it gives about art making might prevent what happened to him happening to others. Whilst he is doing well in recovery he has asked to remain anonymous, not for himself but because he is mindful of the needs of his young family in a close traditional community. I shall therefore refer to him as 'the claimant' throughout. I feel his voice is crncial in focusing the debate on the processes for the participant, rather than on claims of practitioner territory.

The claimant wishes to state from the outset that he would not have resorted to law if he had had his experience taken seriously and received an apology. Indeed, he does not wish the addictions rehabilitation centre to be named because he feels that any failing was specific to the management of the art provision and does not generally represent the other good work they do and would not wish to put any more barriers to people getting help. The rehabilitation centre shall be referred to as 'the centre'.

The case was pursed by the highly reputable firm of Parlett Kent solicitors which has extensive experience in dealing with all areas of clinical negligence including cases involving children with disability, the misdiagnosis and treatment of cancer, fatal cases, sexual abuse and psychiatric negligence claims. The solicitor's application of due process required a rigorous focus on the issues of art-based risk. I believe the outcome of this has offered a more robust and evidence-based framework for exploring this crucial matter than the vagaries of onr present language and debate allow.

The legal process

I personally was enthusiastic to gain experience of the expert witness role in this case because it combined my specialism in addictions with my longstanding interest in the law. I found it challenging and invigorating to examine familiar processes through the eyes of others with different reference points. The process of law forces any statements made about art practices, including art therapy, to be made explicit enough to be subject to the scrutiny of cross examination. Such testing clarifies our language and terms. That, after decades of practice in the arts and health field, I still fonnd it difficult to be explicit with our current terminology, proved to me that clarification is necessary. Both arts and health and art therapy language can be esoteric and unspecific. I feel we need a terminology that creates the means for defining practice so it can be critiqued by others. Far from being reductive, I feel this would increase reasoned debate and sbare practice innovation.

As therapists we are constantly asked to engage with evidence. The concept of evidence as a legal entity is perhaps less familiar to ns, yet arguably it exists in the longer tradition. The law might be said to represent an accumulated response to human interaction over at least a 2000-year period.

Tort law is concerned with ensuring that citizens compensate each other for damage, pain or suffering they may cause each other by behaving carelessly or in bad faith, e.g., by acting negligently towards someone to whom you owe a duty of care and causing them injury. Negligence is a severe breach of duty of care, e.g., a wrongful act or an omission of an action, which results in a damage that was a foreseeable (or likely) consequence of the original wrong. Our system of litigation has its roots in the discipline of rhetoric, where the counsels for both defence and the claimant explicitly aim to use evidence and argument to build a case that is persuasive of their perspective. The process involves an examination of a range of data, such as statements, objects, and reports etc, to try to establish their reliability as evidence. Questioning from polemical positions subjects evidence to deep examination. Because the validity of evidence determines such serious outcomes, its testing is rigorous.

This adversarial approach involves an exchange of claims from claimant to defence, resulting in either admissions or counter claims from the defence in return. The word tort comes from the word 'tortuous'

because the resulting twists and turns the legal argument must take were felt to resemble a twisted shape of a branch. The underlying assumption is that the truth is the strongest argument.

Once a negligence case is started then it will go to trial unless it settles out of court because it is admitted that one side is clearly going to win. The Civil Procedure Rules oblige all clinical negligence actions to have supportable expert evidence on both sides. The expert must establish their credentials for the job and then must not comment outside of their specialism. The two experts also monitor each other to minimise bias. The expert does not advocate for any side. They are led by questions asked by counsel as they attempt to build their case.

The experts in this case were from art therapy, psychiatry and orthopedic surgery. I think it would be illuminating to now put the evidence before the reader. The following is taken from formal statements exchanged between the claimant's and the defence's legal teams which formed the basis of the case prepared for court.

The context

The centre offered addictions rehabilitation treatment in England. It employed a variety of staff based on their roles and job descriptions (e.g., group leader or team manager) rather than by any particular profession, this being a common and lawful practice in this sector. The treatment programme comprised two stages. Broadly speaking, stage one focused on assessment and stage two on treatment.

The leader of the art group in question was employed as a 'Team Manager' and for anonymity shall be referred to as TM. TM was appointed on the basis of having acted as director and counsellor of a residential rehabilitation clinic and seven years experience of delivering Christian counselling (no qualification was presented). He described having specialised in the use of 'art therapy' to 'facilitate emotional growth and enable recovery' based on two very short non-qualifying courses with art therapy in their title.[2] The charity made him responsible for developing and coordinating the range of individual and gronp work activity.

TM proposed improvements to stage two aimed at making it more 'therapeutic' and within six months of being employed had introduced several new ideas including what was described variously as an 'art course', 'a class in art education' and 'anger management using art'. The claimant disputed these descriptive titles saying the group had been described to him as art therapy. Significantly, there were no written leaflets for the group to clarify the matter. This confusion in description would have a material effect on the outcome of the case.

Sequence leading up to the critical incident

The claimant is a male who was born in Asia and in 1978 came to England at the age of 11. On attending school he snffered both racial abuse and bullying for the first time and describes using bravado to cope. His peer group at the time became engaged in antisocial activity and he was himself convicted for a number of offences including violence. At the age of 20 the claimant started using drugs including crack cocaine. During the 1990s the claimant began to take steps to change his life. He married, had two children and worked in a responsible job. In September 2001 he was accepted on the residential rehabilitation treatment programme at the centre.

Not uncommonly in this taxing process, within one month he experienced difficulties in treatment and was given a written warning for failing to attend a session. Staff noted that he seemed to be 'carrying around a lot of anger'. In November 2001 the claimant went to India, his country of origin, with his brother to take back the ashes of his recently deceased father. During the funeral the claimant had an alcoholic drink, not thinking this was an issue as his problem substance was cocaine but when he returned was he given a further written warning for breaking the programme's no-alcohol policy. At about this time his key-worker also began talking to him about the requirements for stage two of the programme. In December 2001 together with another resident, the claimant apparently smoked some crack cocaine. This was followed by an incident when the same resident had been seen talking to the claimant in an aggressive manner at a meal, resulting in him throwing his food away and leaving the room. The claimant was seen by his key-worker because of these difficulties and it was assessed that he was not yet ready for stage two and his progress would be reviewed at the beginning of January 2002. Soon after this the claimant was given a third and final written warning for using drugs whilst on the programme.

In my experience the above pattern is typical of the struggle to address such a serious and entrenched drug habit, particularly in the context of such a significant bereavement. It is of note that, despite these vulnerabilities, the claimant was still put onto stage two of the programme within two weeks of his last written warning.

The incident on 7 January 2002

The claimant attended the art session on his first day on stage two of the programme. The session began after lunch and the residents taking part were sitting on mats approximately one inch thick placed on a concrete floor. The claimant describes participants each being issued with sheets of paper and some paints and being instructed by TM to 'portray all of

the bad things in our lives, the guilt we felt about what we had done and everything negative into the drawing of an animal'. The claimant then made an image which he described in his statement thus:

> *I drew a picture of a hyena with blood coming out of its mouth. The hyena was surrounded with green grass. The green grass was to me perfect countryside and a representation of my life with my wife and my children. The hyena represented a scavenger inside of me with no conscience or morality, just wanting what it wants.*[3]

The claimant then stopped drawing, at which point TM, who had been talking to others in the group, came over to him. According to the claimant TM asked him what he would like to say to the animal. The claimant replied that he 'did not want to *say* anything but wanted to swear at it, to rip it up and punch it, to smash it up'. The claimant describes what happened next thus:

> *I can't remember if he (TM) actually said to 'express yourself' or 'go with the feelings'. I swore at it (the painting) and it was on the floor or on the mat and I punched it. (TM) was beside me and on my right. I was hitting it (the picture) and punching it and my knuckles were cut and then I got on to my feet and dived down onto the painting with my head, to destroy this animal.*
>
> *I went into a rage that moved from swearing to hitting and punching the picture as hard as I could for 3–4 minutes. I thought (TM) was watching me throughout this time and no one tried to stop me. I was thinking of all the damage that drugs were causing me and to everything I held dear and especially the fact that my drug use was harming my children. I thought of everything I had done in order to obtain drugs, crime and lies and the fact that my addiction had deprived me of both pride and my dignity and had made me cheap and worthless.*
>
> *I couldn't hit any longer but I was still looking to destroy the picture so I got up and dived on to the picture head first. I felt an excruciating pain and started crying out. I wasn't able to move but (TM) did not believe me.*

It was noted that TM's statement conflicted with the above. TM stated that the period between hitting and head-butting the image was instantaneous and all in one movement. He disputed that this transition had taken minutes.

The length of time the claimant was left on the floor after the event was also disputed. The claimant stated he was left, and the centre claimed they responded immediately. The ambulance records show that it was about two and a half hours after the start of the group before they were called. The claimant was taken with his neck in a collar to hospital and cuts were noted on the claimant's knnckles by the ambulance crew. He was later diagnosed as having suffered a wedge fracture of the fifth cervical vertebra resulting in partial tetraplegia. The claimant was later transferred to another hospital for an operation and then some weeks later again for recovery. He was later discharged home but still had weakness and reduced sensation in his upper limbs. He was able to walk slowly using a stick for balance, suffered bladder and sexual dysfunction.

Having gathered this information, the resulting legal argument did indeed twist and turn through what I found to be a compelling interrogation of the data by each team in order to build their case prior to going to court. I would like to present the critiques I was asked to provide from the art therapy perspective and would ask the reader to particularly note where points are admitted by the defence.

The twists of the branch: The legal argument

To start with I was asked by the claimant's counsel to compare the charity's management of the development of art activity on its therapeutic programme with the clinical governance of art therapy required within the NHS. I commented that, in my role as a manager, I would be expected to appraise the risks of any developments in treatment and to match the staff competence to identified risk. I did not think TM had adequate skills for the way art was being used in the therapeutic programme because, whatever it was called, it was *in practice* using art as a therapy (as per the definition above). Moreover, the charity had not made any provision for being able to ensure, or even know if, TM would remain within the scope and limits of his skills developing art as therapy for the programme. Given that information on art therapy is readily available, it was neglectful to not have sought advice from the Health Professions Council (who offer employer advice) and BAAT to compensate for this lack of knowledge and skills in the organisation. The defence team admitted the point that there was a breach of dnty by the charity in causing or permitting TM to assume the role of an 'art therapist'.

Having conceded this point the defence then attempted to distance it as an issue by pleading contributory negligence in the defence, seeking to argue that the claimant was responsible for his own actions and therefore failed in his duty of care to himself when he head-butted the picture. To build a counter-argument I was asked to comment on this and highlighted that the material point was that the claimant was specifically in treatment for his addictions and a major strand of treatment for this involves trying to gain mastery over chaotic emotional states and impulsiveness. I was asked if the claimant should reasonably expect to trust that his therapists would be competent to assess him in this context and to not offer treatment which would take him beyond his tolerance for heightened emotional states. I did think that this was reasonable given that such rehabilitation

organisations are set up to take people when they are vulnerable and disorientated.

This point of trusting the organisation is strengthened by noting that stage one of the programme was concerned with assessment. I was asked to make a comparison between how the centre and myself as an art therapist would have approached the session. I stated that an art therapist would assess the patient by integrating long-term history, preceding events and current emotional state to make a psychological assessment and to balance this with their knowledge of the effect the art medium might have on such a psychological state. The assessment would be ongoing, with particular concern to monitor how the participant experienced the art in terms of being emotionally stirred.

I considered the centre was in possession of the information needed to perform such an assessment, e.g.: the history indicated poor impulse control; physical violence; difficulty with unwanted feeling states; the recent death of the claimant's father; the trip to Asia; his recent relapse and the incident at breakfast. I noted that the centre had also attempted direct observations of the current emotional state and had recorded observations of the claimant such as: 'passive/aggressive'; 'reluctant'; 'struggling'; and 'angry' just prior to the session. The failure was therefore in the competence to make sense of the data they were in possession of via the form of an assessment.

On the basis of this the claimant's team put it to the defence that it was a failure by the centre to perform a competent assessment to determine the claimant's vulnerability, particularly with regards to impulsiveness and therefore his ability to fulfil a duty of care to himself. The defence then admitted that the centre was in breach of duty in allowing the claimant to participate in the art therapy session and that TM knew or ought reasonably to have known that the claimant was or might be emotional, vulnerable, unpredictable and/or potentially unable to control his feelings.

The next set of questions focused on the approach to treatment. I was asked to comment on the role that treatment information would have on treatment progression and outcome. I commented that this would have an affect on how a patient would assume they should approach and use the therapy. For this reason an art therapist would check the participant's understanding of the proposed intervention as a part of the consent process. In this case, there was no evidence of this having been done and noting the various ways the group had been described the participant appeared to have been left to glean his own understanding. Given the group existed in stage two of the programme, i.e. the 'therapeutic stage', I suggested that it would be reasonable for the claimant to assume that the session involved working 'therapentically' on feelings.

The claimant's counsel asked him directly if he entered his feelings to this degree because he assumed that was the best way to maximise the effects of therapy. The claimant replied:

> *I had a lot of issues at the time. My father's death was on my mind. Whatever the programme required, I would have done it wholeheartedly.*

This is a prime example of how the lack of clarity of terms and language adds serious risk.

I was asked to critique the choice of art therapy technique. I put it that being asked to 'portray all of the bad things in our lives' was inappropriate in these circumstances because it would encourage the very splitting dynamic and black and white thinking that causes addicts so many problems in the first place. The claimant had many difficult things in his life at that point and concentrating such negativity in the form of an art image was dangerous.

I also criticised the 'talking to the image' method TM used to help engage the image at a personal level as additionally and excessively provocative for that circumstance. For clarity, I suggested a material differentiation between talking *to* an image and talking *about* an image thus:

- 'Talking *to* an image' implies an intention to embody feeling and perceptions in the image by way of provoking an experience of their realness, by acting and relating to them as real in the world. The problem is that it can be unwise to over-validate subjective experience at the expense of reality testing for people with the claimant's history of violence. Impulsiveness is often caused by the individual being misled by misperceptions (projections, transference reactions, etc) which already feel too real. Moreover, relating so exclusively to the image by talking to it can marginalise the therapist, who might offer alternative mitigating perspectives and emotional containment.
- 'Taking *about* an image' implies a process of talking *to* the therapist about the picture. This is preferable in these circumstances because it does not emphasise the subjective experience of the image to such a degree. Indeed the distance from the immediacy of the image's content gained by talking about it is helpful in developing a thinking, rather than impulsive, approach.

I felt the claimant's statement to the defence's psychiatric expert witness (below) substantiated that the poor choice of theme and the problems raised by talking *to* the artwork had combined to make the artwork too powerful by making it over-real:

(The picture) showed all the negativeness about me, separating all the badness in front of me into an animal that had destroyed my life and I intended to smash it up and kill it. The more I spoke to it, the more alive it became. As I spoke I don't know what happened because it sort of came alive. Everything about it came into my head – shame, guilt, people I've hurt. I hated this thing. It wasn't a piece of paper, it was the feelings. Before the conversation I had with it, it was a painting, but when I spoke to it, it seemed more real – not that the picture was real, but the feelings made it seem alive and so I dived in to destroy it. I don't know what happened. The more I spoke to it, the more angry it made me, like it was taking out all the negativeness and putting it in front of you.

In describing this to the legal counsel, I was concerned that such specialist differentiations may somehow be too esoteric for non art therapists but I was pleased to be wrong. The legal team understood these points and their relevance well and used this as the basis to argue against TM's approach. It was admitted by the defence that this theme was provocative for someone with the claimant's history.

The claimant's team had now posited the type of direct causal link between the power of art and the injury sustained needed to establish negligence. This exclusivity of cause is termed the 'but for' test of a legal argument (Williams, 2002). From the defence's perspective, this focnsed their task onto the production of an alternative explanation of causality in order to throw doubt on the directness of that causal link. If they could do this the case would collapse. The claimant's experience of realness of the picture was subjected to examination from a psychiatrist for the defence. If it could be said that the picture became too real, not because of the power of art, but because the claimant may have experienced psychiatric phenomena, then it could not be said with safety which had caused the injury. There would always be a confounding variable in the argument. The claimant's experience of his art seeming real was subjected to the following medical hypotheses by the psychiatrist for the defence and this is the result:

Brief Psychotic Disorder: This particular condition is typically associated with emotional turmoil and although the claimant was indeed in such a state, his reaction was too short (lasting only seconds) to qualify for this diagnosis as described in DSM-IV-TR requires psychosis to last for at least a day.

Drug Induced Psychosis: The claimant's reaction was not at all typical of the psychosis sometimes associated with cocaine. This would not include fleeting psychotic experiences but more usually includes persistent delusions and the claimant did not show evidence of this.

Dissociative Trance: The claimant reaction was only consistent with a limited number of aspects of a dissociative trance disorder. It was described as 'atypical' because this would typically include amnesia for the event itself and the claimant remembered, lucidly, what happened.

This report effectively failed to find that a reliable psychiatric defmition could be applied to the experience of the art becoming real. Likewise the psychiatrist for the claimant dismissed the notion of any psychosis 'lasting seconds'.

However, faced with the failure to find a medical variable, the psychiatrist attempted a qualifying remark that she had, in decades of medical experience 'never heard of an episode similar to this'. This presumably was attempted as an argument against foreseeability by the defence. I was therefore asked by the claimant's counsel to comment from an art therapist's perspective on this psychiatric assessment of the art session. Noting the lack of a formal psychiatric diagnosis, I suggested any comments beyond this wonld constitute an 'over-medicalisation' of experience of the art activity. Moreover, to have offered the statement of 'never having heard such an episode' as an argument against foreseeability was disingenuous to the remit of the role of 'expert' witness. A psychiatrist would be unlikely to have gained experience of such episodes in the use of art in therapy. As an art therapist this activity is my primary task and I had discussed similar patient reactions to art with art therapist colleagues. Regrettably, I was acutely aware of how few of these are documented in art therapy literature. Still the point remained, in the absence of a convincing psychiatric explanation for causality, the focus continued to point to something about the art itself.

My counter-argument aimed to substantiate that the arts have a power to help us suspend disbelief and to make us feel as if we were experiencing something beyond the concrete presence of the object. This would better explain the claimant's statement that 'It wasn't a piece of paper, it was the feelings'. Evidence from the arts that suggests objects becoming 'real and alive', to a range of degrees, is far from unheard of and actually nearer to the norm. The experience of the subjective as real is one we all have in art and could be said to be the very reason art doggedly continues to exist in our culture. People regularly have strong, visceral reactions to art, as if something beyond the material object itself were real. Many cry watching films even though at the most concrete level they are merely watching lights on a screen. It is not just the story; it is the arrangement of abstract elements such as sounds, colours, and gestures etc that create the effect. This effect would not happen if we just read the script. Our current age rating certificating system for films is an acknowledgement of the developmental aspect of realness in cinema. Many parents sit in cinemas telling terrified children 'it's just a film, it's not real'. But how many of ns have said just

this to ourselves as adults during an effective horror film? Similarly we are deeply moved by music even though it is just sound and painted images which are just pigment on canvas, etc. When I have run art workshops for clinical staff, where usually it is reasonable to assume a low presence of diagnosable psychiatric condition exists, I have had to use considerable skill and care because people are routinely awestruck by the vivid 'realness' of the experience of their own art. It would be unreasonable to argue that the general population's reaction to art is always determined by temporary mental illness.

This evidence matters. Establishing probability of cause by making a link from art to harm was what won the case. Such a clear case of arts-based injury has wider implications for the risk debate in the arts and health field. Given its importance, then, I would like to put more detail of my rationale before the reader.

The realness of art and harm

That the injury was sustained by an arts practitioner working beyond their competence was established. But if we are to learn the lessons of this case it is important to attempt to be as explicit as possible about what the causal elements were. Clearly, TM had exceeded his competence in two parallel domains of assessment:

1. General psychological: evaluating the claimant's tolerance to unwanted feeling states
2. Art therapeutic: a specialist assessment of the effect of the art on the participant.

For the purpose of this paper I would like to focus on the second. Because TM was not an art therapist he was unable to make sense of the information before him. If we look at the following statement made by the claimant to the defence's psychiatrist, it is clear the picture already had effected a substantial power even before TM tried to engage the claimant by 'talking to' it:

> *The picture showed all the negativeness about me, separating all the badness in front of me into an animal that had destroyed my life and I intended to smash it up and kill it.*

A clear observation of an art property can be made here, that the effect of the art was powered by mind-reality isomorphy. The claimant had a confirming experience of his internal and subjective state as a real object in the world through his art. Even prior to his neck injury the claimant has already been harmed by this. He has been taken beyond his tolerance and his functioning diminished by his art. My clinical experience of this state is that impulsiveness would in all likelihood result. Moreover, we should not be misled by ideas that the neck injury was somehow unusually harmful. There may have been a host of other outcomes such as violence or disengagement from treatment altogether. Both of these are highly dangerous and sometimes fatal in this context.

Because TM was incapable of recognising the isomorphic power of the art already exerted on the claimant, he chose an engagement technique which was too strong. TM's suggestion to talk to the picture merely re-enforced the image's realness, thus pouring petrol on the flames. To test the isomorphic concept, we might ask that given that the patient was sufficiently aroused and upset by this point, would 'talking to' anything other than an artwork have sparked this reaction? Had the claimant been asked to talk to a different object, such as an empty chair for example, would this effect have worked in the same way? The evidence of his statement suggests the picture already appeared so similar to the content of his mind as to become convincingly isomorphic. Contrastingly, had this been a chair, the brute fact of its 'chairness', no matter how you talk to it, has a much lower accuracy of symbolic equation. This is not to deny that such a 'talking to' method may also have been overwhelming for the claimant in that state of mind. But it can be argued that the absurdity of the mismatch between mind and reality would be *the* helpful quality which diminishes psychic equivalence and allows an easier return to reality for the participant after the exercise.

The recognition of the power of art to make inner states real is the basis of the art therapy profession itself. Understanding how art interacts with psychological states is essential in assessing its optimum effect on the participant. The art therapist understands that the power of art must be titrated to be useful. If it is not real enough then the disengagement with the inner world will make it ineffective and irrelevant, but eqnally if it is too real then objectivity and thinking can get lost and the participant overwhelmed with a terrifying experience of mind-as-reality. An art therapist would tend to start therapy in this context with the assumption that the art made might already be too powerful. The art therapist's primary concern then would be moderation of art-realness and the establishing a state of 'play' in the art session. The optimum state of art therapy play is where the art is *felt* to be real but *known* not to be. That is, the maker can experience their image in an 'as if' way, as being like the contents of their mind, as distinct from the type of concrete realisation of mind the claimant experienced. I would suggest this is a defining feature running through art therapy literature in the UK.

I argued for the claimant, and argue now, that competence to assess this effect of art must be gained through substantial experiential learning within a psychological framework. This learning is particular to art therapy training. It might be said that without this

experiential-based learning, the power of art is actually counter-intuitive. It is not immediately credible that grown people might be overwhelmed by pictures to such effect. Only by experiencing what it is like when an image continuously signals its unnerving similarity to one's subjective reality can one understand, or even believe, the claimant's statement (above) about the picture becoming real. Moreover, an image's power is likely to be greater if the participant has made it themselves: the employment of their own symbolic language creates an uncanny familiarity when it so accurately mirrors the inner world. TM's failure was to attempt to increase the impact of the art because his lack of training made him unable to assess that the participant's reflective capacity was already compromised by his art making. TM simply lacked this and his assessment of the power he was handling was catastrophic.

If I were making this assertion without evidence I could accept the criticism that such a self-proclaimed claim to special understanding might be professional protectionism. Being aware of this point I asked the claimant to add his perspective. This is his statement:

> *All through my time at the hospital even the nurses, after reading my medical report, looked at me as though I was a mad man. Even some members of my own family thought my injury was self inflicted. No one could understand what it was like for me and how I felt after having to get in touch with the addict inside of me. To externalise it into a painting and to talk to it was like giving it life of its own and to think of the agony and shame and guilt that has caused me made me want to kill or destroy it. No one could understand it. I tried to explain to people but most people could not see beyond me head-butting a painting. In the legal conference when I first met (the art therapist) and he spoke was the first time that I felt relieved that someone could understand. He was exactly right when he said about one should not tap into just the negativity as it is a dark place for most addicts.* (The claimant, May 2008)

These points were used to make the argument that using art is powerful intervention, but particularly so where the participant has a psychological vulnerability. In the absence of any confounding variable, the claimant's counsel made the case that the injury was caused by the art as therapy session. Rather than continue to court on the basis of that argument, the defence surrendered their case and settled out of court for over a quarter of a million pounds in favour of the claimant. TM resigned from his job at the charity soon after the incident. He has since taken up a role as a clinical director in another addictions centre on another continent.

Conclusion

It is a sad fact that extreme consequences in treatment offer us the clearest lessons in cause and effect. Whilst the particular injury in this case might be said to be unforeseeable, the approach used meant an injury of some sort was foreseeable. Moreover, in my experience in the field such risky practices are not uncommon in art as therapy sessions, but it is precisely because the sessions occur outside of professional or governance structures that they do not get documented. Settling this case out of court is an admission by the defence that it was unwinnable. It sets a helpful legal precedent establishing that both art and art as therapy carries risk of harm if it is applied beyond the competence of the practitioner. This risk is amplified massively where the participant has a vulnerable psychological predisposition, particularly where they tend to excessive subjectivity or poor reality testing for whatever reason. Safety and effectiveness is determined by the practitioner's skill performing parallel assessments of the participant's general psychological disposition and how art as a process is likely to interact with their mental state and the behaviour this may produce.

Therefore it seems clear we must now think in terms of when, rather than if, an arts injury happens again, and relying on an anecdotal system of describing practice ill prepares us for that. A simple extrapolation shows this case starkly highlights the risk that organisations bring on themselves when they work beyond their competence in offering programmes which use art as therapy, no matter how it is described. Neither TM nor the centre were aiming to do harm but their naivety did cause injury. This is worrying because it seems the same naivety continues to feature in the arts and health debates and it simply does not protect the public. This art session at the centre drifted from being about art to become a psychological intervention. Lack of knowledge, skills and supervisory structures allowed an unwitting role slippage. The arts practitioner is often not equipped to spot this slippage at the early point but an art therapist is.

I must emphasise that this does not mean that all arts and health activity should be done by art therapists. This would indeed unnecessarily impoverish the field of the good work arts practitioners do. The sensible way forward would be to use art therapists to scope out the risk factors in arts projects with the vulnerable and where necessary to provide supervision to maintain that arts role. Examples of this model are increasing and have been presented at this years BAAT AGM (Aylett, 2008). This example showed arts projects in Wales flourishing and being safe under the support of an art therapist in a dedicated arts and health role. This proves claims of professional protectionism false and demonstrates that we do not need to choose between healthy diversity of arts and safety.

We can now say that the legal view is that art can carry risk and injury is foreseeable if vulnerable people are exposed to it. Art can help people because it has power, but that power is not innately helpful. Psychological knowledge and skill is required to keep the practice safe. The claimant and I share a common hope that this paper will clarify that whilst ignorance may embolden an arts practitioner, it is no defence in law for them or the service provider.

Acknowledgements

I would like to thank Parlett Kent for their help in those aspects of this paper which relate to the law and Malcolm Learmonth, BAAT arts and health lead, for continued advice and guidance on the arts and health context.

Notes

[1] Note I shall only be concerned with the visual arts in this paper.

[2] In using the term 'art therapy', rather than describing himself as an 'art therapist', he did not infringe the Health Professions Council protected title.

[3] This picture was mislaid by the charity and so was not available during the case. The claimant states that the picture had traces of his blood on it.

References

Aylett, L.(2008). *Meeting the challenges of the current political context and health and social care policies, primarily in the context of leading a trust-wide arts in health Wellbeing programme in Wales.* Paper presented at the BAAT AGM afternoon session: 'The emerging picture – diversity of art therapy practice', St David's Hall, Cardiff.

Hansard. (2008, 6 March). Arts in health debate, House of Lords, London.

Sandford. (2007). Patient and staff safety. In *A prospectus for arts and health* (p. 87). London Arts Council/Department of Health.

Williams, G. (2002). *Learning the law.* London: Sweet and Maxwell.

Biographical details

Neil Springham trained in fine art painting. He exhibited artwork, and was prize winning at a national level. He worked in the arts and health/community arts field before training in art therapy in 1988. He practiced art therapy in all aspects of mental health with a specialism in addictions and personality disorder. He was a course leader at Goldsmiths College, University of London and is currently chair of BAAT and Trust Head of art psychotherapy at Oxleas NHS Foundation Trust.

July 25th, 2018
Dear Ms. Jackson,

My name is Christina Hagemeier and I am writing to you as an individual that works in Fairfax County public schools. I am a recent graduate of the George Washington University's Master's of Art Therapy program and I am working with the Virginia Art Therapy Association (VATA) to raise awareness of a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment, in VA – and believe a state art therapy license with help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapists use mart media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

As a new employee of the Fairfax County Public Schools and having done one year of internship in the school system, I am aware of just how vital art therapists are for the well-being of our students. Art therapy provides cognitive growth, emotional support, and behavioral regulation for many students. I have witnessed on many occasions that power of art therapy to help a student overcome a challenge or regulate their behavior, which helps them participate, thrive, and excel in the classroom. Many students respond well to this form of therapy because they do not have to talk or have to possess the words needed to describe what they are expericing. The art and creative process provide a safe and healthy container for students to express frustration, deal with emotions, and regulate behaviors. As and art therapist in the public schools, I am still required to have a teacher license. An art therapy license would help distinguish my professions from the teaching profession, and guarantee that students receive art therapy service from a trained, qualified professionals, rather than a professional with no mental health training.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, education, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.

- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payments of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment of (but not limited to):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities*** (i.e. autism) who need specially trained, qualified professionals.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Christina Hagemeier
405-517-1033, 1john349@gmail.com

Laura Jackson

From: Lacy Mucklow
Sent: Wednesday, July 25, 2018 8:24 PM
To: laura.jackson@dhp.virginia.gov
Subject: Open Comment for the Virginia Art Therapy License

Dear Ms. Jackson,

My name is Lacy Mucklow and I am writing to you as a resident of Springfield, VA. I am working with the Virginia Art Therapy Association (VATA) to raise awareness of art therapy, to advocate for the safety of Virginians, and to establish a state art therapy license in Virginia.

Art therapy is a distinct mental health profession facilitated by a master's degreed professional, in which clients use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Although art therapy is not regulated in Virginia at this time, when looking for private practice opportunities, I was looked over and had no responses from potential employers because I do not possess a Virginia license despite my clinical training, years of experience, and other national credentials in art therapy. I had to look for work in another state that does have a clinical art therapy license (Maryland), which is miles away from my home and takes away from seeing Virginian clientele.

One thing that I believe is very important to consider for a Virginia art therapy license is that it needs to be a clinical license with the ability to diagnose and bill for insurance just like our other master's-level mental health colleagues. The fact that we are not yet on par with them in regards to licensing makes it that much more difficult to provide the much-needed art therapy services that are desired in the community. Even if a license were passed but it does not allow for comparable insurance billing, the number of clients who will choose to and can afford to self-pay is minimal, and will make art therapy services still hard to come by, so it is imperative to pass a state art therapy license that is comparable to other master's-level mental health providers.

By licensing clinical art therapists, it will support the assessment and treatment for clients including military veterans, active duty, and families, eldercare, cancer patients and survivors, individuals with developmental disabilities, those experiencing depression or anxiety, and trauma survivors, aside from the everyday stressors of life that cause some to seek out additional support.

By passing an art therapy-specific license, it will protect the public as well so that highly-trained art therapists can provide genuine art therapy services and prevent others who have not had the rigorous training in our complex field from presenting themselves as art therapists or providing art therapy when they are not. In addition, having an art therapy license will help retain art therapists who live in Virginia and art therapy students from the two significant and acclaimed Virginia-based art therapy master's programs at The George Washington University (Alexandria) and Eastern Virginia Medical School (Norfolk) and thus help contribute to the economy of the Commonwealth.

Your support and attention to a state clinical art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state. Thank you again for your time, energy, and service to the residents of the Commonwealth of Virginia. We look forward to being in touch.

Sincerely,

Lacy Mucklow

Lacy Mucklow, MA, ATR-BC, LPAT, LCPAT, ATCS

Art Therapist
Art_therapist@artlover.com
703-863-4323

Laura L. Jackson
The Virginia Board of Health Professions
9960 Maryland Drive, Suite 300
Richmond, VA 23233-1463

July 25, 2018

Dear Mrs. Jackson,

I am writing to you in my multiple capacities as a credentialed and Board-Certified art therapist who lives in Virginia, as the Immediate Past President of the American Art Therapy Association, as the Clinical Research Advisor for Creative Forces: NEA (National Endowment for the Arts) Military Healing Arts Network, and as an Adjunct Associate Professor in the Graduate Art Therapy Program at the George Washington University (Alexandria, VA). I am also a member of the Virginia Art Therapy Association (VATA).

Thank you for this opportunity to submit a letter. I am writing in wholehearted support of a license for art therapists in the state of Virginia. I am among the credentialed and Board Certified art therapists, art therapy clients, and mental health colleagues in Virginia who strongly believe that an art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved and accredited training, educational, credentialing and certification requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.
- State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):
- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

DONNA BETTS

From 2015-2017, during my tenure as Board Chair and President of the American Art Therapy Association (AATA), the AATA worked closely with other national art therapy organizations, in particular the British Association of Art Therapists (BAAT). In the UK, art therapy is nationally recognized through the NHS (National Health Service) and art therapists are registered with the regulatory body, the Health and Care Professions Council (HCPC). Importantly, our British colleagues have endeavored to generate examples of harm, potential harm, and prevented harm by interventions with clients by clinicians providing art therapy or claiming to provide art therapy without being a trained art therapist. They provide this relevant resource on the BAAT website: http://www.baat.org/About-BAAT/Blog/167/Through-the-eyes-of-the-law-What-is-it-about-art-that-can-harm-people

In addition, from an economic standpoint, I also want to make you aware that graduates of the George Washington University Graduate Art Therapy Program, based in Alexandria, VA, often move to Maryland (or another state that has an art therapist license) after successful completion of the degree (https://health.maryland.gov/bopc/Pages/lgpat.aspx). It is time for Virginia to join the 12 other states that currently provide an avenue for art therapists to pursue a license specific to their qualifications, scope of practice, standards of practice, and ethical code.

On a final note, as you are aware, some art therapists have had to opt for a license in another profession in order to practice art therapy. I, however, have purposefully never pursued a license in another profession, as a firm advocate for the recognition of art therapy as a distinct profession. I implore the Virginia Board of Health Professions to move forward with the establishment of the art therapist license in Virginia. I thank you for your time and attention for the sake of the health, safety, and well-being of Virginians across the state. Your efforts and service to the residents of Virginia is deeply appreciated.

Sincerely,

Donna Betts

Donna Betts, PhD, ATR-BC
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Through the eyes of the law: What is it about art that can harm people?

Neil Springham

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ORIGINAL ARTICLE

Through the eyes of the law: What is it about art that can harm people?

NEIL SPRINGHAM

Abstract
The notion of arts-based risk is rarely acknowledged outside of art therapy. This paper describes an injury sustained as a result of art activity. The case was subject to legal proceedings which established arts practitioner and organisational negligence. The case was consequently settled out of court for a large sum. The paper reports the legal argument and explores what the process tells us about how art can both help and harm participants. This specifically concerns the power of art to make the subjective seem real and the need for practitioners to able to competently assess participants' psychological vulnerability to this. The case represents an important milestone in the current arts and health debate, particularly with regard to the protection of the public. Lessons to be learnt for organisations seeking to deliver arts and health projects to vulnerable people are discussed.

Keywords: *Arts and health risk, injury, law, evidence*

Introduction

In March 2008 Lord Howarth of Newport launched a debate in the House of Lords asking Her Majesty's Government how they intend to develop their policies to link the arts with healthcare (Hansard, 2008). Positive examples of the arts helping with a range of physical and mental health conditions were offered and the need for research and coordination was highlighted. Whilst the debate represents a welcome recognition of the power of art to help people, the notable lack of any reference at all to risk was typical of how the subject is currently construed by many. This is a worrying naivety. In what other area of health would we describe an agent having power but not risk?

Arts therapists attempted to raise the issue of arts-based safety and risk when the arts and health prospectus was being developed, but achieved only one referenced title to it (Sandford, 2007). Admittedly, such risk will vary greatly because the arts and health is not a single homogenous practice but a range of very different interventions. Unfortunately, the current language is very poor at differentiating practice elements across the range of creative and psychological interventions. Because of this I have attempted to identify a subset of arts and health practices by deliberately employing the term art as therapy in the paper[1] which I define as having three key elements:

1. A participant who is vulnerable
2. An art activity
3. Some kind of linkage between the art and the participant's personal material.

This linkage to personal material may still vary greatly from being asked to choose images which have individual significance in an art group to a full psychotherapeutic process.

This definition of art as therapy would not then include a range of excellent practice such as art classes, attending galleries or participating in mural projects etc. I must also emphasise that I make no differentiation about whether art as therapy interventions are run by art therapists or non therapy trained artists because in practice training does not determine who delivers what type of intervention. Many arts and health practitioners deliver art as therapy and many art therapists deliver recreational or wellbeing interventions as part of their wider roles. I also think it is very important to highlight that this description shows some arts and health activities exist in a grey area where creative projects which involve linkage to personal material can become art as therapy interventions by default. This should be a concern.

In terms of managing risk in art as therapy, the British Association of Art Therapists (BAAT) position has been that it is practitioner training and professional structures add the essential value. Our experience at arts and health conferences and meetings has been that some (but not all) continue to

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criticise the professional body for this. The allegation is that this is self-interested professional protectionism, an attitude which risks narrowing the arts and health field and its benefit to so many. This opinion has not yet been put in writing but it seems to pervade as some kind of received wisdom. Actually, it seems to me there is some validity in all these points individually but the meta-problem here is that the debate is rather stuck in a polarised stalemate between practitioners. It misses the more important question about the experience of the participant. It is of course important to acknowledge that many people engage in art and improve their wellbeing significantly without harm ensuing. But whilst many benefit it is a fact, inconvenient or otherwise, that causalities do occur in this process and particularly so in the grey areas around art as therapy. For instance, I recently worked as an expert witness on a legal case involving a serious injury sustained as a result of art as therapy delivered by a non art therapist in an addictions treatment centre. I wish to report this case and to look at the issues it raises for the field.

The fact of the case makes the question of *if* harm can happen in arts and health redundant. The more pressing question is now *what* it is that can harm people and this is the focus of this paper.

I have written this paper in collaboration with the individual who suffered this injury. My co-author wishes this story to be told because he hopes the lessons it gives about art making might prevent what happened to him happening to others. Whilst he is doing well in recovery he has asked to remain anonymous, not for himself but because he is mindful of the needs of his young family in a close traditional community. I shall therefore refer to him as 'the claimant' throughout. I feel his voice is crucial in focusing the debate on the processes for the participant, rather than on claims of practitioner territory.

The claimant wishes to state from the outset that he would not have resorted to law if he had had his experience taken seriously and received an apology. Indeed, he does not wish the addictions rehabilitation centre to be named because he feels that any failing was specific to the management of the art provision and does not generally represent the other good work they do and would not wish to put any more barriers to people getting help. The rehabilitation centre shall be referred to as 'the centre'.

The case was pursed by the highly reputable firm of Parlett Kent solicitors which has extensive experience in dealing with all areas of clinical negligence including cases involving children with disability, the misdiagnosis and treatment of cancer, fatal cases, sexual abuse and psychiatric negligence claims. The solicitor's application of due process required a rigorous focus on the issues of art-based risk. I believe the outcome of this has offered a more robust and evidence-based framework for exploring this crucial matter than the vagaries of our present language and debate allow.

The legal process

I personally was enthusiastic to gain experience of the expert witness role in this case because it combined my specialism in addictions with my longstanding interest in the law. I found it challenging and invigorating to examine familiar processes through the eyes of others with different reference points. The process of law forces any statements made about art practices, including art therapy, to be made explicit enough to be subject to the scrutiny of cross examination. Such testing clarifies our language and terms. That, after decades of practice in the arts and health field, I still found it difficult to be explicit with our current terminology, proved to me that clarification is necessary. Both arts and health and art therapy language can be esoteric and unspecific. I feel we need a terminology that creates the means for defining practice so it can be critiqued by others. Far from being reductive, I feel this would increase reasoned debate and share practice innovation.

As therapists we are constantly asked to engage with evidence. The concept of evidence as a legal entity is perhaps less familiar to us, yet arguably it exists in the longer tradition. The law might be said to represent an accumulated response to human interaction over at least a 2000-year period.

Tort law is concerned with ensuring that citizens compensate each other for damage, pain or suffering they may cause each other by behaving carelessly or in bad faith, e.g., by acting negligently towards someone to whom you owe a duty of care and causing them injury. Negligence is a severe breach of duty of care, e.g., a wrongful act or an omission of an action, which results in a damage that was a foreseeable (or likely) consequence of the original wrong. Our system of litigation has its roots in the discipline of rhetoric, where the counsels for both defence and the claimant explicitly aim to use evidence and argument to build a case that is persuasive of their perspective. The process involves an examination of a range of data, such as statements, objects, and reports etc, to try to establish their reliability as evidence. Questioning from polemical positions subjects evidence to deep examination. Because the validity of evidence determines such serious outcomes, its testing is rigorous.

This adversarial approach involves an exchange of claims from claimant to defence, resulting in either admissions or counter claims from the defence in return. The word tort comes from the word 'tortuous'

because the resulting twists and turns the legal argument must take were felt to resemble a twisted shape of a branch. The underlying assumption is that the truth is the strongest argument.

Once a negligence case is started then it will go to trial unless it settles out of court because it is admitted that one side is clearly going to win. The Civil Procedure Rules oblige all clinical negligence actions to have supportable expert evidence on both sides. The expert must establish their credentials for the job and then must not comment outside of their specialism. The two experts also monitor each other to minimise bias. The expert does not advocate for any side. They are led by questions asked by counsel as they attempt to build their case.

The experts in this case were from art therapy, psychiatry and orthopedic surgery. I think it would be illuminating to now put the evidence before the reader. The following is taken from formal statements exchanged between the claimant's and the defence's legal teams which formed the basis of the case prepared for court.

The context

The centre offered addictions rehabilitation treatment in England. It employed a variety of staff based on their roles and job descriptions (e.g., group leader or team manager) rather than by any particular profession, this being a common and lawful practice in this sector. The treatment programme comprised two stages. Broadly speaking, stage one focused on assessment and stage two on treatment.

The leader of the art group in question was employed as a 'Team Manager' and for anonymity shall be referred to as TM. TM was appointed on the basis of having acted as director and counsellor of a residential rehabilitation clinic and seven years experience of delivering Christian counselling (no qualification was presented). He described having specialised in the use of 'art therapy' to 'facilitate emotional growth and enable recovery' based on two very short non-qualifying courses with art therapy in their title.[2] The charity made him responsible for developing and coordinating the range of individual and group work activity.

TM proposed improvements to stage two aimed at making it more 'therapeutic' and within six months of being employed had introduced several new ideas including what was described variously as an 'art course', 'a class in art education' and 'anger management using art'. The claimant disputed these descriptive titles saying the group had been described to him as art therapy. Significantly, there were no written leaflets for the group to clarify the matter. This confusion in description would have a material effect on the outcome of the case.

Sequence leading up to the critical incident

The claimant is a male who was born in Asia and in 1978 came to England at the age of 11. On attending school he suffered both racial abuse and bullying for the first time and describes using bravado to cope. His peer group at the time became engaged in antisocial activity and he was himself convicted for a number of offences including violence. At the age of 20 the claimant started using drugs including crack cocaine. During the 1990s the claimant began to take steps to change his life. He married, had two children and worked in a responsible job. In September 2001 he was accepted on the residential rehabilitation treatment programme at the centre.

Not uncommonly in this taxing process, within one month he experienced difficulties in treatment and was given a written warning for failing to attend a session. Staff noted that he seemed to be 'carrying around a lot of anger'. In November 2001 the claimant went to India, his country of origin, with his brother to take back the ashes of his recently deceased father. During the funeral the claimant had an alcoholic drink, not thinking this was an issue as his problem substance was cocaine but when he returned was he given a further written warning for breaking the programme's no-alcohol policy. At about this time his key-worker also began talking to him about the requirements for stage two of the programme. In December 2001 together with another resident, the claimant apparently smoked some crack cocaine. This was followed by an incident when the same resident had been seen talking to the claimant in an aggressive manner at a meal, resulting in him throwing his food away and leaving the room. The claimant was seen by his key-worker because of these difficulties and it was assessed that he was not yet ready for stage two and his progress would be reviewed at the beginning of January 2002. Soon after this the claimant was given a third and final written warning for using drugs whilst on the programme.

In my experience the above pattern is typical of the struggle to address such a serious and entrenched drug habit, particularly in the context of such a significant bereavement. It is of note that, despite these vulnerabilities, the claimant was still put onto stage two of the programme within two weeks of his last written warning.

The incident on 7 January 2002

The claimant attended the art session on his first day on stage two of the programme. The session began after lunch and the residents taking part were sitting on mats approximately one inch thick placed on a concrete floor. The claimant describes participants each being issued with sheets of paper and some paints and being instructed by TM to 'portray all of

the bad things in our lives, the guilt we felt about what we had done and everything negative into the drawing of an animal'. The claimant then made an image which he described in his statement thus:

> *I drew a picture of a hyena with blood coming out of its mouth. The hyena was surrounded with green grass. The green grass was to me perfect countryside and a representation of my life with my wife and my children. The hyena represented a scavenger inside of me with no conscience or morality, just wanting what it wants.*[3]

The claimant then stopped drawing, at which point TM, who had been talking to others in the group, came over to him. According to the claimant TM asked him what he would like to say to the animal. The claimant replied that he 'did not want to *say* anything but wanted to swear at it, to rip it up and punch it, to smash it up'. The claimant describes what happened next thus:

> *I can't remember if he (TM) actually said to 'express yourself' or 'go with the feelings'. I swore at it (the painting) and it was on the floor or on the mat and I punched it. (TM) was beside me and on my right. I was hitting it (the picture) and punching it and my knuckles were cut and then I got on to my feet and dived down onto the painting with my head, to destroy this animal.*
>
> *I went into a rage that moved from swearing to hitting and punching the picture as hard as I could for 3–4 minutes. I thought (TM) was watching me throughout this time and no one tried to stop me. I was thinking of all the damage that drugs were causing me and to everything I held dear and especially the fact that my drug use was harming my children. I thought of everything I had done in order to obtain drugs, crime and lies and the fact that my addiction had deprived me of both pride and my dignity and had made me cheap and worthless.*
>
> *I couldn't hit any longer but I was still looking to destroy the picture so I got up and dived on to the picture head first. I felt an excruciating pain and started crying out. I wasn't able to move but (TM) did not believe me.*

It was noted that TM's statement conflicted with the above. TM stated that the period between hitting and head-butting the image was instantaneous and all in one movement. He disputed that this transition had taken minutes.

The length of time the claimant was left on the floor after the event was also disputed. The claimant stated he was left, and the centre claimed they responded immediately. The ambulance records show that it was about two and a half hours after the start of the group before they were called. The claimant was taken with his neck in a collar to hospital and cuts were noted on the claimant's knuckles by the ambulance crew. He was later diagnosed as having suffered a wedge fracture of the fifth cervical vertebra resulting in partial tetraplegia. The claimant was later transferred to another hospital for an operation and then some weeks later again for recovery. He was later discharged home but still had weakness and reduced sensation in his upper limbs. He was able to walk slowly using a stick for balance, suffered bladder and sexual dysfunction.

Having gathered this information, the resulting legal argument did indeed twist and turn through what I found to be a compelling interrogation of the data by each team in order to build their case prior to going to court. I would like to present the critiques I was asked to provide from the art therapy perspective and would ask the reader to particularly note where points are admitted by the defence.

The twists of the branch: The legal argument

To start with I was asked by the claimant's counsel to compare the charity's management of the development of art activity on its therapeutic programme with the clinical governance of art therapy required within the NHS. I commented that, in my role as a manager, I would be expected to appraise the risks of any developments in treatment and to match the staff competence to identified risk. I did not think TM had adequate skills for the way art was being used in the therapeutic programme because, whatever it was called, it was *in practice* using art as a therapy (as per the definition above). Moreover, the charity had not made any provision for being able to ensure, or even know if, TM would remain within the scope and limits of his skills developing art as therapy for the programme. Given that information on art therapy is readily available, it was neglectful to not have sought advice from the Health Professions Council (who offer employer advice) and BAAT to compensate for this lack of knowledge and skills in the organisation. The defence team admitted the point that there was a breach of duty by the charity in causing or permitting TM to assume the role of an 'art therapist'.

Having conceded this point the defence then attempted to distance it as an issue by pleading contributory negligence in the defence, seeking to argue that the claimant was responsible for his own actions and therefore failed in his duty of care to himself when he head-butted the picture. To build a counter-argument I was asked to comment on this and highlighted that the material point was that the claimant was specifically in treatment for his addictions and a major strand of treatment for this involves trying to gain mastery over chaotic emotional states and impulsiveness. I was asked if the claimant should reasonably expect to trust that his therapists would be competent to assess him in this context and to not offer treatment which would take him beyond his tolerance for heightened emotional states. I did think that this was reasonable given that such rehabilitation

organisations are set up to take people when they are vulnerable and disorientated.

This point of trusting the organisation is strengthened by noting that stage one of the programme was concerned with assessment. I was asked to make a comparison between how the centre and myself as an art therapist would have approached the session. I stated that an art therapist would assess the patient by integrating long-term history, preceding events and current emotional state to make a psychological assessment and to balance this with their knowledge of the effect the art medium might have on such a psychological state. The assessment would be ongoing, with particular concern to monitor how the participant experienced the art in terms of being emotionally stirred.

I considered the centre was in possession of the information needed to perform such an assessment, e.g.: the history indicated poor impulse control; physical violence; difficulty with unwanted feeling states; the recent death of the claimant's father; the trip to Asia; his recent relapse and the incident at breakfast. I noted that the centre had also attempted direct observations of the current emotional state and had recorded observations of the claimant such as: 'passive/aggressive'; 'reluctant'; 'struggling'; and 'angry' just prior to the session. The failure was therefore in the competence to make sense of the data they were in possession of via the form of an assessment.

On the basis of this the claimant's team put it to the defence that it was a failure by the centre to perform a competent assessment to determine the claimant's vulnerability, particularly with regards to impulsiveness and therefore his ability to fulfil a duty of care to himself. The defence then admitted that the centre was in breach of duty in allowing the claimant to participate in the art therapy session and that TM knew or ought reasonably to have known that the claimant was or might be emotional, vulnerable, unpredictable and/or potentially unable to control his feelings.

The next set of questions focused on the approach to treatment. I was asked to comment on the role that treatment information would have on treatment progression and outcome. I commented that this would have an affect on how a patient would assume they should approach and use the therapy. For this reason an art therapist would check the participant's understanding of the proposed intervention as a part of the consent process. In this case, there was no evidence of this having been done and noting the various ways the group had been described the participant appeared to have been left to glean his own understanding. Given the group existed in stage two of the programme, i.e. the 'therapeutic stage', I suggested that it would be reasonable for the claimant to assume that the session involved working 'therapeutically' on feelings.

The claimant's counsel asked him directly if he entered his feelings to this degree because he assumed that was the best way to maximise the effects of therapy. The claimant replied:

> *I had a lot of issues at the time. My father's death was on my mind. Whatever the programme required, I would have done it wholeheartedly.*

This is a prime example of how the lack of clarity of terms and language adds serious risk.

I was asked to critique the choice of art therapy technique. I put it that being asked to 'portray all of the bad things in our lives' was inappropriate in these circumstances because it would encourage the very splitting dynamic and black and white thinking that causes addicts so many problems in the first place. The claimant had many difficult things in his life at that point and concentrating such negativity in the form of an art image was dangerous.

I also criticised the 'talking to the image' method TM used to help engage the image at a personal level as additionally and excessively provocative for that circumstance. For clarity, I suggested a material differentiation between talking *to* an image and talking *about* an image thus:

- 'Talking *to* an image' implies an intention to embody feeling and perceptions in the image by way of provoking an experience of their realness, by acting and relating to them as real in the world. The problem is that it can be unwise to over-validate subjective experience at the expense of reality testing for people with the claimant's history of violence. Impulsiveness is often caused by the individual being misled by misperceptions (projections, transference reactions, etc) which already feel too real. Moreover, relating so exclusively to the image by talking to it can marginalise the therapist, who might offer alternative mitigating perspectives and emotional containment.
- 'Taking *about* an image' implies a process of talking *to* the therapist about the picture. This is preferable in these circumstances because it does not emphasise the subjective experience of the image to such a degree. Indeed the distance from the immediacy of the image's content gained by talking about it is helpful in developing a thinking, rather than impulsive, approach.

I felt the claimant's statement to the defence's psychiatric expert witness (below) substantiated that the poor choice of theme and the problems raised by talking *to* the artwork had combined to make the artwork too powerful by making it over-real:

(The picture) showed all the negativeness about me, separating all the badness in front of me into an animal that had destroyed my life and I intended to smash it up and kill it. The more I spoke to it, the more alive it became. As I spoke I don't know what happened because it sort of came alive. Everything about it came into my head – shame, guilt, people I've hurt. I hated this thing. It wasn't a piece of paper, it was the feelings. Before the conversation I had with it, it was a painting, but when I spoke to it, it seemed more real – not that the picture was real, but the feelings made it seem alive and so I dived in to destroy it. I don't know what happened. The more I spoke to it, the more angry it made me, like it was taking out all the negativeness and putting it in front of you.

In describing this to the legal counsel, I was concerned that such specialist differentiations may somehow be too esoteric for non art therapists but I was pleased to be wrong. The legal team understood these points and their relevance well and used this as the basis to argue against TM's approach. It was admitted by the defence that this theme was provocative for someone with the claimant's history.

The claimant's team had now posited the type of direct causal link between the power of art and the injury sustained needed to establish negligence. This exclusivity of cause is termed the 'but for' test of a legal argument (Williams, 2002). From the defence's perspective, this focused their task onto the production of an alternative explanation of causality in order to throw doubt on the directness of that causal link. If they could do this the case would collapse. The claimant's experience of realness of the picture was subjected to examination from a psychiatrist for the defence. If it could be said that the picture became too real, not because of the power of art, but because the claimant may have experienced psychiatric phenomena, then it could not be said with safety which had caused the injury. There would always be a confounding variable in the argument. The claimant's experience of his art seeming real was subjected to the following medical hypotheses by the psychiatrist for the defence and this is the result:

Brief Psychotic Disorder: This particular condition is typically associated with emotional turmoil and although the claimant was indeed in such a state, his reaction was too short (lasting only seconds) to qualify for this diagnosis as described in DSM-IV-TR requires psychosis to last for at least a day.

Drug Induced Psychosis: The claimant's reaction was not at all typical of the psychosis sometimes associated with cocaine. This would not include fleeting psychotic experiences but more usually includes persistent delusions and the claimant did not show evidence of this.

Dissociative Trance: The claimant reaction was only consistent with a limited number of aspects of a dissociative trance disorder. It was described as 'atypical' because this would typically include amnesia for the event itself and the claimant remembered, lucidly, what happened.

This report effectively failed to find that a reliable psychiatric definition could be applied to the experience of the art becoming real. Likewise the psychiatrist for the claimant dismissed the notion of any psychosis 'lasting seconds'.

However, faced with the failure to find a medical variable, the psychiatrist attempted a qualifying remark that she had, in decades of medical experience 'never heard of an episode similar to this'. This presumably was attempted as an argument against foreseeability by the defence. I was therefore asked by the claimant's counsel to comment from an art therapist's perspective on this psychiatric assessment of the art session. Noting the lack of a formal psychiatric diagnosis, I suggested any comments beyond this would constitute an 'over-medicalisation' of experience of the art activity. Moreover, to have offered the statement of 'never having heard such an episode' as an argument against foreseeability was disingenuous to the remit of the role of 'expert' witness. A psychiatrist would be unlikely to have gained experience of such episodes in the use of art in therapy. As an art therapist this activity is my primary task and I had discussed similar patient reactions to art with art therapist colleagues. Regrettably, I was acutely aware of how few of these are documented in art therapy literature. Still the point remained, in the absence of a convincing psychiatric explanation for causality, the focus continued to point to something about the art itself.

My counter-argument aimed to substantiate that the arts have a power to help us suspend disbelief and to make us feel as if we were experiencing something beyond the concrete presence of the object. This would better explain the claimant's statement that 'It wasn't a piece of paper, it was the feelings'. Evidence from the arts that suggests objects becoming 'real and alive', to a range of degrees, is far from unheard of and actually nearer to the norm. The experience of the subjective as real is one we all have in art and could be said to be the very reason art doggedly continues to exist in our culture. People regularly have strong, visceral reactions to art, as if something beyond the material object itself were real. Many cry watching films even though at the most concrete level they are merely watching lights on a screen. It is not just the story; it is the arrangement of abstract elements such as sounds, colours, and gestures etc that create the effect. This effect would not happen if we just read the script. Our current age rating certificating system for films is an acknowledgement of the developmental aspect of realness in cinema. Many parents sit in cinemas telling terrified children 'it's just a film, it's not real'. But how many of us have said just

this to ourselves as adults during an effective horror film? Similarly we are deeply moved by music even though it is just sound and painted images which are just pigment on canvas, etc. When I have run art workshops for clinical staff, where usually it is reasonable to assume a low presence of diagnosable psychiatric condition exists, I have had to use considerable skill and care because people are routinely awestruck by the vivid 'realness' of the experience of their own art. It would be unreasonable to argue that the general population's reaction to art is always determined by temporary mental illness.

This evidence matters. Establishing probability of cause by making a link from art to harm was what won the case. Such a clear case of arts-based injury has wider implications for the risk debate in the arts and health field. Given its importance, then, I would like to put more detail of my rationale before the reader.

The realness of art and harm

That the injury was sustained by an arts practitioner working beyond their competence was established. But if we are to learn the lessons of this case it is important to attempt to be as explicit as possible about what the causal elements were. Clearly, TM had exceeded his competence in two parallel domains of assessment:

1. General psychological: evaluating the claimant's tolerance to unwanted feeling states
2. Art therapeutic: a specialist assessment of the effect of the art on the participant.

For the purpose of this paper I would like to focus on the second. Because TM was not an art therapist he was unable to make sense of the information before him. If we look at the following statement made by the claimant to the defence's psychiatrist, it is clear the picture already had effected a substantial power even before TM tried to engage the claimant by 'talking to' it:

> *The picture showed all the negativeness about me, separating all the badness in front of me into an animal that had destroyed my life and I intended to smash it up and kill it.*

A clear observation of an art property can be made here, that the effect of the art was powered by mind-reality isomorphy. The claimant had a confirming experience of his internal and subjective state as a real object in the world through his art. Even prior to his neck injury the claimant has already been harmed by this. He has been taken beyond his tolerance and his functioning diminished by his art. My clinical experience of this state is that impulsiveness would in all likelihood result. Moreover, we should not be misled by ideas that the neck injury was somehow unusually harmful. There may have been a host of other outcomes such as violence or disengagement from treatment altogether. Both of these are highly dangerous and sometimes fatal in this context.

Because TM was incapable of recognising the isomorphic power of the art already exerted on the claimant, he chose an engagement technique which was too strong. TM's suggestion to talk to the picture merely re-enforced the image's realness, thus pouring petrol on the flames. To test the isomorphic concept, we might ask that given that the patient was sufficiently aroused and upset by this point, would 'talking to' anything other than an artwork have sparked this reaction? Had the claimant been asked to talk to a different object, such as an empty chair for example, would this effect have worked in the same way? The evidence of his statement suggests the picture already appeared so similar to the content of his mind as to become convincingly isomorphic. Contrastingly, had this been a chair, the brute fact of its 'chairness', no matter how you talk to it, has a much lower accuracy of symbolic equation. This is not to deny that such a 'talking to' method may also have been overwhelming for the claimant in that state of mind. But it can be argued that the absurdity of the mismatch between mind and reality would be *the* helpful quality which diminishes psychic equivalence and allows an easier return to reality for the participant after the exercise.

The recognition of the power of art to make inner states real is the basis of the art therapy profession itself. Understanding how art interacts with psychological states is essential in assessing its optimum effect on the participant. The art therapist understands that the power of art must be titrated to be useful. If it is not real enough then the disengagement with the inner world will make it ineffective and irrelevant, but equally if it is too real then objectivity and thinking can get lost and the participant overwhelmed with a terrifying experience of mind-as-reality. An art therapist would tend to start therapy in this context with the assumption that the art made might already be too powerful. The art therapist's primary concern then would be moderation of art-realness and the establishing a state of 'play' in the art session. The optimum state of art therapy play is where the art is *felt* to be real but *known* not to be. That is, the maker can experience their image in an 'as if' way, as being like the contents of their mind, as distinct from the type of concrete realisation of mind the claimant experienced. I would suggest this is a defining feature running through art therapy literature in the UK.

I argued for the claimant, and argue now, that competence to assess this effect of art must be gained through substantial experiential learning within a psychological framework. This learning is particular to art therapy training. It might be said that without this

experiential-based learning, the power of art is actually counter-intuitive. It is not immediately credible that grown people might be overwhelmed by pictures to such effect. Only by experiencing what it is like when an image continuously signals its unnerving similarity to one's subjective reality can one understand, or even believe, the claimant's statement (above) about the picture becoming real. Moreover, an image's power is likely to be greater if the participant has made it themselves: the employment of their own symbolic language creates an uncanny familiarity when it so accurately mirrors the inner world. TM's failure was to attempt to increase the impact of the art because his lack of training made him unable to assess that the participant's reflective capacity was already compromised by his art making. TM simply lacked this and his assessment of the power he was handling was catastrophic.

If I were making this assertion without evidence I could accept the criticism that such a self-proclaimed claim to special understanding might be professional protectionism. Being aware of this point I asked the claimant to add his perspective. This is his statement:

> *All through my time at the hospital even the nurses, after reading my medical report, looked at me as though I was a mad man. Even some members of my own family thought my injury was self inflicted. No one could understand what it was like for me and how I felt after having to get in touch with the addict inside of me. To externalise it into a painting and to talk to it was like giving it life of its own and to think of the agony and shame and guilt that has caused me made me want to kill or destroy it. No one could understand it. I tried to explain to people but most people could not see beyond me head-butting a painting. In the legal conference when I first met (the art therapist) and he spoke was the first time that I felt relieved that someone could understand. He was exactly right when he said about one should not tap into just the negativity as it is a dark place for most addicts.* (The claimant, May 2008)

These points were used to make the argument that using art is powerful intervention, but particularly so where the participant has a psychological vulnerability. In the absence of any confounding variable, the claimant's counsel made the case that the injury was caused by the art as therapy session. Rather than continue to court on the basis of that argument, the defence surrendered their case and settled out of court for over a quarter of a million pounds in favour of the claimant. TM resigned from his job at the charity soon after the incident. He has since taken up a role as a clinical director in another addictions centre on another continent.

Conclusion

It is a sad fact that extreme consequences in treatment offer us the clearest lessons in cause and effect. Whilst the particular injury in this case might be said to be unforeseeable, the approach used meant an injury of some sort was foreseeable. Moreover, in my experience in the field such risky practices are not uncommon in art as therapy sessions, but it is precisely because the sessions occur outside of professional or governance structures that they do not get documented. Settling this case out of court is an admission by the defence that it was unwinnable. It sets a helpful legal precedent establishing that both art and art as therapy carries risk of harm if it is applied beyond the competence of the practitioner. This risk is amplified massively where the participant has a vulnerable psychological predisposition, particularly where they tend to excessive subjectivity or poor reality testing for whatever reason. Safety and effectiveness is determined by the practitioner's skill performing parallel assessments of the participant's general psychological disposition and how art as a process is likely to interact with their mental state and the behaviour this may produce.

Therefore it seems clear we must now think in terms of when, rather than if, an arts injury happens again, and relying on an anecdotal system of describing practice ill prepares us for that. A simple extrapolation shows this case starkly highlights the risk that organisations bring on themselves when they work beyond their competence in offering programmes which use art as therapy, no matter how it is described. Neither TM nor the centre were aiming to do harm but their naivety did cause injury. This is worrying because it seems the same naivety continues to feature in the arts and health debates and it simply does not protect the public. This art session at the centre drifted from being about art to become a psychological intervention. Lack of knowledge, skills and supervisory structures allowed an unwitting role slippage. The arts practitioner is often not equipped to spot this slippage at the early point but an art therapist is.

I must emphasise that this does not mean that all arts and health activity should be done by art therapists. This would indeed unnecessarily impoverish the field of the good work arts practitioners do. The sensible way forward would be to use art therapists to scope out the risk factors in arts projects with the vulnerable and where necessary to provide supervision to maintain that arts role. Examples of this model are increasing and have been presented at this years BAAT AGM (Aylett, 2008). This example showed arts projects in Wales flourishing and being safe under the support of an art therapist in a dedicated arts and health role. This proves claims of professional protectionism false and demonstrates that we do not need to choose between healthy diversity of arts and safety.

We can now say that the legal view is that art can carry risk and injury is foreseeable if vulnerable people are exposed to it. Art can help people because it has power, but that power is not innately helpful. Psychological knowledge and skill is required to keep the practice safe. The claimant and I share a common hope that this paper will clarify that whilst ignorance may embolden an arts practitioner, it is no defence in law for them or the service provider.

Acknowledgements

I would like to thank Parlett Kent for their help in those aspects of this paper which relate to the law and Malcolm Learmonth, BAAT arts and health lead, for continued advice and guidance on the arts and health context.

Notes

[1] Note I shall only be concerned with the visual arts in this paper.

[2] In using the term 'art therapy', rather than describing himself as an 'art therapist', he did not infringe the Health Professions Council protected title.

[3] This picture was mislaid by the charity and so was not available during the case. The claimant states that the picture had traces of his blood on it.

References

Aylett, L.(2008). *Meeting the challenges of the current political context and health and social care policies, primarily in the context of leading a trust-wide arts in health Wellbeing programme in Wales*. Paper presented at the BAAT AGM afternoon session: 'The emerging picture – diversity of art therapy practice', St David's Hall, Cardiff.

Hansard. (2008, 6 March). Arts in health debate, House of Lords, London.

Sandford. (2007). Patient and staff safety. In *A prospectus for arts and health* (p. 87). London Arts Council/Department of Health.

Williams, G. (2002). *Learning the law*. London: Sweet and Maxwell.

Biographical details

Neil Springham trained in fine art painting. He exhibited artwork, and was prize winning at a national level. He worked in the arts and health/community arts field before training in art therapy in 1988. He practiced art therapy in all aspects of mental health with a specialism in addictions and personality disorder. He was a course leader at Goldsmiths College, University of London and is currently chair of BAAT and Trust Head of art psychotherapy at Oxleas NHS Foundation Trust.

Laura Jackson

From: Janet and Jim Johnson
Sent: Wednesday, July 25, 2018 10:39 PM
To: laura.jackson@dhp.virginia.gov
Subject: Licensure of Art Therapists in Virginia

Janet S. Johnson
10701 Ellies Court
Fairfax Station, VA 22039

Virginia Board of Health Professions
Attn.: Laura L. Jackson
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463
July 25, 2018

Dear Ms. Jackson:

My daughter is a credentialed art therapist (ATR–BC, CTT) in private practice at Shenandoah Art Therapy, LLC and I am writing in full support of the licensure advocacy and efforts of professional art therapists in Virginia.

I am a retired principal and teacher with thirty-two years of service in Fairfax County Public Schools, Virginia. Like licensed educators, the licensure of art therapists will ensure that individuals in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.

The American Art Therapy Association (AATA) defines art therapy as a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Therapeutic goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Sound standards for educating and licensing art therapists will prevent untrained practitioners from unwittingly harming members of the public. The risk of harm from persons misrepresenting the title of "art therapist" can include: inadequate intake assessments; faulty interpretation of client data; miscommunicating assessment results or treatment recommendations to clients; failure to refer the client to a physician when needed; and failure to maintain confidentiality.

Art therapy is a distinct mental health profession closely aligned with levels of education, training, and scope of practice to that of other behavior and mental health specialists – who are licensed. Like counselors, social workers, marriage or family therapists and other masters-level mental health professionals, art therapists are trained to evaluate a person's mental health and use therapeutic techniques based on specific training programs. The licensure of art therapists would mandate training, require competency and provide information that both practitioners and the public need. Additionally, disciplinary action could be taken against an art therapist for failure to adhere to the professional ethics in art therapy settings.

We need to use all of our mental health professionals efficiently and effectively. Several studies note that youth in Virginia who are battling depression are among the least likely in the nation to receive treatment for their mental illness. The Commonwealth of Virginia is working hard to overcome its

shortage of mental health professionals. Providing licensing of professional art therapists could include provisions allowing for licensing reciprocity between states encouraging qualified art therapists to seek work in Virginia.

Art therapists are part of the team of mental health professionals in Virginia. Properly licensed and regulated, art therapists can improve access to and outcomes for clients who are experiencing a variety of mental and behavioral health problems including: depression, abuse, post-traumatic stress disorder, brain injury and suicidal thoughts.

Thank you for reading my comments in support of licensing professional art therapists. I appreciate your time, energy, and service to the residents of Virginia.

Sincerely,

Janet S. Johnson, retired FCPS principal
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703.541.8517

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Alexandria, Virginia 22312
phone (703) 914-1078 fax (703) 663-8817
e-mail annemills@cox.net

July 25, 2018

Laura L. Jackson
Virginia Board of Health Professions
9960 Mayland Dr., #300
Richmond, VA 23233-1463

fax (804) 527-4434
laura.jackson@dhp.virginia.gov

RE: Art Therapy licensure

Dear Ms. Jackson,

I write in hearty support of licensure for art therapists.

I am an art therapist and a proud Virginian. Years ago I worked at Fairfax Hospital and the Hospice of Northern Virginia. Now I work in private practice, as I have for three decades, but I cannot do this important work in my home state, nor can I get a job here, because I am not licensable here.

I am licensed as a Counselor in the District of Columbia, where I am in private practice. More than 2/3rds of my clients live in Virginia. It would bring many positive changes to my life and those of my clients if I were licensable in Virginia. I would move my practice closer to my home and my clients without delay. Although many people choose to travel great distances for the benefits accruing from art therapy, not every Virginian has the means to do so.

In Richmond, it seems there are two trained and properly credentialed art therapists in private practice. This is not sufficient to meet the needs of the many people of all ages with serious emotional conditions. Perhaps that is why there are 27 mental health professionals or pre-licensure graduates offering Art Therapy services in Richmond who have no art therapy training or credentials. It is wrong for therapists to offer services beyond their area of competence to vulnerable consumers, especially when skilled art therapists who want to work are unlicensable.

I teach at professional gatherings about my art therapy work with survivors of severe, early abuse. I cannot count the number of times mental health professionals who are not art therapists have buttonholed me at conferences to show me drawings they have elicited from distressed clients. These psychologists, social workers, and others are confused by the deleterious effects of their unwise actions and do not know what they have done wrong. It is chilling to hear about the harm done to clients, such as a young woman's overwhelming terror, mutism and head banging, as a consequence of someone introducing art into their treatment without proper training.

I know you always consider the mental health needs of the citizens of Virginia. Art therapists who provide reasonably priced services are already hard to find here. Meanwhile, experienced art therapists who live in Virginia are practicing elsewhere, such as the District of Columbia and Maryland, because licensure in Virginia is unavailable. I ask you not to add the CACREP requirement, which would render it impossible for seasoned art therapists to get a job in Virginia. I am a former Chair of the Research Committee of the American Art Therapy Association and was director of a university Master's program in Art Therapy. Yet I cannot get a job that requires a Virginia license, and since I graduated some years ago, I would never be licensable if my degree were assessed according to CACREP requirements.

People seeking referrals to art therapists in Virginia call me weekly. They want help for daughters who are dieting themselves to death or husbands whose explosive anger has caused them to be fired. In Virginia, a licensed art therapist should be able to help, and with your support, we will.

Thank you for giving this matter every consideration. I sincerely hope for a positive response.

Respectfully submitted,

(Elizabeth) Anne Mills, MA, ATR-BC, LPC, LCPAT

Laura L. Jackson The Virginia Board of Health Professions 9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

July 26, 2018

Dear Mrs. Jackson,

I am writing to you in my multiple capacities as a credentialed and Board-Certified art therapist who lives in Virginia, as the President of the Virginia Art Therapy Association, as the Crisis and Clinical Director of the James House, and as a Clinical Supervisor in Richmond, Virginia. I am also a member of the AMerican Art Therapy Association (VATA). Additionally, I am a Certified Substance Abuse Counselor, a trained auricular acupuncturist, and have had post-graduate training in trauma therapies.

I am pleased at the invitation to submit a letter and thank you for the opportunity to show my support of a license for art therapists in the state of Virginia. I am one of the many credentialed and Board Certified art therapists, along with art therapy clients, and mental health colleagues in Virginia who strongly believe that an art therapy license through the VA Department of Health is urgently needed to:

• Protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved and accredited training, educational, credentialing and certification requirements.

• Increase affordable access to mental health services by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.

• ***Attract and retain qualified art therapy professionals and art therapy students in Virginia.***

• Contribute to the economy of the state through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

• State licensure of professional art therapists will also support assessment and treatment for (but not limited to):

  • Veterans, active duty military, and their families who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.

  • The growing numbers of older adults suffering with dementia and depression.

  • People of all ages with cancer who need complementary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.

  • Individuals with developmental disabilities (i.e., autism) who need specially trained, qualified therapists.

  • Those experiencing trauma from natural disasters, abuse, drug dependency, or other

mental health problems in the general population.

- ***Those experiencing trauma from interpersonal violence (domestic violence, rape, stalking, dating violence and trafficking) that do not have the resources to find specialized treatment. Rape crisis and domestic violence centers would like to hire specialized trauma therapists and those with enhanced skills like art therapists but often can not because funding will only allow licensed therapists to be hired.***

During my tenure as current President and former President/Founder of the Virginia Art Therapy Association, we have worked closely with the American Art Therapy Association (AATA) to enhance the field of art therapy in all states. We supported AATA's collaboration with other national art therapy organizations, in particular with the British Association of Art Therapists (BAAT). In the UK, art therapy is nationally recognized through the NHS (National Health Service) and art therapists are registered with the regulatory body, the Health and Care Professions Council (HCPC). Importantly, our British colleagues have endeavored to generate examples of harm, potential harm, and prevented harm by interventions with clients by clinicians providing art therapy or claiming to provide art therapy without being a trained art therapist. They provide this relevant resource on the BAAT website: http://www.baat.org/About-BAAT/Blog/167/Through-the-eyes-of-the-law-What-is-it-about-art-that-can-harm-people

From an economic standpoint, I also want to make you aware that graduates of the George Washington University Graduate Art Therapy Program, based in Alexandria, VA, often move to Maryland (or another state that has an art therapist license) after successful completion of the degree (https://health.maryland.gov/bopc/Pages/lgpat.aspx). And graduates of the Art Therapy program at Eastern Medical School located in Norfolk have to seek work outside Virginia as well. We have two well known, well established and excellent schools offering art therapy programs in Virginia yet Virginia hampers their ability to practice upon graduation. It is time for Virginia to join the 12 other states that currently provide an avenue for art therapists to pursue a license specific to their qualifications, scope of practice, standards of practice, and ethical code.

Additionally, I manage agencies that hire therapists and I have a hard time retaining art therapists due to lack of licensure and **lack of consistent pay-scales appropriate for their level of education** that result in lack of opportunities for professional growth.

On a final note, as you are aware, some art therapists have had to opt for a license in another profession in order to practice art therapy. I am one of those, willing to invest in my ability to practice. However, I am distinct in my categories of practice and make it clear to clients whether they want verbal therapy or art therapy and they overwhelmingly choose art therapy. I, like most other art therapists in Virginia are willing to further invest in our chosen field. I implore the Virginia Board of Health Professions to move forward with the establishment of the art therapist

license in Virginia. I thank you for your time and attention for the sake of the health, safety, and well-being of Virginians across the state. Your efforts and service to the residents of Virginia is deeply appreciated.

Carol Olson, M.A., M.A., LPC, ATR-BC

4536 West Seminary Avenue, Richmond, VA 23227

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Laura Jackson

From:	Karen Montgomery
Sent:	Thursday, July 26, 2018 9:32 AM
To:	laura.jackson@dhp.virginia.gov
Subject:	Fwd: I support Art Therapy and Therapists in Virginia

---------- Forwarded message ---------
From: **Eileen Mulcahy** <mulcahy@trschool.org>
Date: Thu, Jul 26, 2018, 9:17 AM
Subject: I support Art Therapy and Therapists in Virginia
To: laura.jackson@dhp.virginia.gov. <laura.jackson@dhp.virginia.gov>
Cc: karen montgomery <kinskimont@gmail.com>

Dear Ms. Jackson,

In the past I have had the pleasure of working with an excellent art therapist LPC candidate, her ability to have less verbal children and teens express themselves so openly through various art mediums was amazing and extremely helpful to my therapy work with them. I believe there is a need for their specialty in serving clients in Virginia. Recently as a cancer patient at Shenandoah Oncology in Winchester Virginia at the Winchester Medical Center they also offer Art therapy as part of the patient services in the Integrative Care Program. The work done in the art therapy graces the lobby and walls and makes the space more welcoming and friendly . There should be no doubt as to the value of the work Art therapists provide in many settings throughout the life span all over the Commonwealth of Virginia. As an LCSW I hope the Board will do what is needed to see that these creative and valuable clinicians are able to continue to work to benefit the public in a wide variety of settings. Thank you.

Eileen M. Mulcahy MSW, LCSW

Dogwood Unit Clinical Counselor

Timber Ridge School

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To Whom it May Concern,

My name is Mary Ellen Ruff and I am writing to you as an Art Therapist and LPC in Alexandria, VA. I am also a member of the Potomac Art Therapy Association (PATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

For the past several years, I have served as an Approved Clinical Supervisor for the LPC. Some of my supervisees have Master's degrees in Art Therapy and some have Master's degrees in Counseling. At times, Residents have been part of a group supervision format and have mutually benefited from their diverse training and educational experiences, creating a richer, more meaningful supervision experience. In a recent supervision group, someone from a counseling background talked about how much she has learned from being in a group with art therapists and that she has incorporated art techniques into her work with clients. While counselors may incorporate creative or expressive arts into their work, this supervisee was operating outside of the scope of any training she had received. This undermines the rigorous training of art therapists to include not only the art therapy coursework that provides the path towards Board Certification in Art Therapy, but also the counseling coursework that enables licensure as Professional Counselors in most states. State licensure for Art Therapists would prevent situations such as this from arising because it would support independent practice, title protection, and protect the public from those practicing outside of their scope.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Mary Ellen Ruff, MS, LPC, ATR-BC, ACS
Art Therapist
maryellenruff@verizon.net / 703-303-4983

Laura Jackson

From: Sangeeta Prasad
Sent: Thursday, July 26, 2018 12:04 PM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapy

Dear Ms. Jackshon,

Below is the email for the Virginia Art Therapy Association petition.

To Whom it May Concern:

I am writing to share pertinent information that may help legislators in better understanding the position of art therapists who work or would like to work, under licensure in the Commonwealth of Virginia. I am currently in private practice and feel there is a need for art therapists to be licensed. We need to protect clients from persons claiming to provide art therapy when they do not have the required training or skills to offer such services.

Although these comments are the point of view of one Virginia Art Therapist, I believe many art therapists share these thoughts and perceptions. I also work internationally, and since art therapy began in our country, USA, we need to set the standards for this profession.

The field of art therapy requires completion of a highly rigorous academic program which includes a comprehensive internship experience spanning a variety of settings. This education includes monetary costs and many hours of hard work. It is thus expected that art therapy requires persons to have a license to practice. Licensure will protect the consumer and the provider.
The field is unique because it combines the properties of both creating art (and all that that involves), as well as the rich and layered therapeutic process. Using art as a tool for communication and expression provides healing for many who may need a bridge to their unconscious or traumatized minds. (Trauma is stored in the part of the brain where art originates.) The art can become the client's dialogue.

By offering licensure to trained and attained art therapists, the public will be made aware of our qualifications. This will raise awareness of the unique skills possessed by art therapists, and elevate the credentials of ATR-BC (Registered and Board Certified Art Therapist) in the eyes of the public, as well as our colleagues in both the medical and mental health fields. It also protects the public from clinicians as well as non-clinicians from claiming they are using art therapy. Please check Psychology Today and you will find many therapists who are using art therapy with minimal training. Also, places like schools, hospitals, and senior homes that find art therapy a useful therapeutic tool among the various services that they provide discover that they cannot hire an art therapist since art therapy is not covered by Medicare, Medicaid or other insurances. This means that where a client population cannot use verbal treatment,

they do not have an option for other forms of treatment. Art therapy is also a useful tool for PTSD and during disaster relief. We find many organizations give out art supplies and think they are providing therapy when they could hurt a person by how they react to the art or what they say and do with the art. For instance, in a case where a child had used drawing to convey his shock during a particular disaster, the agency providing the art materials used the art to the market the work they were doing without consent or consideration on how the person would feel seeing their art used. This is unethical, and as art therapists, we are trained on the ethics of the use of art created in therapy. If we do use the art of a client we are aware that it first benefits the client and the goals they are working on.

I have experienced a trivialization of the Art Therapy field when, for example, others who are therapists, counselors, doctors, feel that it is ethical to use art materials when working with clients/patients, and call it art therapy, without the extensive and specialized training. Having earned a graduate degree in the field of Art Therapy, having earned the designations of Board Certified (BC), and ATR (Registered Art Therapist), and having worked in the field for over 33 years, it is shocking to note how this powerful and unparalleled field has not yet been acknowledged in the enlightened Commonwealth of Virginia with the formalization of licensure.

Invariably, working with each client brings new challenges, which in turn continues to confirm in me the power of the tool that art offers when using Art Therapy.

Thank you very much for considering these thoughts when formulating the new licensure designation for those in the field of Art Therapy.

Sangeeta Prasad

Sangeeta Prasad, ATR-BC

Private Practice - Circle Art Studio, Fairfax, Virginia
Directory, American Art Therapy Association
Vice President, The Prasad Family Foundation

Warmly,

Sangeeta Prasad, ATR-BC
http://www.sangeetaprasad.com
http://circleartstudio.com

Laura Jackson

From: Jordan Potash
Sent: Thursday, July 26, 2018 2:01 PM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapy Open Comment Submission

Dear Virginia Board of Health Professions:

My name is Jordan Potash and I am writing to you as someone who works in Alexandria, VA. I am supporting the Virginia Art Therapy Association (VATA) to raise awareness of art therapy and advocate for the safety of Virginians by establishing a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I have been serving Virginia residents as an art therapist since 1998. I began as an art therapy intern at the Leary School in Alexandria, worked in a school and community-based program for Child and Family Services in Arlington, and as an expressive arts programmer in the Art Unit in Arlington. I am currently an Assistant Professor in Art Therapy at The George Washington University at the Alexandria campus where I have offered workshops in coordination with Beatley Library. In all of this time, I have worked with children with special needs, adolescents with mental disorders, adults with intellectual impairments, senior adults engaged in life review, immigrants with distress, and general members of the public looking to increase wellness. Despite the diversity of these groups, I have found that art therapy offers a unique combination of psychology with the arts that promotes imaginative expression and metaphoric perspectives. With the increased need for licensure, it has become more difficult to make sure that clients are able to partake in the full benefits that art therapy has to offer.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for *(but not limited to)*:

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Jordan S. Potash, PhD, ATR-BC, LCPAT (MD), LCAT (NY), Art Therapist
jpotash@gwu.edu / (703) 299-4147

Jordan S. Potash, PhD, ATR-BC, REAT, LCPAT (MD), LCAT (NY)
Assistant Professor, Art Therapy Program, The George Washington University
GW Webpage: http://arttherapy.columbian.gwu.edu/jordan-potash
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703.299.4147
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Hlavek Art Therapy, LLC
Elizabeth Hlavek, ATR-BC, LCPAT
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www.hlavekarttherapy.com

July 26, 2018

To Whom It May Concern:

I am contacting you regarding art therapy licensure in the state of Virginia. In 2012 I led the initiative to develop an art therapy license in Maryland, which was signed into law later that year. Licensure for art therapists has been beneficial in the following ways:

- Consumers in the state are now able to access art therapy services knowing that their provider is experienced and regulated by the state.
- Many consumers can use, or be reimbursed by, their insurance provider for art therapy services, which makes treatment more affordable and ultimately more accessible.
- Job opportunities for art therapists have increased.
- License holders pay an annual licensing fee, which contributes to the state budget.

Surely Virginia residents, including potential art therapy consumers and providers, would experience similar benefits if a license was developed. Art therapy has been proven to be a valuable treatment options for veterans, individuals struggling with PTSD, eating disorders, and myriad other medical and behavioral health concerns. These populations exist in Virginia and deserve evidence based treatment such as art therapy.

I also was elected to sit on Maryland's Board of Professional Counselors and Therapists as the art therapy representative once the license was in effect. I found that my master's education in art therapy to be just as rigorous and clinically focused as that of my peers in counseling and marriage and family therapy. Indeed, art therapists are trained in ways quite similar to other master's level mental health

professionals and should be recognized as such.

On a personal note, I want to share that I previously contracted with an outpatient group psychotherapy practice in Herdon and considered relocating to Northern Virginia for a full time position. However, I am licensed as an art therapist in Maryland and could not receive parity in Virginia. Had there been an equivalent license in Virginia, I would have happily moved. Perhaps graduates of Eastern Virginia Medical School's art therapy master's program would be able to stay in the state and thrive if they were able to be licensed.

I appreciate your attention to this matter and am happy to answer any questions regarding Maryland's art therapy licensing process.

Respectfully,

Elizabeth Hlavek
Doctoral Candidate
LCPAT, ATR-BC

To Whom it May Concern,

My name is Lindsay Downs and I am writing to you as a resident and individual that works in Manassas, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I am currently in residence towards my ATR-BC and work as an in-home clinician to prevent out-of-home placement and psychiatric hospitalization. I work with a diverse population, mostly children, adolescents and their families, with extensive trauma histories and reoccurring trauma that often requires more than traditional therapy modalities to meet wellness needs and progress in treatment. I am aware of colleagues I work with attempt to utilize what art therapists do with their clients and find non-art therapists are ill-informed about the creative process, how and what materials are used in session and are unaware of ethical considerations when engaging with clients on sensitive subject matter incorporated with art making and the creative process. This is no different than a pediatrician going into to do heart surgery, despite a pediatrician and a heart surgeon both being medical professionals, one not having the specific training to carry out the required work is not providing quality care or professionalism and may cause more harm than good.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for *(but not limited to)*:

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.

- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. Looking forward to being in touch.

Kind regards,
Lindsay Downs, Art Therapist
ldowns@taculture.com
lindsaykdowns@gmail.com
(720) 209-1223

Laura Jackson

From: Vaughan, Michelle
Sent: Thursday, July 26, 2018 3:31 PM
To: Laura.Jackson@dhp.virginia.gov
Subject: Art Therapy Licensure in Virginia

Virginia Board of Health Professions,

My name is Michelle Vaughan and I'm a registered board certified art therapist working in Leesburg, Virginia. I'm also undergoing the supervision process for LPC licensure. I'm writing to you today because it's imperative that the field of art therapy become a licensed profession in the state of Virginia. State licensure would benefit art therapists, clients and the mental health field alike.

Art therapy is it's own independent mental health profession. In order to become a registered art therapist it takes undergraduate education, graduate school, 100 hours of supervision and 1,000 direct service hours of work experience providing art therapy interventions. Unfortunately, without a license, some people continue to hold the preconceived notion that anyone can be an art therapist after a weekend workshop and a misconception that coloring books are "art therapy". These misconceptions and misunderstandings about the field could be detrimental to us as art therapists, and to the clients we serve.

As an art therapist, I'm trained in providing specific, tailored interventions that will ideally benefit the population I work with. I have the training to provide assessments that can give me a wealth of knowledge about the clients I see. The only reason I'm qualified to administer these assessments and directives, is that I spent years reading, learning and researching about them. I understand which interventions will be most appropriate for which individuals and I use my own knowledge and my knowledge of the client to inform my decision-making process.

I currently work with an adult SMI population as part of a psychosocial rehabilitation program and I can't tell you the amount of people I see in my groups that benefit from having two art therapists on our staff. I've seen our clients learn to work together and collaborate through artistic production, I've seen them process past experiences and trauma through their art. I've been there as they've stepped out of their comfort zone to create with their non-dominant hand and I've seen them come together to create an amazing mural that they take pride in as a whole. Art brings people together and allows a glimpse into their subconscious mind. Art has no walls and it allows the individual a chance to let go.

Without the education, experience and knowledge, regular clinicians, who are not art therapists, attempting to provide "art therapy" may make assumptions about someone's artwork that could negatively impact them. These clinicians may try to analyze an individual's artwork and project their own identity or feelings into the piece. They may conduct an assessment that's not appropriate for the individual and could lead to the resurfacing of traumatic flashbacks, negative feelings or cause them to develop a sense of low self-esteem. There are so many potential harmful responses that it's obvious why art therapy needs to be a regulated and licensed profession in the state of Virginia.

I'm fortunate that I graduated when I did. I had the opportunity to pursue both ar therapy board certification in Virginia and LPC licensure simply because I graduated in 2014. With the new CACREP accreditation process, not all students graduating from art therapy programs will even have the opportunity to pursue licensure

anymore. Licensure is so incredibly important when it comes to regulation and also it helps us advance in our field as employees. Many doors open as a licensed clinician and if art therapy programs aren't able to offer the opportunity for students to graduate and get their LPC, there has to be another licensure process available to them to help them advance their careers. This licensure process should be pursuing an art therapy license in the state of Virginia.

So what are we really asking for? We're asking that you help us further legitimize this incredible field by allowing us to obtain a license in Virginia. I've seen some incredible transformations from my clients over my previous 4 years out in the field. Some of these transformations would not have been possible with just verbal therapy. With my knowledge and their passion for art, my clients have been able to process, expose, release and transform their experiences through art production and that's an amazing thing. In order to help us continue this work the field has to keep growing and adapting. I think the next step in that process is to allow us to have a license in the state of Virginia.

Thank you for your time and please don't hesitate to call or email with any questions.

Michelle Vaughan

Michelle Vaughan, ATR-BC
Board Certified Art Therapist
PSR Day Support Counselor
Friendship House
(cell) 703-203-5878
(work cell) 571-528-7960

Laura Jackson

From: Gretchen Graves
Sent: Thursday, July 26, 2018 12:50 PM
To: Laura.jackson@dhp.virginia.gov
Subject: Art Therapy License in Virginia

Good Morning Ms. Jackson,

It almost seems redundant that I am writing a separate letter of support for this license, as I have been working to get Virginia art therapists to this point for several years.

I write as a Board Certified Art Therapist in Virginia, immediate past President of Virginia Art Therapy Association, former Speaker of the Chapters, American Art Therapy Association and long time resident of Virginia.

Art therapy is a highly qualified mental health profession, with years of research of efficacy. We have training in mental health service that is similar, but different to other mental health professions. It is rich in psychotherapy and developmental knowledge. The American Art Therapy Association has outcomes of many studies listed on their web page regarding research: https://arttherapy.org/research/.

There are many professionals out there that are claiming to also practice art therapy without proper training. This can be very detrimental to clients. Recently the British Association of Art Therapy published a large body of evidence supporting this. This can be found at: http://www.baat.org/About-BAAT/Blog/167/Through-the-eyes-of-the-law-What-is-it-about-art-that-can-harm-people.

Virginia needs more highly qualified art therapists. A shining example of this is the incident that poor Senator Creigh Deeds had to experience with his son. Lack of qualified health professionals should never be the reason someone suffers. Art therapists are trained to work with children, adolescents, and adults. We work with military, Alzheimer's patients, people with physical disabilities, ADHD, dually diagnosed and scores of other diagnosis.

I personally work at a children's hospital with severally disabled youth. I had a client for a while who was a quadriplegic with no ability to talk. He had a sharp brain and knew his life was shortened by the accident, causing obvious depression. For over ten years he lived a cage of a body. I was able to help him learn to paint with his mouth and thereby gave him a voice. With that voice he could communicate his fears, and his joy at being able to give to others again and to have a new talent. This is not a simple task we just did one day, and honestly if I did not have the training as an art therapist that I have I would not have known giving him that opportunity would be so rich. But I did know, and I was able to take that skill of mouth painting to a very healing place for my client.

Mental health is such a serious issue in our country and state. Please help us create more opportunities for client safety, and jobs in our state.

Thank you so much for the opportunity to express my hope that our profession becomes regulated in Virgina.

Sincerely,

Gretchen Graves, MS, ATR-BC, CDATA
Ms.Gretchengraves@gmail.com

Art Therapist
Hospital Education Program
Children's Hospital of Virginia - Medical College of Virginia
GGraves@RHEP.org

AMERICAN arttherapy ASSOCIATION

ART THERAPY RESEARCH

A SAMPLING OF EVIDENCE-BASED PUBLICATIONS THAT DEMONSTRATE THE BREADTH OF ART THERAPY RESEARCH

> Research in art therapy is critical in order to inform our clinical practice, and to communicate to employers and other decision makers that art therapy is evidence-based. I am energized by this study because it's the first known randomized controlled trial of art therapy and combat PTSD and lends support to the efficacy of art therapy as benefiting the mental health of veterans. We found that participants who received art therapy in addition to the verbal therapy didn't drop out of the study, showed improvements in PTSD symptoms and depression, and reported that seeing portrayals of their own trauma was helpful in thinking through and processing trauma – and then consigning it to the past. They were excited about art therapy.

Sarah Deaver, PhD, ATR-BC, HLM

TRAUMA | PTSD

Campbell, M., Decker, K., *Kruk, K., & Deaver, S. (2016). Art therapy and Cognitive Processing Therapy for combat-related PTSD: A randomized, controlled trial. *Art Therapy: Journal of the American Art Therapy Association,* 33(4), 169-177.

The addition of art therapy to Cognitive Processing Therapy (CPT) was more effective than CPT alone in reducing symptoms of combat-related PTSD in veterans.

Example of a Trauma Narrative (printed with permission)

HIV/AIDS

Rao, D., Nainis, N., Williams, L., Langner, D., Eisin, A., & Paice, J. (2009). Art therapy for relief of symptoms associated with HIV/AIDS. *AIDS Care,* 21(1), 64-69.

Patients with a diagnosis of HIV infection (N=79) participated in an hour-long art therapy session or viewed a video about art therapy. Covariance analysis of pre- and posttest measures of psychological and physical symptoms showed better physical symptom mean scores in the art therapy group after adjusting for pretest score, age, gender, and race/ethnicity.

ALZHEIMER'S | DEMENTIA

Chancellor, B., Duncan, A., & Chatterjee, A. (2014). Art therapy for Alzheimer's disease and other dementias. *Journal of Alzheimer's Disease,* 39(1), 1-11.

Given that pharmacologic treatments for dementia are limited in efficacy, treatments that improve neuropsychiatric symptoms and quality of life are needed. This literature review sought to explore the efficacy of art therapy with this diagnosis. The study concluded: "art therapy engages attention, provides pleasure, and improves neuropsychiatric symptoms, social behavior, and self-esteem." The study also offers a theoretical framework to inform the use of art therapy with this population.

AUTISM SPECTRUM DISORDER

Van Lith, T., Stallings, J.W., & Harris, C.E. (2017). Discovering good practice for art therapy with children who have Autism Spectrum Disorder: The results of a small scale survey. *The Arts in Psychotherapy* 54, 78-84.

Researchers interviewed 14 art therapists who work with children who have autism spectrum disorder (ASD) to study current practice in the field. Five domains of practice were determined: (1) art therapists' level of experience and scope, (2) unique aspects of using art therapy with children who have ASD, (3) preferred choice of art materials for children with ASD, (4) primary aims when using art therapy for children with ASD, and (5) preferred theoretical approaches and their practical application. These findings were used to establish practical guidelines to follow when providing art therapy for children who have ASD.

MEDICAL

Beebe, A., Gelfand, E. W., & Bender, B. (2010). A randomized trial to test the effectiveness of art therapy for children with asthma. *The Journal of Allergy and Clinical Immunology,* 126(2), 263-6.

Children with asthma who participated in one hour of art therapy per week showed improvements after six months in measures of quality of life, worry, communication, anxiety, and self-concept relative to the control group of art therapy with this population.

Pielech, M., Sieberg, C.B., Simons, L.E. (2013). Connecting parents of children with chronic pain through art therapy. *Clinical Practice in Pediatric Psychology,* 1(3), 214-226.

Fifty-three parents of children and adolescents enrolled in an intensive interdisciplinary pediatric pain rehabilitation day hospital program participated in weekly group art therapy sessions. Overall, participants found it to be a supportive and validating experience. Parents agreed that they would try art therapy again and recommend the intervention to other parents of children with chronic pain.

NEGATIVE MOOD

Kimport, E. R., & Robbins, S.J. (2012). Efficacy of Creative Clay Work for Reducing Negative Mood: A Randomized Controlled Trial. *Art Therapy: Journal of the American Art Therapy Association*, 29(2), 74-79.

Adults (N=102) engaged with a series of negative mood-inducing exercises and were randomly assigned to one of four conditions. Two conditions involved art-making with clay, and two involved non-art-based activities utilizing stress balls. Participants in the clay conditions experienced more than 50% greater mood improvement. Further, the clay group with structure (a goal to create a pinch pot) demonstrated greater mood improvement than the group that worked with clay with no structured activity.

> As we discover more about the workings of the human brain, we also have the opportunity to learn more about how art making and art therapy affect brain activity. Art therapists and their clients have long known that creativity and art making have positive effects. New innovations in research allow us to quantify these outcomes in a language that, paired with other research design studies, can demonstrate the benefit of art therapy.

Girija Kaimal, EdD, MA

NEUROSCIENCE

A functional near-infrared spectroscopy band monitors activation of the prefrontal cortex at rest and during the participant's engagement in coloring, doodling, and free drawing (printed with permission)

Kaimal, G., Ayaz,H., Herres, J., Dieterich-Hartwell, R., Makwana, B., Kaiser, D. H., & Nasser, (2017). Functional near-infrared spectroscopy assessment of reward perception based on visual self-expression: Coloring, doodling, and free drawing. *The Arts in Psychotherapy* 55, 85-92.

Functional near-infrared technology (FNIRS) was used to examine blood flow in the medial prefrontal cortex as 26 participants engaged in three discrete drawing conditions: coloring, doodling, and free drawing. All three conditions activated the reward pathway in the brain with doodling resulting in the most activation. Participants reported changes in their self-perceptions of imaginativeness and the ability to generate good ideas after completing all three drawing conditions. The study highlights the potential of artmaking to improve self-perceptions of creativity.

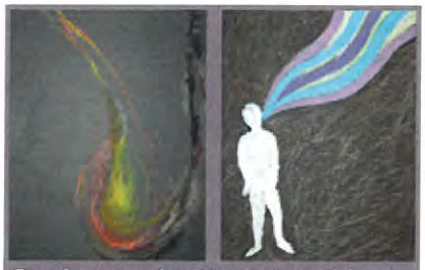
SOCIAL CHANGE

Sutherland, J., Waldman, G., & Collins, C. (2010). Art Therapy Connection: Encouraging Troubled Youth to Stay in School and Succeed. *Art Therapy: Journal of the American Art Therapy Association*, 27(2), 69-74.

This study tracked the progress of 150 students of inner-city Chicago schools who were identified as being at risk of failing grades 3–12 and were enrolled in a year-long school art therapy program called Art Therapy Connection (ATC). Objectives included exploration of group identity, group cohesion, and cooperation. Students' participation, cooperation, attachment, and trust were measured; all four increased during the second half of the school year in five schools, particularly in student participation and trust. ATC students also showed improvements in school attendance, adjustment, and academic achievement.

Betts, D.J., & Potash, J.S. (2015). An art therapy study of visitor reactions to the United States Holocaust Memorial Museum. *Museum Management and Curatorship* 30 (1), 21-43.

Museum visitors viewed exhibitions on the Holocaust: Nazi Assault and The 'Final Solution.' The group that engaged in art therapy interventions showed increased immediate empathy, and their emotional response was sustained at 2, 7, and 12 months. The art therapy group was also more likely to share with family and friends complex reflections about different aspects of their museum visit, rather than solely their distress or historical information.



Drawings completed by study participants (printed with permission)

National Office
The American Art Therapy Association
4875 Eisenhower Ave. Suite 240
Alexandria, VA 22304

Phone
888-290-0878 | 703-548-5860
Visit **arttherapy.org** or email **info@arttherapy.org**

Beebe, A., Gelfand, E. W., & Bender, B. (2010). A randomized trial to test the effectiveness of art therapy for children with asthma. *Journal of Allergy and Clinical Immunology, 126*(2), 263-266.

In order to measure the effectiveness of art therapy to help cope with chronic illness, twenty-two children with asthma were randomized to an art therapy group who received art therapy interventions once a week for 6 weeks, or in the wait-list control group. Post intervention analysis on The Pediatric Quality of Life (PedsQL)—Asthma Module, The Beck Youth Inventories and Draw a Person Picking an Apple from a Tree show significant differences (at $p < .05$) from baseline to completion of art therapy with (1) improved problem-solving and affect drawing scores; (2) improved worry, communication, and total quality of life scores; and (3) improved Beck anxiety and self concept scores in the art therapy group in comparison to the control group. The results were also striking with persisting benefits of art therapy when measured after 6 months. The study provides encouraging data on the use of art therapy interventions to improve emotional health of chronically ill children.

Nan, J. K., & Ho, R. T. (2017). Effects of clay art therapy on adults outpatients with major depressive disorder: A randomized controlled trial. *Journal of affective disorders*, 217, 237-245.

Adults (N=102) adults with depression were randomized into clay art therapy (CAT) group or visual art (VA) recreational group. Multivariate analysis of covariance results indicated significant effect for CAT than for VA group on depressive symptoms, general health, body–mind–spirit well-being, and alexithymia (all $p < 0.05$) after 6 week intervention. Both qualitative and quantitative data demonstrated the therapeutic effects of clay in releasing energy and tension, providing and channeling sensation, evoking emotion, and regulating emotion through the creation of form.

Kaimal, G., Ayaz,H., Herres, J., DieterichHartwell, R., Makwana, B., Kaiser, D. H., & Nasser, (2017). Functional near-infrared spectroscopy assessment of reward perception based on visual self-expression: Coloring, doodling, and free drawing. *The Arts in Psychotherapy 55*, 85-92.

Visual self-expression helps with attention and improves health and well-being. Few studies have examined reward pathway activation during different visual art tasks. This pilot study is the first to examine brain activation via functional near-infrared spectroscopy (fNIRS) during three distinct drawing tasks—coloring, doodling, and free drawing. Participants (11 men, 15 women; 8 artists, 16 non-artists) engaged in each task separated by equal intervals of rest in a block design experimental protocol. Additional data included a pre- and post survey of self-perceptions of creativity, prior experience with drawing tasks, and reflections on study participation. Overall, the three visual arts tasks resulted in significant activation of the medial prefrontal cortex compared to the rest conditions. The doodling condition resulted in maximum activation of the medial prefrontal cortex compared to coloring and free drawing; however, differences between the drawing conditions were not statistically significant. Emergent differences were seen between artists and non-artists for coloring and doodling. All three visual self-expression tasks

activated the medial prefrontal cortex, indicating potential clinical applications of reward perception through art making. Participants improved in their self-perceptions of problem solving and having good ideas. Participants found the drawing tasks relaxing but wanted more time per task. Further study with varied art media and longer time on tasks are needed to determine potential interactions between participants' backgrounds and reward activation.

Kopytin, A., & Lebedev, A. (2013). Humor, self-attitude, emotions, and cognitions in group art therapy with war veterans. ***Art Therapy:Journal of the American Art Therapy Association 30*****(1), 20-29.**

Therapaeutic effects of group art therapy were studied on 112 veterans randomly assigned to experimental group (art therapy) and a control group. Art therapy interventions aimed at creative exploration, safe expressions of emotions and presentation of current emotional state. Significant posttest scores were reported after one month on depression scale, hostility scale and general condition scale (all $p < .05$). Findings also included a high frequency of humorous responses in both groups, and an increase of humor in the art therapy group post treatment. The study suggests that image formation and artistic activity foster cognitive and creative problem solving and increased self-esteem, and that humor serves as an important therapeutic function in this population.

Laurer, M., & Vennet, R. v. (2015). Effect of art production on negative mood and anxiety for adults in treatment for substance abuse. ***Art Therapy: Journal of the American Art Therapy Association*****, 177-183.**

Twenty eight adults with substance use disorder participated in randomly assigned groups of art production and art viewing/sorting. Paired sample t tests for pre-and-post test measures shows mean difference of scores as 52% demonstrating a reduction of negative mood, and state and trait anxiety on all the three measures used by the researchers. Further, no significant reduction in negative mood was seen for the groups merely viewing art. This study has direct implications on demonstrating the promise for reducing negative mood states and anxiety for clients struggling with substance abuse through engagement in art production.

Pretorius, G., & Pfeifer, N. (2010). Group art therapy with sexually abused girls. ***South African Journal of Psychology, 40*****(1), 63-73.**

Sexually abused girls (n=25) aged 8-11 years participated in group art therapy intervention focused at reducing depression, anxiety, sexual trauma and low self-esteem. The Solomon four-group design was used to investigate the efficacy of the intervention. Independent sample t tests on pre and post scores for the experimental group and control group indicated significant differences in depression (measured by TSCC) and Anxiety (measured by HFD). The mean difference in the scores in pre-and-post measure on depression is 30% which shows that the intervention led to a drop in depression.

A randomized trial to test the effectiveness of art therapy for children with asthma

Anya Beebe, MA, LPC,[a] Erwin W. Gelfand, MD,[b] and Bruce Bender, PhD[a] *Denver, Colo*

Background: Art therapy has been used to help children cope with chronic illness but has not been specifically tested with children who have asthma.
Objective: To test an art therapy intervention in a randomized controlled trial in children with asthma.
Methods: Twenty-two children with asthma were randomized to an active art therapy or wait-list control group. Those in the active art therapy group participated in 60-minute art therapy sessions once a week for 7 weeks. Sessions included specific art therapy tasks designed to encourage expression, discussion, and problem-solving in response to the emotional burden of chronic illness. Measures taken at baseline, immediately after, and 6 months after the final art therapy session included the Formal Elements Art Therapy Scale applied to the Person Picking an Apple from a Tree assessment, the parent and child versions of the Pediatric Quality of Life Asthma Module, and the Beck Youth Inventories. Those children assigned to the wait-list control group completed all evaluations at the same intervals as the children receiving art therapy but did not receive the art therapy interventions.
Results: Score changes from baseline to completion of art therapy indicated (1) improved problem-solving and affect drawing scores; (2) improved worry, communication, and total quality of life scores; and (3) improved Beck anxiety and self concept scores in the active group relative to the control group. At 6 months, the active group maintained some positive changes relative to the control group including (1) drawing affect scores, (2) the worry and quality of life scores, and (3) the Beck anxiety score. Frequency of asthma exacerbations before and after the 6-month study interval did not differ between the 2 groups.
Conclusion: This was the first randomized trial demonstrating that children with asthma receive benefit from art therapy that includes decreased anxiety and increased quality of life. (J Allergy Clin Immunol 2010;126:263-6.)

Key words: *Children, asthma, art therapy*

Abbreviations used
FEATS: Formal Elements of Art Therapy Scale
HRQOL: health-related quality of life
PedsQL: Pediatric Quality of Life

Asthma is a chronic inflammatory disorder of the airways that causes recurrent episodes of coughing, wheezing, chest tightness, and dyspnea (difficulty breathing), affecting an estimated 9.3% of children under 18 years of age (http://www.cdc.gov/asthma/). The severity, acuteness, triggers, and symptoms of asthma vary considerably. Asthma episodes can develop quickly and are often the source of significant emotional distress for children with asthma and their families. Many children with severe asthma have restricted levels of activity and exposure to environments that threaten their disease. Further, the illness can interfere with a child's education, acceptance by peers, and participation in extracurricular activities.[1] Such restrictions in turn may limit childhood experiences important to the child's psychological development. The chronically ill child with many limitations may have difficulty developing a healthy self-concept.[2] Not surprisingly, children with asthma demonstrated increased rates of anxiety, depression, and behavior problems.[3]

Art therapy is a form of psychotherapy often used with chronically ill children. In art therapy, patients are encouraged by an art therapist to express their thoughts and feelings through art materials and interventions. Art therapy services have become more common in hospital settings and have been shown to help children cope with the psychological distress resulting from illness and hospitalization.[4] Few art therapy interventions have been evaluated in controlled studies, and none have been tested with children who have asthma. This study used a randomized controlled trial to test whether art therapy can improve emotional health and quality of life for children with asthma.

METHODS

The 22 children 7 to 14 years old enrolled in this study had a diagnosis of persistent asthma requiring daily treatment. All participants were students in the Kunsberg School, a school for children located on the campus of National Jewish Health. Information about the study was provided to all students at Kunsberg School and their families; those interested in participating identified themselves to school personnel and were scheduled for a baseline interview, where further information about the study was provided. If the family chose to participate in the study, a parent or guardian provided informed consent, and each participating child provided assent. The study was approved by the Institutional Review Board of National Jewish Health.

Once consented, participants were randomized to treatment or wait-list control groups. The participants randomized to the active group met for a 1-hour art therapy session for 7 weeks. The sessions included an opening activity, discussion of the weekly topic and art intervention, art making, opportunity for the patients to share their feelings related to the art they created, and the closing activity. In each session, a new topic and art intervention related to chronic illness were presented (see this article's Appendix E1 in the Online Repository at www.jacionline.org).

Asthma is managed in a 3-nurse clinic within the Kunsberg School, and during school hours, all medications are administered by the nurses. Children

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TABLE I. Quality of life scores (higher scores represent higher quality of life)

Score	Active		Control		*P* value
	Mean	SD	Mean	SD	
Immediate					
Parent total	6.167	17.492	−13.091	20.335	.0250*
Child total	9.727	13.705	−13.364	23.479	.0123*
Parent communication	14.583	135.45	22.727	89.061	.5673
Parent worry	47.917	86.902	−13.182	76.723	.0144*
Parent treatment	64.583	260.154	31.818	209.789	.5555
Parent severity	12.501	226.008	−32.27	245.320	.1101
Child communication	15.909	109.700	−9.545	96.707	.3151
Child worry	54.545	96.059	−45.909	113.067	.0142*
Child treatment	70.455	231.791	22.727	202.007	.3271
Child severity	13.636	190.841	−33.636	202.597	.5580
Six months					
Parent total	4.500	16.043	−3.800	5.146	.256
Child total	10.556	15.765	1.375	10.623	.177
Parent communication	22.500	121.020	10.000	113.162	.593
Parent worry	58.333	108.362	−40.909	86.799	.024*
Parent treatment	52.500	260.462	40.000	136.524	.895
Parent severity	82.500	149.560	−45.000	230.278	.162
Child communication	80.556	55.590	59.900	113.662	.618
Child worry	79.545	82.778	−25.000	118.849	.0279*
Child treatment	108.333	225.000	30.000	288.145	.516
Child severity	19.440	225.616	−130.00	150.831	.116

*Significant difference ($P < .05$).

experiencing asthma exacerbations that cannot be managed by the school nurses are seen on campus in the National Jewish Pediatric Outpatient Clinic. Medical charts and nursing records were examined for asthma exacerbations, defined as any event requiring a physician's consultation, during the period of 6 months before and 6 months after the study.

Instruments and measures

All participants in the active art therapy group completed questionnaires and the art assessment before the first therapy session, after the last one, and 6 months after the seventh session. Those children assigned to the wait-list control group completed all evaluations at the same intervals as the children receiving art therapy but did not receive the art therapy interventions. Measures included the following:

1. The Pediatric Quality of Life (PedsQL)—Asthma Module—Child Report and the PedsQL—Asthma Module—Parent Report for Children[5] were included to evaluate the impact of asthma on the quality of life of the child and their parent. These assessments used a health-related quality of life (HRQOL) modular approach to measuring quality of life in children and adolescents. The pediatric HRQOL self-report was completed by children in the active art therapy group, and the parent-reported HRQOL was completed by parents of children in the active art therapy group. These questionnaires both include 28 questions using a Likert scale (1-5 from never to almost always) and yield 5 scores (communication, worry, treatment, severity, and total).
2. The Beck Youth Inventories—Second Edition[6] is an assessment for children and adolescents that measures self-reported adaptive and maladaptive behaviors and emotions of children. The Beck Youth Inventories—Second Edition includes 100 questions with 5 components (disruptive behavior, anger, depression, anxiety, and self-concept).
3. The Draw a Person Picking an Apple from a Tree evaluation[7] is an art therapy drawing evaluation from the Formal Elements of Art Therapy Scale (FEATS).[7] In this evaluation, the children were asked to draw a picture of a person picking an apple from an apple tree. The FEATS scoring system rates 14 variables (promotion of color, color fit, implied energy, space, integration, logic, problem-solving, realism, developmental level, details of objects, line quality, person, rotation, preservation) in each drawing on a scale from 0 to 5, with each providing an evaluation of the child's coping abilities and resourcefulness.[7] All scoring was completed by a second art therapist blind to treatment condition.

Statistical analysis

All statistical analyses were performed with JMP (SAS Institute, Inc). Scores presented here represent the baseline score subtracted from the immediate or 6-month scores. An ANOVA with the Dunnett test compared scores between the intervention and control groups.

RESULTS

Score changes immediately after art therapy indicated a reduction of parent-reported and child-reported worry scores from the PedsQL questionnaires (Table I); a reduction in the anxiety score and an increase in the self-concept score from the child-reported Beck Inventories (Table II); and improvements in the color, logic, and details scores from the FEATS (Table III) in the intervention group compared with the control group. Six months after completion of the therapy, improved parent-reported and child-reported worry and total scores from the PedsQL questionnaires (Table I), a lower anxiety score from the Beck Inventories (Table II), and higher color and detail scores from the FEATS persisted (Table III) remained in the intervention group. During the 6 months before study participation, 3 children in the art therapy group and 4 in the control group experienced exacerbations requiring that they be seen by a physician in the outpatient clinic. For the period of 6 months after study completion, 2 children in each group experienced an exacerbation. No emergency department visits or hospitalizations occurred in either group during either interval.

TABLE II. Beck Inventories scores (higher scores represent greater problems except for self-concept)

Score	Active		Control		*P* value
	Mean	SD	Mean	SD	
Immediate					
Disruptive behavior	−2.182	7.85898	−6.0000	7.72010	.2639
Anger	−10.091	14.0389	2.300	9.6615	.1531
Depression	−10.909	12.9031	1.300	19.7093	.2102
Anxiety	−15.600	10.8341	5.300	9.7872	.0388*
Self-concept	12.091	5.6649	−3.545	13.5600	.0222*
Six months					
Disruptive behavior	−5.000	6.185	−7.900	8.825	.790
Anger	−10.889	12.762	−9.200	15.325	.398
Depression	−11.556	13.164	−7.600	18.664	.299
Anxiety	−14.000	14.304	0.545	19.387	.030*
Self-concept	3.800	13.382	−4.100	7.666	.127

*Significant difference ($P < .05$).

TABLE III. Change in drawing scores (higher scores represent more positive content)

Score	Active		Control		*P* value
	Mean	SD	Mean	SD	
Immediate					
Prominence of color	0.833	1.404	−0.318	1.124	.041*
Color fit	0.364	0.552	−0.046	0.789	.176
Implied energy	0.455	1.150	0.182	1.055	.569
Space	1.000	1.204	0.818	1.401	.748
Integration	0.364	0.869	0.046	0.879	.403
Logic	0.273	0.344	−0.136	0.505	.040*
Problem-solving	−0.364	0.977	−0.727	1.618	.532
Realism	−0.046	0.789	0.136	0.595	.549
Develop level	−0.046	0.151	−0.046	0.350	1.000
Details objects	1.500	1.379	0.136	0.951	.015*
Line quality	0.182	0.337	0.182	0.603	1.000
Person	0.501	0.548	−0.346	0.850	.546
Rotation	−0.227	0.410	0.091	0.736	.229
Preservation	0.000	0.000	−0.046	0.151	.341
Total	2.773	7.132	1.091	6.220	.562
Six months					
Prom color	0.136	1.583	−1.727	1.191	.006*
Color fit	0.200	1.289	0.000	1.269	.678
Implied energy	−0.850	1.334	−0.500	0.913	.504
Space	−0.250	1.620	0.200	1.033	.470
Integration	0.250	1.458	−0.100	1.126	.556
Logic	0.200	0.350	−0.200	0.633	.102
Problem-solving	0.600	2.799	−0.750	2.312	.255
Realism	−0.350	1.001	−0.200	0.823	.719
Develop level	0.350	−0.580	0.050	0.438	.100
Details objects	1.182	1.309	−0.546	1.557	.011*
Line quality	0.300	−0.483	0.200	0.753	.097
Person	−0.300	0.715	0.100	1.445	.448
Rotation	−0.200	0.633	−0.050	0.927	.678
Preservation	−0.500	0.158	−0.500	0.369	1.000
Total	0.050	9.932	−3.150	5.452	.387

*Significant difference ($P < .05$).

DISCUSSION

Results from this study establish for the first time in a randomized clinical trial that a program of art therapy lowers anxiety and improves quality of life and self-concept in children with asthma. These results were striking, and benefits from the art therapy persisted even 6 months after treatment. The use of art therapy for children with severe, chronic asthma is clearly of benefit.

The impact of asthma is not only physical but also has a considerable effect on a child's psychological development. When chronically ill children are frequently absent from school and other activities, they often miss opportunities to grow educationally and socially. Because the presence of a chronic illness can inhibit healthy social and psychological development, it is not unexpected that many children with asthma tend to be anxious and have low self-esteem. One of the greatest fears among children with severe asthma is not being able to breathe, which in turn can contribute to ongoing psychological distress. For many children, simply thinking about past asthma attacks can bring on feelings of anxiety. In turn, heightened levels of anxiety may contribute to precipitating an exacerbation or worsening an ongoing mild episode. Children with asthma who perceive their asthma as dangerous and life-threatening have increased depression rates.[8] Further, adolescents who demonstrate feelings of depression are more likely to be nonadherent with medications.[9] In addition, depression has been linked to increased risk of death in children with severe asthma.[10] For some children with asthma, feelings of low self-esteem, anxiety, and depression may be as challenging to manage as their medical symptoms. Improved emotional regulation is vital in controlling and minimizing asthma episodes. Because emotions can play a significant role in maintaining asthma control, it is important for children with asthma to learn self-management skills and coping techniques to help regulate their feelings of depression and anxiety.

Art therapy is 1 effective tool that can be used to help children cope with troubling feelings and to master a difficult experience.[11] Art therapy can be particularly effective with children because they often do not have the adult capabilities to articulate verbally their emotions, perceptions, or beliefs, and they often can more comfortably convey ideas in ways other than talking.[4] In 1 uncontrolled study, drawings were observed to be a valuable clinical tool in helping children with asthma express their feelings about their illness that could not otherwise be verbalized.[12] When physically ill children engage in the creation of art, their experiences and feelings can be expressed and understood. By creating art about their illness, trauma, or medical procedures, children are able to establish some distance between themselves and their medical concerns. By processing their emotions through art, children often come to understand that their problems are separate from themselves and that the children have an identity outside of their illness.[4] Art helps children come to terms with their asthma, learn to cope and adapt to their situation, and move forward in their lives.[13]

In summary, this randomized, controlled study using art therapy with children with asthma provides encouraging initial data about how the emotional health of chronically ill children may be improved by using art therapy interventions. More specifically, this study demonstrates the positive impact of using art therapy for reduction of anxiety in children with asthma. This study, with a limited number of participants, was not designed to address specifically the question of whether art therapy affected medical outcomes. Significant asthma exacerbations were infrequent in the art therapy or control groups before or after the study interval, likely because of the regular nursing care provided to patients in the Kunsberg School. Nonetheless, 1 important extension of this research will be to determine whether art therapy in conjunction with routine outpatient asthma medical care can help enhance patient and family self-management capacity and

thereby reduce the frequency and severity of asthma exacerbations and the need for urgent care visits or hospitalization. Additional investigation may examine the time frame of art therapy in relation to medical treatment, especially the impact of a shorter course of art therapy on children during hospitalization.

Clinical implications: Art therapy for children with asthma can help reduce anxiety and increase quality of life.

REFERENCES

1. Bender B. Are asthmatic children educationally handicapped? Psychol Q 1995;10: 274-91.
2. Perrin E, Gerrity S. Development of children with a chronic illness. Pediatr Clin North Am 1984;31:19-31.
3. McQuaid E, Kopel S, Nasasu J. Behavioral adjustment in children with asthma: a meta-analysis. J Dev Behav Pediatr 2001;22:430-9.
4. Malchiodi K. Medical art therapy with children. London, United Kingdom: Jessica Kingsley Publications; 1999.
5. Varni J, Burwinkle T, Rapoff M, Kamps J, Olson N. The PedsQL in pediatric asthma: reliability and validity of the Pediatric Quality of Life Inventory Generic Core Scales and Asthma Module. J Behav Med 2004;27:297-318.
6. Beck J, Beck A, Jolly J. Beck Youth Inventories. 2nd ed. San Antonio: NCS Pearson Education Inc; 2005.
7. Gannt T, Tabone C. The formal elements of art therapy scale: a measurement system for the Draw a Person Picking an Apple from a Tree (PPAT) drawing evaluation. Morgantown: Gargoyal Press; 2003.
8. Blackman J, Gurka M. Developmental and behavioral comorbidities of asthma in children. J Dev Pediatr 2007;28:92-9.
9. Bender B, Zhang L. Negative affect, medication adherence and asthma control in children. J Allergy Clin Immunol 2008;122:490-5.
10. Strunk R, Mrazek D, Wofson F, LaBrecque J. Physiological and psychological characteristics associated with deaths from asthma in childhood: a case-controlled study. JAMA 1985;254:1193-8.
11. Ruben J. Medical art therapy with children. In: Malchiodi K, editor. London, United Kingdom: Basic Kingsley Publications; 1999.
12. Gabriels R, Wamboldt M, McCormick D, Adams T, McTaggart S. Children's illness drawings and asthma symptom awareness. J Asthma 2000;37:565-74.
13. Weinberg DJ. The potential of rehabilitative computer art therapy for the quadriplegic, cerebral vascular accident and brain trauma patient. Art Ther 1985;2:66-72.

APPENDIX E1

ART THERAPY SESSION CONTENT

To begin the first art therapy session, the opening activity, "The Jewels Within," was introduced with the metaphorical explanation that we all have "jewels" inside, and our jewels are the good feelings we have about ourselves. For this activity, the group was presented with a tray of colored glass jewels used for craft projects. The patients were encouraged to think about 3 of their characteristics that made them proud, and to pick 3 jewels to represent these characteristics. The children were given a satin bag in which to keep their jewels, and added to it 3 more jewels every week during this repeated opening activity.

The topic of the first session was, "Who am I?" The group members introduced themselves and were asked to talk about how they felt about themselves in relation to their illness. The members were encouraged to draw a picture expressing their feelings further about who they were and to share with the group.

At the end of the session, the group gathered for a closing activity called "Transformation." To begin this activity, the group members were given a clear piece of cord and were asked to pick 2 beads to put on the cord. It was explained to them that the beads signified their involvement and importance in the art therapy group. This became the weekly closing activity, allowing the children to add 2 beads to their cord each week.

In the second session, "Feelings Related to Illness," the art therapist explained that most children experience many feelings about having a chronic illness. The group members were asked to think about and write down their feelings about their asthma. The art intervention was then presented to the group, and the children were given 2 papier-mâché masks to paint, 1 to represent how they felt when sick and 1 to show how they felt when they were healthy. The group members shared their feelings about their masks and were encouraged to think about how to transition emotionally from feeling sick to feeling better.

The third art therapy session was titled "Healthy Expressions of Anger." The group discussed how being sick made them feel mad or angry, discussed positive ways to express angry feelings, and learned to channel their feelings by using clay. The group was encouraged to think about any angry feelings they might have about their asthma and made clay volcanoes to express how they felt. The group then shared their art process with each other and talked further about positive ways to express anger.

Session 4 was "Transforming the Anger." In this session, the group discussed ways they could transform their feelings about their asthma, including angry feelings. The children were asked to use paint colors that made them feel good and happy to help transform their "angry volcanoes" into "calm mountains." The group then placed their colorful mountains on a painting of a calm blue sea and talked about ways they could help replace angry feelings by engaging in calming activities and by imagining the colors they used to transform their volcanoes.

In the fifth session, "Pain Management, Painting and Imagery," the patients were asked to think about what it felt like for them when they were in pain or were having an asthma attack and what helped them to feel better. After this discussion, the group members were given palettes of soothing hues of paints and were asked to pretend that they were younger and were just discovering how to use paint. They were encouraged not make any particular image, just to use the colors together, fill the paper with color, and paint in silence for 5 minutes. This exercise was repeated 6 times using different selections of colors. After the paints were cleaned up, the group members were asked to think about how they felt doing this exercise and what colors helped them feel the best. Further discussion focused on how certain colors can help soothe people and make them feel better. The children were asked to imagine their favorite soothing color covering them like a blanket and helping them feel good, and were reminded that this was an image that they could use in the future when feeling ill.

Session 6 was, "What Makes Me Feel Good?" The group talked about examples of how negative emotions and stress can sometimes affect the severity of an asthma attack, and discussed that it is helpful to focus on thoughts that made them feel good inside. The children learned how to counter negative thoughts with positive affirmations and practiced using them in the group setting. They then decorated paper stars, butterflies, and kites and wrote affirmative statements about the images.

In the final session, the group began with the opening activity that included choosing 3 jewels. They talked about the 3 pieces of art work from the last 7 weeks that made them most proud and added the jewels to their satin bags. The group was encouraged to continue this practice of acknowledging their accomplishments at home and were given an extra bag of crystals to add to their first bag when they did something that made them feel proud.

For the main activity in the last session, "Taking Care of Myself," the children discussed self-care and the importance of taking medications and seeing their doctors when they felt sick and for regular check-ups. They were asked to use markers to draw a picture of themselves taking their medications. The group also reviewed the different topics and art interventions from the previous sessions.

At the end of the final session, the group gathered for the closing activity. The group members put their last 2 beads on the cord that they had been given in the first art therapy session. In addition, the children were given a charm of their choice to add to the cord. Once the beads and the charm were complete, it was revealed that what they had made was actually a sun catcher. The children were asked to hold their sun catcher up to the window to see that the beads they had put on the cord now changed color and turned bright when exposed to the sun. The group was encouraged to think of how, like the beads, they were able to transform themselves, and think and feel differently about their asthma.

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Research paper

Effects of clay art therapy on adults outpatients with major depressive disorder: A randomized controlled trial

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ABSTRACT

Background: Depression has become a critical global health problem, affecting millions of people. Cost-effective nonpharmacological treatment in community settings has been proposed to complement medical treatment. Short-term clay art therapy (CAT) is an alternative treatment that promotes the enhancement of various aspects of mental health for depressed individuals.

Methods: One-hundred and six adults with depression were randomized into a CAT group or visual art (VA) control group for six 2.5-h weekly sessions. Intervention effects were measured using the Beck Depression Inventory, 12-Item General Health Questionnaire (Chinese version), Body–Mind–Spirit Well-Being Inventory, and 20-Item Toronto Alexithymia Scale (Chinese version) at baseline, immediately postintervention (T1), and 3-weeks postintervention (T2).

Result: Multivariate analysis of covariance results indicated a more significant time × group effect for CAT than for VA on depressive signs, general health, and body–mind–spirit well-being (all $p < 0.05$). Significant within-groups changes were observed in these three aspects after treatment and at T2 (all $p < 0.001$) and in alexithymia at T2 ($p < 0.01$) in the CAT group, but the change was nonsignificant in the VA group at T1 and T2.

Limitations: The homogeneity of the participants affected the generalizability of the study findings. The short-term postintervention follow-up (3 weeks) presented difficulties in demonstrating the long-term effects of CAT.

Conclusions: CAT can aid emotion regulation and benefit various aspects of mental health in adults. The short duration of the intervention suggests additional application value in treating depression. Further investigation is warranted regarding the potential effect of CAT on alleviating physical symptoms and improving social function.

1. Introduction

Depression has become an unprecedentedly serious global health problem. According to the World Health Organization (2008, 2012), depression is projected to become the leading cause of disability-adjusted illness in the world by 2030, affecting at least 350 million people. Cost-effective, short-term adjunct treatment in community settings has been proposed to complement conventional medical treatment (Hong Kong Hospital Authority, 2011; McCrone et al., 2008). Art therapy is an adjunct treatment approach that can complement pharmacological treatment.

Nonadherence and social stigma are crucial shortcomings in using antidepressant to treat depression (van Geffen et al., 2007). The focus on reducing depressive signs is also challenged by a lack of focus on enhancing holistic well-being and function (Knekt et al., 2013), presenting the risks of incomplete treatment and remission (Sato and Yeh, 2013), which result in a high degree of disability (Ebmeier et al., 2006).

A substantial body of literature has demonstrated the efficacy of various psychotherapeutic approaches, including art therapy, in treating major depressive disorder (MDD). Previous studies have reported that adults with depression have a higher adherence rate to psychotherapy when they display more incentive to share their thoughts with psychotherapists than when passively receiving pharmacological treatment alone (Lee et al., 2007), and that psychotherapy enables more effective control of relapse (Thase, 2009). Other studies have shown that psychotherapy can increase serotonin 5HT-1A receptor densities (Karlsson, 2012), whereas treatment with fluoxetine cannot (Karlsson et al., 2013). The efficacy of art therapy has been shown to alleviate depressive signs and symptoms (Bar-Sela et al., 2007; Gussak, 2009),

Abbreviations: CAT, Clay art therapy; VA, nondirective Visual Art; BDI-II-C, Beck Depression Inventory-II, Chinese version; GHQ-12, 12-Item General Health Questionnaire, Chinese version; BMSWBI, Body–Mind–Spirit Well-Being Inventory; TAS-20-C, 20-Item Toronto Alexithymia Scale, Chinese version

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Fig. 1. Involvement of somatosensory processes and haptic perception of clay art therapy (CAT).

reduce stress (Curl, 2008), and strengthen emotional expression, spirituality, and psychological well-being (Puig et al., 2006). As a form of art therapy, clay work has been shown to reduce emotional distress (Kimport and Robbins, 2012), strengthen ego resilience (Jang and Choi, 2012), and help in integrating multisensory processes through three-dimensional creative work (Elbrecht and Antcliff, 2014; Sholt and Gavron, 2006). de Morais et al. (2014) applied a 8-session clay work therapy on 6 patients with depression and 6 patients with anxiety in two groups. The treatment effects were evaluated and compared with two corresponding control groups which did not undergo the therapy. Results of Mann-Whitney test with BDI suggested that there was significant difference in depression outcome between the experimental and control group (depression: $p=0.004$) and marginal significant improvement was observed in anxiety ($p=0.066$). Qualitative research results endorsed the effectiveness of clay work in promoting positive affect, alleviation of depression and anxiety signs and symptoms. Nevertheless, art therapy research has been criticized for lacking a rigorous study design and evidence, such as randomized controlled trials (RCTs), which has hindered its endorsement in mainstream psychotherapy (Ebmeier et al., 2006; Kimport and Robbins, 2012).

There is a rich literature investigating the relationship between depression and emotion regulation. Emotion regulation (ER) generally refers to both the autonomic processes and adopted tactics that impact on the incidence, scale, length and manifestation of an emotional reaction (Gross, 2014), despite that the definition of emotion regulation is debatable (Siener and Kerns, 2012). Emotion regulation is closely related to the human fundamental emotional systems that comprise three interrelated aspects of processes. The first aspect is the affective states. Major Depressive Disorder (MDD) is typically marked with a sustained negative affective state. Recent research trend is also investigating the impaired state of positive affect and the strategies to increase the experience of it (Joormann and Stanton, 2016; Werner-Seidler et al., 2013). The second aspect is the physiological arousal systems of the brain and the neural mechanisms that correlate with affective (Cooney et al., 2007) and bodily states, as well as cognitive processes (Schore, 2009). Affect can be dysregulated in a hypoaroused state, as an individual has been exposed to a prolonged period of despair (Schore, 2002). An extended state of depressed mood has negative effects on the limbic system and influences regulatory functions of the Autonomic Nervous System (ANS). It could eventually cumulate in depression, exhibiting in both a prolonged negative affective state and in various physical symptoms (Schore, 2009; Werner-Seidler et al., 2013).

The third aspect of emotional systems is cognition–emotion processes, as emotion and cognition can influence each other (Joormann and Stanton, 2016). Cognitive difficulties occurred in depression typically exhibits in diminished memory, indecisiveness, and loss of cognitive flexibility (Trivedi and Greer, 2014). The inability to use positive memories to repair negative affect or strategies to stir up positive affect in depression have become the foci of current research direction (Joormann and Stanton, 2016; Werner-Seidler et al., 2013). Another deficit in the cognitive process in depression is alexithymia – a broad term referring to a deficit in the cognitive processing of affects, such as difficulty in verbal articulation of feelings (Karlsson et al., 2008). Alexithymia is regarded as a construct to measure cognitive-emotion regulation patterns (Ziadni et al., 2016). A growing literature has investigated the relationship of alexithymia with depressive symptoms (Kronholm et al., 2007; Ziadni et al., 2016). To conclude, different studies on MDD have used these three interrelated aspects to assess emotion regulation, in addition to assessing subjective or behavioral response, such as strategies to enhance emotion regulation skills (Mattias Berking et al., 2013). Emotions and the ability to regulate them are also considered interpersonal when framed in social contexts. For instance, the quality of the interaction between children and their caregivers can affect emotion regulation (Halligan et al., 2013).

Clay art therapy (CAT) involves various processes. The somatosensory processes of CAT involving the hands are rich in haptic perception (Elbrecht and Antcliff, 2014), ranging from a gentle touch on clay to the intense input of physical energy (e.g., pounding, rolling, and molding clay slumps) (Fig. 1). The visual processes guiding aesthetic judgment and the creation of personally meaningful clay products require an intense application of perceptual skills, cognitive functions (memory, decision making, and concentration) (Bastos et al., 2013), and affective expression (Hinz, 2009) (Figs. 2–3). These processes involved in art making require complex coordination of different cortical regions (Liu and Miller, 2008; Lusebrink, 2004). The experience, reshaping, and expression of emotion in clay work function similarly to the process of emotional learning in verbal psychotherapy (Bastos et al., 2013; Karlsson, 2012). Art making also involves autonomic nervous activities, hormonal responses, and complex interactions between the amygdala and prefrontal cortex to administer working memory, enable positive and negative emotional expressions, and make decisions (Carr, 2008; Fuster, 2003). The various internal processes involved in making clay art can interact to aid emotion regulation in its various respects and enable psychophysiological attunement (Hinz, 2009), which enhances the regulatory functions of the ANS (Schore, 2009). In an MRI study, Vessel et al. (2012) showed that the process of nonverbal means of creative art appreciation involves two distinct neuronal networks that

Fig. 2. Creation of personally meaningful clay products.

Fig. 3. Involvement of perceptual skills, cognitive functions, and affective expression in the processes of CAT.

connect to the frontal cortex and subcortical regions for executing tasks that require emotional regulation and self-reflection. In general, as a nonverbal modality, art making can aid the right brain in processing nonverbal communication and bodily-based affective information associated with various motivations (Schore, 2002, 2009). Therefore, creative art appreciation or art making can potentially assist in regulating emotion (Nan and Ho, 2014).

To date, few studies have investigated the use of clay in art therapy by patients with mental health problems. The present study investigated the benefits of CAT as a treatment for individuals with depression in community settings. The study objectives are as follows: (1) to aid participants in reducing symptoms of MDD; (2) to improve the general health of the participants; (3) to improve the participants' holistic body–mind–spirit (BMS) well-being; and (4) to improve participants' ability to verbally express their feelings.

2. Methods

2.1. Design

The study adopted an RCT design. A CAT group was compared with a nondirective visual art (VA) control group to determine the reduction in depressed mood and the associated signs and symptoms of MDD. All the participants were outpatients receiving pharmacological medication by visiting psychiatric clinics in the community, where individual follow-up by social workers were implemented. Assessments were taken at baseline (T0), immediately postintervention (T1), and 3-weeks postintervention (T2). Randomization to the CAT and VA groups was implemented using computer-generated random numbers.

The sample size was calculated on the basis of a medium effect size of 0.25, at 80% power and a significance level of 0.05 in a repeated measures multivariate analysis of covariance (MANCOVA) for the proposed experimental and control groups (Ho et al., 2012, 2016a; Nan, 2015). Three time point were integrated into the design. Given the clinical and demographic factors affecting the intervention outcome and allowing for a 25% attrition rate, 120 adult with depression (60 per arm) were required for the study.

Ethical approval was obtained from the Human Research Ethics Committee of a local university before the commencement of the study, and informed consent was obtained from all the participants.

2.2. Participants

The participants were recruited from three Integrated Community Centres for Mental Wellness (ICCMWs) located in different districts in Hong Kong. Inclusion and exclusion criteria are listed in Table 1. All the participants were referred by social workers at these ICCMWs. The participants were informed of the study objectives, duration, content, group processes, and other ethical considerations prior to signing the consent forms for joining this study. The written consent included the agreement to allow the researchers to use the demographic data of the participants, the scores obtained from the outcome measures, and the digital copies of the artworks created by the participants during the treatment process, for research purposes. Upon confirmation of participant inclusion scores, which were determined using the Beck Depression Inventory-II, Chinese version (BDI-II-C; Nan and Ho, 2013), the participants were randomized to either the CAT or VA treatment groups. The baseline scores of the three other outcome measures would be collected after randomization. The treatment commenced the following week.

Table 1
Recruitment criteria for the participants.

Inclusion criteria:
1. Adults who had received an MDD diagnosis from registered psychiatrists under Hong Kong Hospital Authority, where suitable psychiatric interviews and appropriate scales were administered.
2. Adults aged 18–60 years, male or female.
3. Adults who were outpatients receiving pharmacological medication by visiting psychiatric clinics in the community, where individual follow-up by social workers were implemented. The patients were pharmacologically stabilized.
4. The Chinese version of the Beck Depression Inventory-II (BDI-II-C) was applied for screening. Regarding the posttreatment test results from the pilot study, the mean and minimum scores were 19/12 (Time 1); 18/3 (Time 2); the cutoff point for inclusion was set at a score of 19, the upper limit for mild forms of depression (scores 14–19; (Beck et al., 1988; Nan and Ho, 2013).
5. Participants were receiving services from an ICCMW for adults with depression.
6. Approximately 6–8 group members in each group were recruited through a convenience sampling approach.
Exclusion criteria:
Individuals with psychosis and/or suicidal tendencies were excluded.

2.3. Interventions

According to the framework of the expressive therapies continuum (Hinz, 2009), CAT consists of four major treatment processes:kinesthetic/sensory, perceptual/affective, cognitive/symbolic, and creative processes. The primary goal in applying these treatment components is to monitor the dysregulated affective process by enhancing and balancing activities of the physical process (i.e., kinesthetic/sensory) with the functions of the other psychological processes (i.e., perceptual/affective, cognitive/symbolic, and creative; (Hinz, 2009).

The CAT group attended six 2.5-h weekly sessions. At the end of each session, a brief discussion and reflection session on the treatment process and a sharing of clay products were held. A qualified art therapist facilitated the clay art-making process, and an activity worker in the serving ICCMW as assigned as the group cofacilitator and was mainly responsible for administrative work.

The VA control group also attended six 2.5-h weekly sessions, and was facilitated by social workers. This group content was similar to that of ordinary recreational classes provided by the ICCMW. Activities including making handcraft work, coloring mandalas, listening to relaxation music, verbal sharing, or a combination of these activities were held. All VA group members joined the CAT group for art therapy treatment for depression after the completion of the study.

2.4. Measures

The measures and the subscales of measures assessed change in

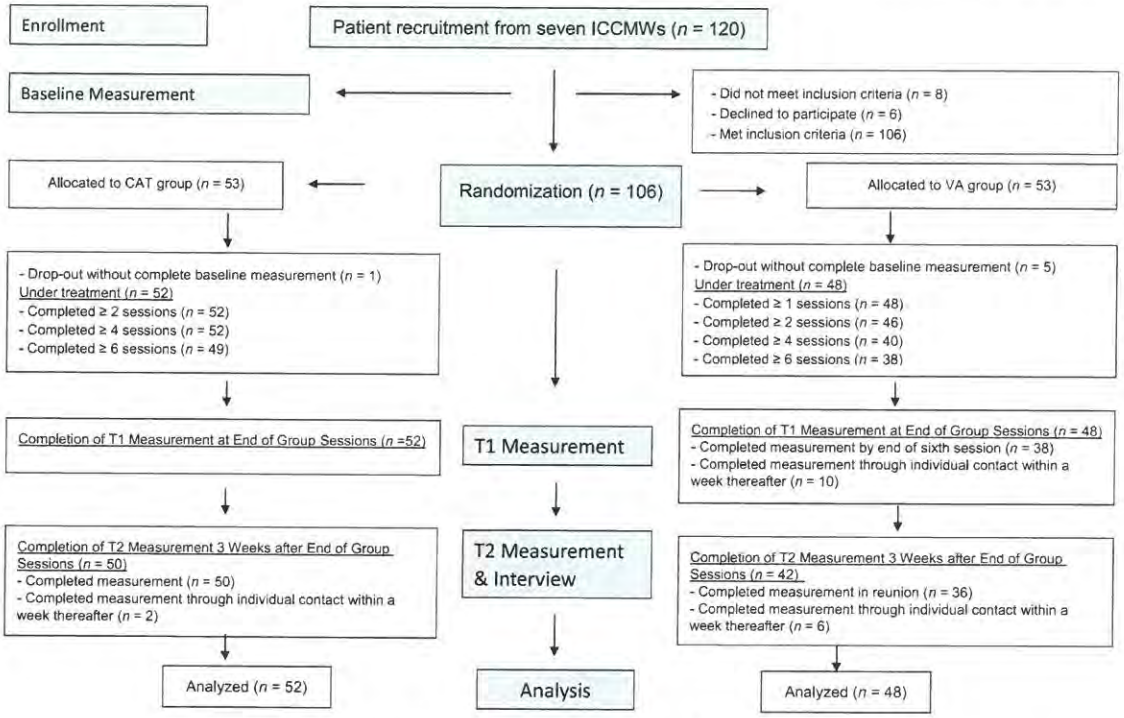

Fig. 4. Multistage process of recruiting and randomizing group participants.

depression symptoms, physical symptoms, positive and negative affective states, cognitive process of affect, and holistic wellbeing. All measures corresponded with the various facets of emotion regulation (Joormann and Stanton, 2016).

The BDI-II-C was adopted as the primary outcome measure to assess multiple aspects of depression symptoms which included cognitive, emotional, behavioral, and physical aspects (Chen et al., 2011; Diedrich et al., 2016). BDI measure has important relationship and implication on emotion regulation (Berking et al., 2013; Besharat et al., 2013; Diedrich et al., 2016; Riskind et al., 2013; Siener and Kerns, 2012). In a study conducted by Bastos et al. (2013) on patients with depression, BDI was found to have negative correlation with the Negative Mood Regulation (NMR) Scale, a measure assessing generalized expectancies for negative mood regulation including general, cognitive, and behavioral strategies to cope with negative moods (Backenstrass et al., 2010). In this study, the BDI-II-C was adapted from the original BDI-II and is an established and validated scale for measuring levels of depression in Chinese-speaking populations (Beck et al., 1988; Byrne et al., 2004). Internal consistency and reliability were assessed using Cronbach's alpha values; the measure attained a value of 0.722 in the present study. The BDI-II-C has 21 questions; each answer is scored on a 4-point scale ranging from 0 to 3, with higher total scores representing more severe depressive symptoms.

The 12-Item General Health Questionnaire (Chinese version; GHQ-12) is an established and validated scale, measuring current mental health in two areas: the inability to carry out normal functions, and the appearance of new and distressing experiences (Chong and Wilkinson, 1989; Pan and Goldberg, 1990). In the present study, the Cronbach's alpha of this measure was 0.613.

The Body–Mind–Spirit Well-Being Inventory (BMSWBI) is an established, validated, and reliable scale for measuring holistic body-mind-spirit health in Chinese-speaking populations (Hamid and Cheng, 1996; Ho et al., 2004; Ng et al., 2005). The measure comprises three subscales that assesses physical health in the aspects of physical distress and daily functioning; positive and negative affective states, and spirituality. Spirituality is measured in the aspects of tranquility, resistance to disorientation, and resilience. The BMSWBI has a total of 56 items and uses an 11-point scale (0–10 points). The Cronbach's alpha of the measure in this study was 0.785.

The 20-Item Toronto Alexithymia Scale (Chinese version; TAS-20-C) measures cognitive-emotion regulation patterns (Ziadni et al., 2016) that comprises three factors: (1) DIF, or problems recognizing emotions and differentiating them from their associated bodily sensations (7 items); (2) DDF, or problems conveying emotions to other people (5 items); and (3) EOT, or an externally directed cognitive mode of thinking (8 items). The measure has shown acceptable internal and retest reliability when applied to Chinese-speaking populations (Zhu et al., 2007). The Cronbach's alpha value for this measure was 0.785 in this study.

2.5. Data analysis

All analyses were conducted using SPSS Version 23 (SPSS Inc., Chicago, IL). Continuous data are presented as the mean and standard deviation (SD). Categorical data are presented as frequencies (percentages). Between-groups differences at baseline were assessed using a chi squared test for categorical data and an independent *t*-test for continuous data.

Treatment effects were measured by both between-groups and within-groups changes. A MANCOVA model was used to assess the effects of the two intervention methods on the four outcome variables: depressive signs, BMS well-being, general health, and level of alexithymia. Between-groups effects were analyzed according to the interaction between group x time for each of the four outcome variables and further by the combined effect of the interrelated outcome variables. For the significant between-groups differences in the TAS-20-C baseline scores, the measure was adjusted at baseline. The effect size of the between-groups changes was calculated using partial eta square. The within-groups changes were assessed through a paired *t*-test for each group. The effect size was determined using Cohen's *d*.

Missing data was treated with Intention-to-Treat (ITT) method, where the missing data was replaced by the final observed values. It is an accepted research method to treat nonresponse/missing data and has been adopted in previous studies (Ho et al., 2012, 2016a; Unnebrink

Table 2
Demographic and clinical characteristics of the participants (n =100).

Demographic	Intervention (n =52)		Control (n =48)		P*
	Mean (SD)	N (%)	Mean (SD)	N (%)	
Age (years)	46.1 (10.5)		44.1 (10)		**0.323**
Gender					**0.443**
Female		47 (90.4%)		42 (87.5%)	
Employment					**0.061**
Full-time		7 (13.5%)		2 (4.2%)	
Housewife		18 (34.6%)		7 (14.6%)	
Unemployed		19 (36.5%)		28 (58.3%)	
Other		8 (15.4%)		11 (23%)	
Education					**0.064**
Uneducated/Primary		16 (30.8%)		7 (14.6%)	
Secondary school		24 (46.2%)		32 (66.7%)	
Tertiary or above		12 (23.1%)		9 (18.8%)	
Marital status					**0.068**
Single		13 (25%)		24 (50%)	
Married		22 (42.3%)		12 (25%)	
D Divorced/separated		13 (25%)		10 (20.8%)	
/w Widowed		4 (7.7%)		2 (4.2%)	
Years diagnosed with depression					**0.383**
0–3 years		23 (44.2%)		18 (37.5%)	
3.1 years–7 years		12 (23.1%)		7 (14.6%)	
7.1 years–10 years		6 (11.5%)		6 (12.5%)	
More than 10 years		11 (21.2%)		17 (35.4%)	
BDI-II-C	32.27 (9.18), 1.27 (SE)		28.77 (11.54), 1.67 (SE)		**0.95**
GHQ−12	22.47 (7.50), 1.04 (SE)		20.44 (6.40), 0.92 (SE)		**0.15**
BMSWBI_WHOLE	237.76 (69.17), 9.60 (SE)		263.14 (63.69), 9.19 (SE)		**0.06**
* **TAS−20-C**	65.34 (9.21), 1.27 (SE)		59.98 (10.59), 1.53 (SE)		***.008**

Abbreviations: SD, standard deviation; SE, standard error; BMS_WHOLE, the Body–Mind–Spirit–Well-Being Inventory total scores.
Note: Chi-squared test for categorical variable and T-test for continuous variables;

and Windeler, 2001).

3. Results

3.1. Participant characteristics

A total of 120 adults with depression were recruited for the study. After screening, 106 (88.3%) participants met the inclusion criteria and agreed to participate in the study; 53 of the participants were randomized to the CAT and VA groups, with six participants dropped out after randomization, without completing baseline measurement in the other three outcome measures. The workflow of recruiting the participants is depicted in Fig. 4.

Baseline sociodemographic and clinical variables are detailed in Table 2. The mean age of the participants was 46.1 years (SD =10.5) in the CAT group and 44.1 years (SD =10.0) in the VA group. Eighty-nine percent of the participants were female (90.4% in the CAT group; 87.5% in the VA group). In the CAT and VA groups, respectively, 44.2% and 37.5% of the participants had received diagnoses of MDD within the previous 3 years, whereas 21.2% and 35.4% had received a depression diagnosis more than 10 years earlier. While these results reflected the phenomenon that the time since diagnosis did not appear to affect the motivation of the participants to join the study, more analysis and discussion for the related issues will be accounted in Section 4.

The BDI-II-C baseline scores in both groups revealed moderate depression in the participants. The average TAS-20-C scores in the CAT and VA groups were 65.34 (SD =9.21) and 59.98 (SD =10.59), respectively; between both groups, 60 scores indicated high alexithymia (Zhu et al., 2007). Except for the TAS-20-C, no significant baseline differences were found in the three other measures, and no significant between-groups differences were identified in the sociodemographic variables. TAS-20-C was, thus, adjusted at baseline for between-group difference when conducting repeated measures of MANCOVA analysis.

Processing data involved the analysis of the effect of dropout on the remaining samples and manipulation of missing data (Halligan et al., 2013). For the attrition rate at T2 compared between the CAT and VA groups with a t-test was significant (1/53 vs. 6/48; $p = < 0.01$) (Fig. 4), it was necessary to weight whether the effect in the loss of the 6 samples of the VA group at T2 would create any significant change for the remaining 42 samples at that time-point. ANOVA tests on all measures from T0 to T1 were subsequently conducted to analyze if there were significant differences in the change between the retained participants and the dropout participants of the VA group at that two time-points. The results returned negative (BDI: $p < 0.181$; TAS: $p < 0.243$; BMS: $p < 0.542$; GHQ: $p < 0.321$), therefore indicating retained participants were representative of those who dropped out (Halligan et al., 2013). Missing data were then modelled using ITT (Intention-to-Treat) by mean imputation (Ho et al., 2016a, 2016b).

3.2. Effectiveness

Table 3 summarizes the outcomes of the measures for the two treatment groups, as well as the between-groups and within-groups differences. The effects of CAT versus VA on the primary and secondary outcome variables were compared using MANCOVA models. Regarding the primary outcome, CAT resulted in a greater decrease in depressive signs than did nondirective VA ($p < 0.01$, $\eta^2 = 0.051$). For the secondary outcomes, a significant between-group difference was identified in general health ($p < 0.01$, $\eta^2 = 0.055$) and BMS well-being ($p < 0.05$, $\eta^2 = 0.043$). A significant between-groups difference was identified in the combined effect on the interrelated outcome variables of depressive signs, general health, BMS well-being major scales and subscales, and alexithymia ($p < 0.001$, $\eta^2 = 0.464$). The mean variance of the four measures of the treatment groups over the three time points is shown in Fig. 5.

Concerning the within-groups differences (Table 3), the depressive signs in the CAT group exhibited a rapid drop from baseline to T1 ($d = -1.1$) and T2 ($d = -1.2$). General health evidenced significant improvement after treatment at both T1 ($d = -0.9$) and T2 ($d = -1.1$). Therefore, changes in both the depressive signs and general health in the CAT group revealed a large effect. BMS well-being also showed significant improvement after treatment at both T1 ($d = 0.6$) and T2 ($d = 0.7$). Alexithymia did not improve significantly in the CAT group at T1, but did at T2. Most of the scores in the BMSWBI subscales immediately exhibited significant improvement at T1 (Table 3) in the CAT group. Although the BMSWBI subscales of physical distress and spirituality (resilience) did not significantly improve at T1, changes became significant at T2.

In the VA group, the changes in depressive signs, general health, and BMS well-being, and alexithymia were nonsignificant at T1 and T2. Most of the scores in the BMSWBI subscales showed no significant change at T1 and T2; however, positive and negative affect significantly improved at T1, although only positive affect further revealed a significant change at T2. The change in the BMSWBI spirituality subscale (resistance to disorientation) was nonsignificant at T1, but significant at T2 (Table 3).

4. Discussion

This is the first RCT to investigate the effectiveness of CAT as a complementary treatment for individuals with depression in a community setting. The results suggest that CAT was more effective than nondirective VA in reducing depression levels and improving daily functioning, general mental health, and holistic BMS well-being. Given the growing attention on recognizing affect regulation for affective

Table 3
Measures outcome comparison of the CAT and VA groups at baseline, immediately postintervention, and 3 weeks postintervention.

	Within-Group Effects					Between-Group Effects		
	T0	T1[a]	Effect size	T2[a]	Effect size	Time x Group[b]		Effect size
	Mean (SD)	Mean (SD)	Cohen's *d*	Mean (SD)	Cohen's *d*	*F*	*P*	partial η^2
BDI-II-C						5.26	0.008**	0.051
CAT	32.3 (9.2)	20.4 (11.4)***	−1.1	19.3 (11.8)***	−1.2			
VA	28.8 (11.5)	26.2 (8.8)	−0.3	25.7 (8.3)	−0.3			
GHQ−12						5.61	0.005**	0.055
CAT	22.5 (7.5)	15.6 (8.5)***	−0.9	14.0 (7.5)***	−1.1			
VA	20.4 (6.4)	18.5 (6.4)	−0.3	18.6 (6.0)	−0.3			
BMS_WHOLE						4.38	0.014*	0.043
CAT	237.8 (69.2)	284.5 (79.7)***	0.6	292.0 (88.0)***	0.7			
VA	263.1 (63.7)	279.4 (66.4)	0.3	277.9 (65.6)	0.2			
TAS−20-C						1.71	0.185	0.017
CAT	65.3 (9.2)	63.3 (8.6)	−0.2	61.4 (10.1)***	−0.4			
VA	60.0 (10.6)	58.8 (8.7)	−0.1	59.2 (11.5)	−0.07			
BMS_A						1.87	0.157	0.019
CAT	60.4 (25.4)	56.8 (27.6)	−0.1	52.9 (27.4)*	−0.3			
VA	57.7 (23.2)	59.0 (22.5)	0.06	59.7 (24.5)	0.08			
BMS_B						2.67	0.073	0.027
CAT	39.4 (13.5)	47.7 (17.7)***	0.5	49.4 (16.2)***	0.7			
VA	44.8 (14.4)	48.0 (16.4)	0.21	48.0 (15.7)	0.21			
BMS_PoA						1.01	0.366	0.010
CAT	28.1 (15.1)	38.2 (15.2)***	0.7	37.2 (16.2)***	0.6			
VA	31.9 (15.6)	37.2 (14.0)*	0.4	36.7 (15.7)*	0.3			
BMS_NeA						3.01	0.050*	0.030
CAT	72.0 (21.9)	58.7 (21.9)***	−0.6	57.4 (24.2)***	−0.6			
VA	68.6 (19.9)	61.3 (16.6)*	−0.4	63.9 (18.2)	−0.2			
BMS_D_Tr						3.98	0.023*	0.039
CAT	17.6 (9.7)	22.6 (9.4)***	0.5	22.3 (10.1)***	0.5			
VA	23.0 (11.3)	23.0 (9.1)	0.00	23.7 (8.7)	0.1			
BMS_D_Dis						0.19	0.827	0.002
CAT	30.0 (10.5)	25.4 (9.7)***	−0.5	24.6 (11.4)***	−0.5			
VA	27.3 (9.2)	25.0 (8.9)	−0.3	23.2 (8.8)*	−0.5			
BMS_D_Res						3.98	0.028*	0.039
CAT	15.1 (7.2)	17.0 (6.1)	0.3	18.0 (5.2)**	0.5			
VA	17.1 (6.1)	16.6 (6.0)	0.00	16.4 (5.2)	−0.1			
Combined effect on all interrelated outcome variables						2.99	0.000***	0.464

Abbreviations:
BMS_WHOLE, BMSWBI total scores; BMS_A, physical distress; BMS_B, daily functioning; BMS_PoA, BMS positive affect scale; BMS_NeA, BMS negative affect scale; BMS_D_Tr, BMS spirituality scale of tranquility; BMS_D_Dis, BMS spirituality scale of resistance to disorientation; BMS_D_Res, BMS spirit scale of resilience; SD, standard deviation.
Effect size of Cohen's *d* in *t*-test: 0.2= small effect; 0.5= moderate effect; 0.8= large effect.
Effect size of partial η^2 in MANOVA: 0.01= small effect; 0.06= medium effect; 0.138= large effect.
[a] Compared with baseline using paired *t*-test.
[b] Repeated measures of MANCOVA, adjusting for between-group difference of TAS-20-C at baseline.
* $p < 0.05$,
** $p < 0.01$,
*** $p < 0.001$.

disorders and the interrelatedness of emotion, physiological processes, and cognition (Nan and Ho, 2014; Schore, 2009), the present study established a crucial reference for delivering treatment to adults with depression through a psychotherapeutic approach. The results also accord with the findings from another RCT, in which the strengthening of emotion regulation skills improved the efficacy of cognitive behavioral therapy for treating the emotional symptoms of MDD (Berking et al., 2012). Because MDD is characterized by cognitive impairment (Trivedi and Greer, 2014), it may be challenging for adults with depression to articulate emotions (Panksepp, 2009; Panksepp and Watt, 2011) or differentiate emotion from sensational processes (Karlsson et al., 2008). Nonverbal psychotherapeutic approaches, including various creative arts therapies, have become more effective in helping depressed individuals in expressing feelings and alleviating depressive signs. An example of such therapy is circle dance group therapy (Koch et al., 2007); another example is art therapy, which was exemplified by Gussak (2009) in a study involving prison inmates, although the participants in that study had minimal–mild depression. In another study by Bidabadi and Mehryar (2015), a 12-session course of music therapy was effective in alleviating depression from moderate–severe to mild–moderate, although the sample in that study was small.

Although selective serotonin reuptake inhibitors (SSRIs) are the most common form of treatment for MDD, they might be ineffective for treating both the psychological and physiological symptoms of MDD simultaneously. Greco et al. (2004) found that emotional symptoms were most likely the first to improve following SSRI treatment, followed by positive well-being and physical symptoms. However, pain symptoms were particularly prevalent, indicating the poorest response. The findings of the present study accord with a study by Greco et al. (Greco et al., 2004), in which rapid improvement of emotional symptoms appeared first, and a mild improvement in physical distress occurred last. Residual physical symptoms, such as pain symptoms, can adversely

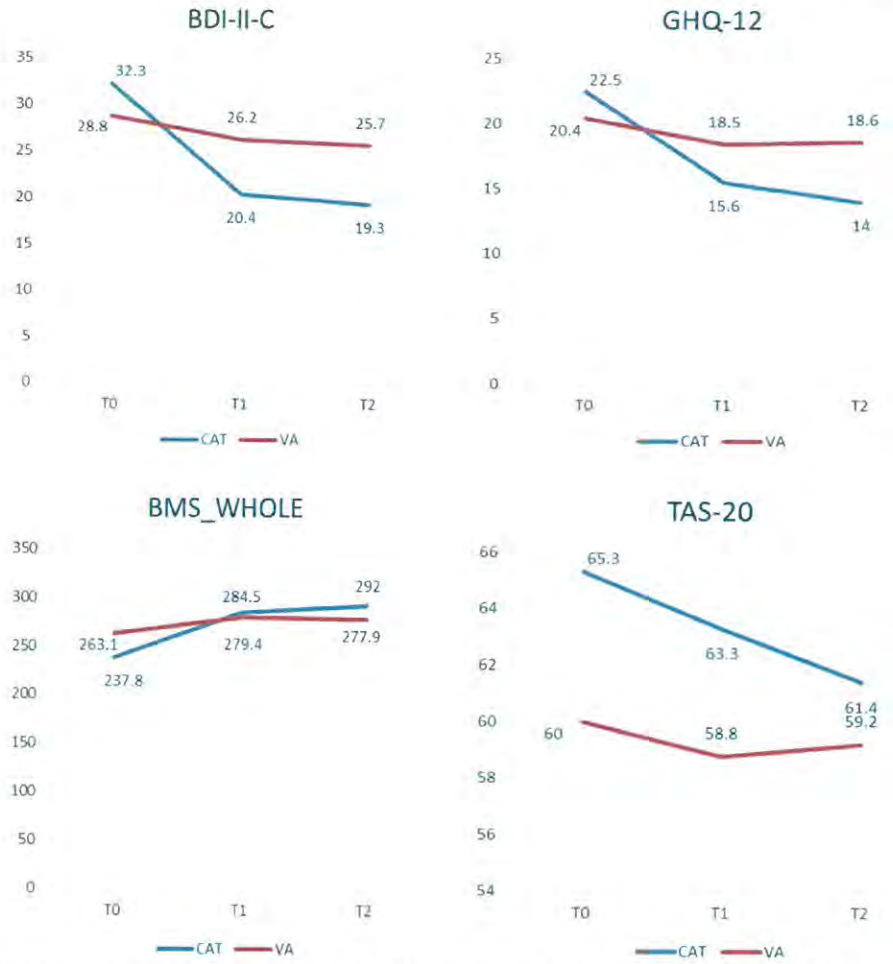

Fig. 5. Mean variance of the four measures showed significant differences for time × group effect in the two treatment groups in the aspects of depressive signs ($p < 0.01$), general health ($p < 0.01$), and body–mind–spirit well-being ($p < 0.05$).

affect depression outcomes and remission (Sato and Yeh, 2013). Therefore, rather than examining and treating a general exhibition as physical distress in a short-term treatment, further investigation is warranted to explore the potential effects of CAT on various forms of physical symptoms of depression over a longer period of treatment (Paykel et al., 1995; Tylee et al., 1999).

Effective intervention plays a crucial role at the early phase of mental health rehabilitation; it aids in preventing a higher degree of disability caused by delayed or ineffective treatment (Sato and Yeh, 2013). In the present study, the baseline sociodemographic characteristics of the participants showed a notable phenomenon regarding the correlations of the time of diagnosis of depression with the individuals' motivation to change and their choice of treatment. First, 44.2% and 37.5% of the participants in the CAT and VA groups, respectively, had received a diagnosis of MDD within the previous 3 years. This accords with the well-known phenomenon that newly diagnosed mental health patients possess higher motivation to participate in treatment. Further analysis on the relationship between the during of diagnosis and treatment outcomes revealed that participants who had the longest (more than 10 years) and the shortest history of diagnosis (less than 3 years) showed a larger effect size than other participants (3–10 years). This suggests that both duration of illness and motivation to participant in the clay art therapy group might impact effect of intervention that influenced emotion regulation. The CAT participants generally exhibited high attendance rate, with 49 of 52 group members (94%) completing all six treatment sessions. The high attendance rate confirmed the findings of previous studies, in which psychiatric patients have shown strong incentive to receive psychotherapy and could thus more effectively control relapse (Lee et al., 2007; Thase, 2009). Generally, the participants expressed that CAT appeared to be more appealing and positive compared with verbal psychotherapy or conventional medical treatments. However, this area of the study, concerning impact of duration of illness on emotion regulation, the attitude, motivation, and perception of adults with depression toward creative arts therapy treatment approaches, is worthy of further analysis and investigation.

Emotional and cognitive processes are complex and inseparable (Siegel, 2009). A cognitive dysfunction often reported among psychiatric MDD patients is alexithymia. Individuals with alexithymia exhibit difficulty in expressing inner processes with conscious verbal forms of communication, as well as in separating emotional expression from sensational processes (Karlsson et al., 2008; Kronholm et al., 2007; Thase, 2011). Previous studies have reported that combining the antidepressant fluoxetine with psychotherapy can improve cognitive symptoms in adults with depression (Bastos et al., 2013; Trivedi and Greer, 2014). However, few studies have investigated verbal psychotherapy and creative arts therapy for treating alexithymia.

In the present study, the baseline scores on alexithymia (measured using the TAS-20-C) approximated those obtained from another study by Karlsson et al. (2008). Despite alexithymia in the CAT group not showing a significant improvement immediately after the CAT intervention, the scores decreased significantly 3 weeks postintervention, with a gradual decrease in the mean variance across the three time points (Fig. 5) and the growing effect size indicating a trend of

improvement (Table 3). By contrast, the VA control group did not exhibit such a change. The results reveal a positive effect of CAT on alexithymia, confirming the potential of creative arts therapy in ameliorating cognitive dysfunction in adults with depression.

CAT adopts a treatment approach that is based on the theoretical underpinnings and understandings of various neurological processes (Hinz, 2009; Lusebrink, 2004). The treatment processes of CAT involve the intense application of multisensory (i.e., somatosensory and visual) and psychological processes (i.e., perceptual, affective, cognitive, symbolic, and creative) that facilitate differentiating and communicating emotion, and relearning emotional regulation (Nan and Ho, 2014). Apart from their effect on intrapersonal functions, emotions affect social functions; effective emotional regulation strategies can influence well-being, financial, and socioeconomic status (Côté et al., 2010). The study demonstrates the positive effects of CAT treatment on emotional symptoms, general health, holistic BMS well-being (i.e., daily functioning, physical distress, and spiritual well-being), and ability to articulate emotions that can potentially promote superior social function.

Depressive disorders are illnesses that affect millions of people. Short-term, cost-effective, and community-based treatments are urgent needed. CAT emerged as an art therapy intervention model that results in rapid reduction of emotional symptoms of MDD within a short period of time. Because extended duration of treatment is regarded as a risk factor of MDD (Rush et al., 2009), short-term treatment could prevent exacerbation of the illness. CAT could thus be more widely applied as an alternative treatment for adults with depression, especially in the initial period of illness, when emotional signs are the most active.

Despite the positive outcomes, some limitations were encountered in this study. One of the major limitations was that the assessment of the intervention outcomes included only self-report measures. Because CAT involves intervention of both the mind and body, assessing its effect on the mechanisms of emotion regulation through psychological and physiological measures that are more objective is highly critical in future research. Another limitation of the present study concerned the dosage of treatment. As shown from the quantitative results, depressive signs were alleviated to the minimal form of depression in both postintervention and follow-up measurement. As evidenced in another study (Knekt et al., 2013), the efficacy of long-term psychotherapy on psychiatric symptom reduction was higher than those of short-term psychotherapy in a 3-year follow up. An investigation of the long-term effects of CAT is warranted that the investigation can include physical symptoms, social function and quality of life (Côté et al., 2010), in addition to depressive signs, BMS well-being, and alexithymia; furthermore, comparisons between short- and long-term effects created by CAT may be performed. Physical symptoms of MDD create serious life disabilities; because CAT can affect physical distress, it is worth deeply investigating the interaction between the physical symptoms of MDD and the various processes of CAT treatment. Moreover, most of the participants in the present study were middle-aged women (89% of all participants were female), which may have affected the generalizability of the study findings. Furthermore, the use of nondirective mixed art media in the control group under social worker supervision might have been less appealing to the participants, thereby reducing their incentive for group involvement. Future control groups may comprise clay work groups led by a ceramicist to determine the therapeutic and nontherapeutic elements of CAT.

In a community setting, a substantial portion of the participants may stop attending sessions to resume work or daily life responsibilities. In the present study, the high mobility of the adults with depression, directly or indirectly limited the size of the sample, and also affected the short-term follow-up (3 weeks) design, limiting the demonstration of the long-term effects of the CAT treatment. According to some researchers, a practical and objective follow-up approach is to double the treatment time; therefore, a 12-week treatment time is recommended (Montag et al., 2014). For future research on short-term CAT, follow-up measurements may be more efficiently obtained through online questionnaires, mail, or telephone, rather than having participants attend follow-up meetings.

References

Backenstrass, M., Joest, K., Gehrig, N., Pfeiffer, N., Mearns, J., Catanzaro, S.J., 2010. The German version of the generalized expectancies for negative mood regulation scale: a construct validity study. Eur. J. Psychol. Assess. 26 (1), 28–38. http://dx.doi.org/10.1027/1015-5759/a000005.

Bar-Sela, G., Atid, L., Danos, S., Gabay, N., Epelbaum, R., 2007. Art therapy improved depression and influenced fatigue levels in cancer patients on chemotherapy. Psycho-Oncology 16 (11), 980–984. http://dx.doi.org/10.1002/pon.1175.

Bastos, A.G., Guimaraes, L.S.P., trentini, C.M., 2013. Neurocognitive changes in depressed patients in psychodynamic psychotherapy, therapy with fluoxetine and combination therapy. J. Affect. Disord. 151, 1066–1075.

Beck, A.T., Steer, R.A., Garbin, M.G., 1988. Psychometric properties of the Beck Depression Inventory: twenty-five years of evaluation. Clin. Psychol. Rev. 8, 77–100.

Berking, M., Ebert, D., Cuijpers, P., Hofman, S.G., 2012. Emotion regulation skills training enhances the efficacy of inpatient cognitive behavioral therapy for major depressive disorder: a randomized control trial. Psychother. Psychosom. 82, 234–245.

Berking, M., Ebert, D., Cuijpers, P., Hofmann, S.G., 2013. Emotion regulation skills training enhances the efficacy of inpatient cognitive behavioral therapy for major depressive disorder: a randomized controlled trial. Psychother. Psychosom. 82 (4), 234–245. http://dx.doi.org/10.1159/000348448.

Besharat, M.A., Nía, M.E., Farahani, H., 2013. Anger and major depressive disorder: the mediating role of emotion regulation and anger rumination. Asian J. Psychiatry 6 (1), 35–41. http://dx.doi.org/10.1016/j.ajp.2012.07.013.

Bidabadi, S.S., Mehryar, A., 2015. Music therapy as an adjunct to standard treatment for obsessive compulsive disorder and co-morbid anxiety and depression: a randomized clinical trial. J. Affect. Disord. 184, 13–17.

Byrne, B., Stewart, S., Lee, P., 2004. Validating the Beck Depression Inventory-II for Hong Kong Community Adolescents. Int. J. Test. 4 (3), 199–216.

Carr, R., 2008. Sensory processes and responses. In: Hass-Cohen, N., Carr, R. (Eds.), Art Therapy and Clinical Neuroscience. Jessica Kingsley Publishers, London & Philadelphia.

Chen, Y.-T., Huprich, S.K., Hsiao, W.-C., 2011. Affect regulation and depressive personality disorder. J. Personal. Disord. 25 (6), 755–764 (http://dx.doi.org/101521pedi2011256755).

Chong, M.Y., Wilkinson, G., 1989. Validation of 30- and 12-item versions of the Chinese Health Questionnaire (CHQ) in patients admitted for general health screening. Psychol. Med. 19 (2), 495–505.

Cooney, R.E., Joormann, J., Atlas, L.Y., Eugène, F., Gotlib, I.H., 2007. Remembering the good times: neural correlates of affect regulation. NeuroReport: Rapid Commun. Neurosci. Res. 18 (17), 1771–1774. http://dx.doi.org/10.1097/WNR.0b013e3282f16db4.

Côté, S., Gyurak, A., Levenson, R.W., 2010. The ability to regulate emotion is associated with greater well-being, income, and socioeconomic status. Emotion 10 (6), 923–933. http://dx.doi.org/10.1037/a0021156.

Curl, K., 2008. Assessing stress reduction as a function of artistic creation and cognitive focus. Art. Ther. 25 (4), 164–169. http://dx.doi.org/10.1080/07421656.2008.10129550.

Diedrich, A., Burger, J., Kirchner, M., Berking, M., 2016. Adaptive emotion regulation mediates the relationship between self-compassion and depression in individuals with unipolar depression. Psychol. Psychother.: Theory Res. Pract. http://dx.doi.org/10.1111/papt.12107.

Ebmeier, K.P., Donaghey, C., Steele, J.D., 2006. Recent developments and current controversies in depression. Lancet 367 (9505), 153–167. http://dx.doi.org/10.1016/S0140-6736(06)67964-6.

Elbrecht, C., Antcliff, L.R., 2014. Being touched through touch. Trauma treatment through haptic perception at the clay field: a sensorimotor art therapy. Int. J. Art. Ther. 19 (1), 19–30.

Fuster, J.M., 2003. Cortex and Mind: Unifying Cognition. Oxford University Press, New York.

Greco, T.M.D., Eckert, G.M.A.S., Kroenke, K.M.D., 2004. The outcome of physical symptoms with treatment of depression. J. General. Intern. Med. 19 (8), 813–818. http://dx.doi.org/10.1111/j.1525-1497.2004.30531.x.

Gross, J.J., 2014. Emotion Regulation: Conceptual and Empirical Foundations. In: Gross, J.J. (Ed.), 2nd ed., pp. 3-20, Chapter xviii, 669 Pages), Guilford Press, New York, NY.

Gussak, D., 2009. Comparing the effectiveness of art therapy on depression and locus of control of male and femaole inmates. Arts Psychother. 36, 202–207.

Halligan, S.L., Cooper, P.J., Fearon, P., Wheeler, S.L., Crosby, M., Murray, L., 2013. The longitudinal development of emotion regulation capacities in children at risk for externalizing disorders. Dev. Psychopathol. 25 (2), 391–406. http://dx.doi.org/10.1017/S0954579412001137.

Hamid, P.N., Cheng, S.T., 1996. The development and validation of an index of emotional disposition and mood state: the Chinese Affect Scale. Educ. Psychol. Meas. 56 (6), 995–1014.

Hinz, L.D., 2009. Expressive TherapiesContinuum: A Framework for Using Art in Therapy. Taylor & Francis Group, New York.

Ho, R.T.H., Chan, S.M., Wang, C.-W., Lau, W.M., So, K.F., Li, P.Y., Chan, L.W., 2012. A randomized controlled trial of qigong exercise on fatigue symptoms, functioning, and Telomerase activity in persons with chronic fatigue or chronic fatigue system. Ann. Behav. Med. 44 (2), 160–170.

Ho, R.T.H., Fong, T.C.T., Cheung, I.K.M., Yip, P.S.F., Luk, M.-y., 2016a. Effects of a short-

term dance movement therapy program on symptoms and stress in patients with breast cancer undergoing radiotherapy: a randomized, controlled, single-blind trial. J. Pain. Symptom Manag. 51 (5), 824–831.
Ho, R.T.H., Fong, T.C.T., Lo, P.H.Y., Ho, S.M.Y., Lee, P.W.H., Leung, P.P.Y., Chan, C.L.W., 2016b. Randomized controlled trial of supportive-expressive group therapy and body-mind-spirit intervention for Chinese non-metastatic breast cancer patients. Support Care Cancer 24 (12), 4929–4937. http://dx.doi.org/10.1007/s00520-016-3350-8.
Ho, S.M.Y., Chan, C.L., Ho, R.T.H., 2004. Posttraumatic growth in Chinese cancer survivors. Psycho-Oncology 13, 377–389.
Hong Kong Hospital Authority, 2011. Mental health service plan for adults 2010–2015. Retrieved from HK.
Jang, H., Choi, S., 2012. Increasing ego-resilience using clay with low SES (Social Economic Status) adolescents in group art therapy. Arts Psychother. 39 (4), 245–250.
Joormann, J., Stanton, C.H., 2016. Examining emotion regulation in depression: a review and future directions. Behav. Res. Ther. 86, 35–49. http://dx.doi.org/10.1016/j.brat.2016.07.007.
Karlsson, H., 2012. Psychotherapy increases the amount of serotonin receptors in the brains of patients with major depressive disorder. In: Levy, R., Ablon, J., Kächele, H. (Eds.), Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence, New York, NY, pp. 233-238.
Karlsson, H., Naatanen, P., Stenman, H., 2008. Cortical activation in alexithymia as a response to emotional stimuli. Br. J. Psychiatry 192 (1), 32–38. http://dx.doi.org/10.1192/bjp.bp.106.034728.
Karlsson, H., Hirvonen, J., Salminen, J., Hietala, J., 2013. Increased serotonin receptor 1A binding in Major Depressive Disorder after psychotherapy, but not after SSRI pharmacotherapy, is related to improved social functioning capacity. Psychother. Psychosom. 82 (4), 260–261. http://dx.doi.org/10.1159/000346143.
Kimport, E.R., Robbins, S.J., 2012. Efficacy of creative clay work for reducing negative mood: a Randomized controlled trial. Art. Ther.: J. Am. Art. Ther. Assoc. 29 (2), 74–79.
Knekt, P., Lindfors, O., Sares-Jäske, L., Virtala, E., Härkänen, T., 2013. Randomized trial on the effectiveness of long- and short-term psychotherapy on psychiatric symptoms and working ability during a 5-year follow-up. Nord. J. Psychiatry 67 (1), 59–68. http://dx.doi.org/10.3109/08039488.2012.680910.
Koch, S.C., Morlinghaus, K., Fuchs, T., 2007. The joy dance: specific effects of a single dance intervention on psychiatric patients with depression. Arts Psychother. 34, 340–349.
Kronholm, E., Partonen, T., Salminen, J.K., Mattila, A.K., Joukamaa, M., 2007. Alexithymia, depression and sleep disturbance symptoms. Psychother. Psychosom. 77 (1), 63–65.
Lee, S., Tsang, A., Kwok, K., 2007. Twelve-month prevalence, correlates, and treatment preference of adults with DSM-IV major depressive episode in Hong Kong. J. Affect. Disord. 98 (1–2), 129–136.
Liu, A., Miller, B., 2008. Visual Art and Brain, Handbook of Clinical Neurology. SFO, USA: Memory and AgingCenter, University of California.
Lusebrink, V.B., 2004. Art therapy and the brain: an attempt to understand the underlying processes of art expression in therapy. Art. Ther.: J. Am. Art. Ther. Assoc. 21 (3), 125–135.
McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., Lawton-Smith, S., 2008. Paying the price: The cost of mental health care in England to 2026. Retrieved from UK:.
Montag, C., Haase, L., Seidel, D., Bayerl, M., Gallinat, J., Herrmann, U., Dannecker, K., 2014. A pilot RCT of psychodynamic group art therapy for patients in acute psychotic episodes: feasibility, impact on symptoms and mentalising capacity. PLoS One 9 (11), e112348. http://dx.doi.org/10.1371/journal.pone.0112348.
de Morais, A.H., Dalecio, M.A.N., Vizmann, S., Bueno, V.L.R. d.C., Roecker, S., Salvagioni, D.A.J., Eler, G.J., 2014. Effect on scores of dep and anx in psychiatric patients after clay work in a day hospital. The Arts in Psychotherapy 41 (2), 205–210.
Nan, J.K.M., 2015. Therapeutic effects of clay art therapy for patients with depression. (Ph.D. e-thesis) The University of Hong Kong, Hong Kong.
Nan, J.K.M., Ho, R.T.H., 2013. Therapeutic Effects of Clay Art Therapy (CAT) Group on Adults with Depression in Community Setting - A Pilot Study. Center on Behavioral Health, University of Hong Kong.
Nan, J.K.M., Ho, R.T.H., 2014. Affect regulation and treatment for depression and anxiety through art: Theoretical ground and clinical issues. Ann. Depress. Anxiety 1 (2), 1–6.
Ng, S.M., Yau, J.K.Y., Chan, C.L.W., Chan, C.H.Y., Ho, D.Y.F., 2005. The measurement of body-mind-spirit well-being: toward multidimensionality and transcultural applicability. Soc. Work Health Care 41 (1), 33–52.
Pan, P.C., Goldberg, D.P., 1990. A comparison of the validity of Ghq-12 and Chq-12 in Chinese primary care patients in Manchester. Psychol. Med. 20 (4), 931.
Panksepp, J., 2009. Brain emotion systems and qualities of mental life - From animal models of affect to implications for psychotherapeutics. In: Fosha, D., Siegal, D.J., Solomon, M.F. (Eds.), The Healing Power of Emotion: Affective Neuroscience, Development, and Clinical Practice. W. W. Norton & Company, New York/London.
Panksepp, J., Watt, D., 2011. Why does depression hurt? Ancestral primary-process separation-distress (PANIC/GRIEF) and diminished brain reward (SEEKING) processes in the genesis of depressive affect. Psychiatry 74 (1), 5–13. http://dx.doi.org/10.1521/psyc.2011.74.1.5.
Paykel, E.S., Ramana, R., Cooper, Z., Hayhurst, H., Kerr, J., Barocka, A., 1995. Residual symptoms after partial remission: an important outcome in depression. Psychol. Med. 25 (6), 1171–1180.
Puig, A., Lee, S.M., Goodwin, L., Sherrard, P., 2006. The efficacy of creative arts therapies to enhance emotional expression, spirituality, and psychological well-being of newly diagnosed Stage I and Stage II breast cancer patients: a preliminary study. Arts Psychother. 33 (3), 218–228.
Riskind, J.H., Kleiman, E.M., Schafer, K.E., 2013. "Undoing" effects of positive affect: does it buffer the effects of negative affect in predicting changes in depression? J. Soc. Clin. Psychol. 32 (4), 363–380 (http://dx.doi.org/101521jscp2013324363).
Rush, A.J., Warden, D., Wisniewski, S.R., Fava, M., Trivedi, M.H., Gaynes, B.N., Nierenberg, A.A., 2009. STAR*D: revising conventional wisdom. CNS Drugs 23 (8), 627–647.
Sato, S., Yeh, T.L., 2013. Challenges in treating patients with major depressive disorder: the impact of biological and social factors. CNS Drugs 27 (1), S5–S10.
Schore, A.N., 2002. Dysregulation of the right brain: a fundamental mechanism of traumatic attachment and the psychopathogenesis of posttraumatic stress disorder. Aust. N.Z. J. Psychiatry 36, 9–30.
Schore, A.N., 2009. Right-brain affect regulation - An essential mechanism ofdevelopment, trauma, dissociation, and psychotherapy. In: Fosha, D., Siegal, D.J., Solomon, M.F. (Eds.), The Healing Power of Emotion: Affective Neuroscience, Development & Clinical Practice. W. W. Norton & Company, New York/London.
Sholt, M., Gavron, T., 2006. Therapeutic qualities of clay-work in art therapy and psychotherapy: a Review. Art. Ther. 23 (2), 66–72.
Siegel, D.J., 2009. Emotion as integration: a possible answer to the question, what is emotion? In: Fosha, D., Siegal, D.J., Solomon, M. (Eds.), The Healing Power of Emotion: Affective Neuroscience, Development, and Clinical Practice. W. W. Norton & Company, New York & London.
Siener, S., Kerns, K.A., 2012. Emotion regulation and depressive symptoms in preadolescence. Child Psychiatry Human. Dev. 43 (3), 414–430. http://dx.doi.org/10.1007/s10578-011-0274-x.
Thase, M., 2009. Psychotherapies for depression in adults: a review of recent development. In: Herrman, H., Maj, M., Sartorius, N. (Eds.), Depressive Disorders, *3rd ed.* WPA Series in Evidence & Experience in Psychiatry, UK.
Thase, M., 2011. Antidepressant combinations: widely used, but far from empirically validated. Can. J. Psychiatry 56 (6), 317–323.
Trivedi, M.H., Greer, T.L., 2014. Cognitive dysfunction in unipolar depression: implications. J. Affect. Disord. 152–154, 19–27.
Tylee, A., Gastpar, M., Lépine, J.P., Mendlewicz, J., 1999. Identification of depressed patient types in the community and their treatment needs: findings from the DEPRES II (Depression Research in European Society II) survey. DEPRES Steering Committee. Int. Clin. Psychopharmacol. 14 (3), 153–165.
Unnebrink, K., Windeler, J., 2001. Intention-to-treat: methods for dealing with missing values in clinical trials of progressively deteriorating diseases. Stat. Med. 24, 3931–3946.
van Geffen, E.C.G., van der Wal, S.W., van Hulten, R., de Groot, M.C.H., Egberts, A.C.G., Heerdink, E.R., 2007. Evaluation of patients' experiences with antidepressants reported by means of a medicine reporting system. Eur. J. Clin. Pharmacother. 63, 1193–1199.
Vessel, E.A., Starr, G.G., Rubin, N., 2012. The brain on art: intense aesthetic experience activates the default mode network. Front. Human. Neurosci. 6 (66). http://dx.doi.org/10.3389/fnhum.2012.00066.
Werner-Seidler, A., Banks, R., Dunn, B.D., Moulds, M.L., 2013. An investigation of the relationship between positive affect regulation and depression. Behav. Res. Ther. 51 (1), 46–56. http://dx.doi.org/10.1016/j.brat.2012.11.001.
World Health Organization, 2008. The global burden of disease: 2004 update, Geneva.
World Health Organization, 2012. Depression: A global crisis. World Mental Health Day, October 10, 2012. USA: WHO.
Zhu, X., Yi, J., Yao, S., Ryder, A.G., Taylor, G.J., Bagby, R.M., 2007. Cross-cultural validation of a Chinese translation of the 20-item Toronto Alexithymia Scale. Compr. Psychiatry 48 (5), 489–496.
Ziadni, M.S., Jasinski, M.J., Labouvie-Vief, G., Lumley, M.A., 2016. Alexithymia, defenses, and ego strength: cross-sectional and longitudinal relationships with psychological well-being and depression. J. Happiness Stud. http://dx.doi.org/10.1007/s10902-016-9800-7.

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Research Article

Functional near-infrared spectroscopy assessment of reward perception based on visual self-expression: Coloring, doodling, and free drawing

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ABSTRACT

Visual self-expression helps with attention and improves health and well-being. Few studies have examined reward pathway activation during different visual art tasks. This pilot study is the first to examine brain activation via functional near-infrared spectroscopy (fNIRS) during three distinct drawing tasks—coloring, doodling, and free drawing. Participants (11 men, 15 women; 8 artists, 16 non-artists) engaged in each task separated by equal intervals of rest in a block design experimental protocol. Additional data included a pre- and post survey of self-perceptions of creativity, prior experience with drawing tasks, and reflections on study participation. Overall, the three visual arts tasks resulted in significant activation of the medial prefrontal cortex compared to the rest conditions. The doodling condition resulted in maximum activation of the medial prefrontal cortex compared to coloring and free drawing; however, differences between the drawing conditions were not statistically significant. Emergent differences were seen between artists and non-artists for coloring and doodling. All three visual self-expression tasks activated the medial prefrontal cortex, indicating potential clinical applications of reward perception through art making. Participants improved in their self-perceptions of problem solving and having good ideas. Participants found the drawing tasks relaxing but wanted more time per task. Further study with varied art media and longer time on tasks are needed to determine potential interactions between participants' backgrounds and reward activation.

Introduction and background

Researchers have been exploring the ways that the experience of viewing and making art affect different parts of the brain. These studies have been made possible by making use of modern technology that identifies brain activity in different locations. Our study used functional near-infrared spectroscopy (fNIRS) to identify brain activity during varied self-expressions of visual art.

Visual art and the brain

Visual forms of self-expression, such as coloring books, are becoming increasingly popular among adults. Little is known, however, about the differences in brain activation and the perceived rewards of engaging visual expression. This study sought to examine differences in brain activation during different drawing activities measured with fNIRS. Although there are currently no fNIRS studies that examine activation during visual expression, there are a number of investigations that have demonstrated the activation of the prefrontal cortex during visual arts activities using other technologies. For example, Chamberlain et al. (2014) used magnetic resonance imaging (MRI) scanning to study the brain regions associated with drawing skills and artistic training. Their findings suggested that being able to draw from observation was associated with an increase in gray matter density in the left anterior cerebellum and the right medial frontal gyrus in the prefrontal cortex. Schlegel et al. (2015) showed that 3 months of art training resulted in changes in prefrontal white matter. Bolwerk, Mack-Andrick, Lang, Dörfler, and Maihöfner (2014) found that there was a clear difference between producing art compared to viewing art. Visual art production has been shown to improve the functional connectivity in several brain areas, particularly between the parietal and frontal cortices, as well as psychological resistance to change (Bolwerk et al., 2014). In their recent study, Miall, Nam, and

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Tchalenko (2014) explored the neural systems engaged in decision making related to drawing observed pictures. Ventral and lateral occipital areas were increasingly activated when participants were drawing faces rather than drawing abstract objects (Miall et al., 2014).

Although these findings suggest that visual art production results in stronger brain connectivity than cognitive art evaluation or viewing art, there is evidence that even passive engagement in art affects the prefrontal cortex (Bolwerk et al., 2014). For example, when viewing art, a reward circuitry is engaged that activates the ventral striatum, including the nucleus accumbens, along with the interconnected medial prefrontal cortex (mPFC) and the orbitofrontal cortex and amygdala (Lacey et al., 2011). Using functional MRI (fMRI) technology, Lacey et al. (2011) found that art imagery alone activated the reward circuitry whereas matched nonart images did not. Likewise, activation of the mPFC, along with the rest of the reward circuitry, occurred while the individual was viewing beautiful visual images or architectural spaces (Chatterjee & Vartanian, 2014). Comparing the brain activity of participants who were emotionally primed with portrait art with those who were not, Baeken et al. (2012) used fMRI and found that the former displayed higher activity in the left midline superior frontal cortex, whereas the latter showed higher right medial frontal cortical activity.

There are no studies on fNIRS and art-making but some exploratory studies have examined patterns in electroencephalogram (EEG) recordings and drawing. Belkofer, Van Hecke, and Konopka (2014) investigated the differences in patterns of brain activity among artists and non-artists during the process of drawing. Results indicated that there was more activity in the left hemisphere of the brain for artists, and more activity reflected in the frontal lobe for non-artists. This result may have been based on the fact that drawing was a new task for them and that stimulation in this area of the brain is a sign of learning. There was an increased presence of alpha waves for both the artists and the non-artists, indicating potentially relaxed creative opportunities generated by drawing tasks. Similarly, in a quantitative electroencephalographic comparison of clay and drawing, activation was noted related to regions of memory processes, meditative states, and spatiotemporal processing (Kruk, Aravich, Deaver, & deBeus, 2014). Art therapy researchers have also focused on the relationship between art and mood states. For instance, art-making has been found to reduce cortisol levels (Kaimal, Ray, & Muniz, 2016) as well as improve mood and self-efficacy (Kaimal & Ray, 2017). In addition, a number of studies have shown the benefits of coloring inside a shape, specifically a predrawn mandala, over free-form coloring (Curry & Kasser, 2005; Drake, Searight, & Olson-Pupek, 2014; Van der Vennet & Serice, 2012). Babouchkina and Robbins (2015) also observed that coloring inside a mandala was more effective in mood enhancement than coloring in a square. Comparing coloring to drawing, Smolarski, Leone, and Robbins (2015) reported that college students who were prompted to draw a positive expression ('something that made them happy', p. 199) had considerably more mood enhancement than when asked to draw their current feeling of stress (i.e., vent or trace a coloring book drawing). Andrade (2010) examined the outcomes of doodling on attention, demonstrating that it was beneficial in recalling information and monitoring tasks. Schott (2011) deduced from Andrade's study that, in some contexts, doodling may trigger an arousal and then stabilize it at an optimal level by reducing boredom and daydreaming.

Functional near-infrared spectroscopy

A noninvasive, safe, and portable imaging method, fNIRS detects blood flow activity in the human prefrontal cortex. This technique was pioneered in 1977 when it was demonstrated that photon transmission in the near-infrared spectrum (650–950 nm) could be used to screen hemoglobin concentrations and oxygenation in the brain (Jöbsis, 1977). Since then, and especially within the last 10 years, fNIRS has emerged as a viable neuroimaging tool, used to monitor neural activity in response to cognitive tasks, motor tasks, stimuli, and language processing (Ayaz et al., 2013; Ferrari & Quaresima, 2012). The typical fNIRS unit is composed of light sources and photodetectors mounted on a flexible sensor band that can be worn as a headpiece. The light sources are made up of either light-emitting diodes (LEDs) or fiberoptic bundles (Irani, Platek, Bunce, Ruocco, & Chute, 2007). Other parts of the equipment include a control box for hardware organization and a computer for data acquisition (Ayaz et al., 2012). Baseline measurements are taken, followed by continuous, real-time measurements at predetermined time intervals. Although there are a variety of possible placements, the near-infrared light is most commonly placed over the scalp to measure tissue oxygenation changes in the outer cortex regions (e.g., the motor or the prefrontal cortex; Izzetoglu et al., 2011). fNIRS uses near-infrared light with spectroscopy principles. Hemoglobin, the oxygen carrier in red blood cells, presents a differential absorption in the near-infrared wavelengths based on whether it is bonded to the oxygen. The optical window of the near-infrared spectrum, on the other hand, allows for light to penetrate several centimeters through the tissue due to the low absorption of main chromophores such as water and allows detection of the changes in concentration of oxygenated and deoxygenated hemoglobin molecules (Ayaz et al., 2013, 2011; Ferrari & Quaresima, 2012; Izzetoglu et al., 2011). In other words, hemoglobin absorbs light at different specific wavelength portions of the NIR spectrum, depending on how much oxygen it is transporting. Cerebral hemodynamic changes are associated with functional brain activity through a process termed neurovascular coupling (Ayaz et al., 2006).

Although fMRI has become the 'gold standard for in vivo imaging of the human brain' (Cui, Bray, Bryant, Glover, & Reiss, 2010), fNIRS has the advantage of being usable and adaptable to measuring brain responses to activities while the activities are occurring, either in the natural environment or under everyday field conditions. Thus, fNIRS is not limited to hospital, clinical, or laboratory settings. Additionally, fNIRS is minimally intrusive and more affordable than the former. Studies have shown that fNIRS signals are often highly correlated with fMRI measurements because both measure the hemodynamic response. Researchers have concluded that fNIRS can be an appropriate compliment to, if not a substitute for, fMRI, especially regarding brain activity related to cognitive tasks (Cui et al., 2010; Ferrari & Quaresima, 2012; Irani et al., 2007). In addition, fNIRS measurements have been shown to be complementary with the event-related EEG potentials (Ehlis et al., 2009; Herrmann et al., 2008). Research using fNIRS spans a wide range of disciplines, topics, and populations. It has been applied in neurology, psychiatry, education, and basic research (Ayaz et al., 2014; Izzetoglu et al., 2011; Ruocco et al., 2016; Teo et al., 2016). fNIRS has been used to examine people with varied conditions (e.g., Alzheimer disease, mood disorders, schizophrenia) and varied behaviors (e.g., language, memory, perception, sleep, pain; Ferrari & Quaresima, 2012).

Reward perceptions pathway in the prefrontal cortex

Though it is clear that the prefrontal cortex is related to higher order cognitive functioning (e.g., regulating our thoughts, actions, and emotions), it is less clear which area of the prefrontal cortex is responsible for different functions and whether there is even a systematic organization across the prefrontal cortex (O'Reilly, 2010; Ramnani & Owen, 2004). The brain is a complex network with functionally linked regions that share information continuously with

each other (Van Den Heuvel & Pol, 2010). Generally, lateral prefrontal cortex areas seem to be involved in sensory, motor, and cognitive processing, whereas mPFC areas play a role in emotional, affective, and motivational systems (O'Reilly, 2010) and are part of the reward circuit (Chatterjee & Vartanian, 2014; Lacey et al., 2011; Russo & Nestler, 2013). The mPFC has been found to be widely connected to the amygdala, the nucleus accumbens, the hypothalamus, and temporal visual association areas and is involved in higher-order sensory processing and regulating emotional responses and somatic states (Arnsten, 2009; Damasio, Everitt, & Bishop, 1996; Wood & Grafman, 2003). The mPFC region has been associated with social cognition, long-term memory processing, and emotional processing (Euston, Gruber, & McNaughton, 2012; Grossmann, 2013). In addition, the mPFC, along with the perigenual anterior cingulate cortex and the dorsal anterior cingulate cortex, has also been implicated in an inferential track that is thought to select and learn actions that maximize reward (Donoso, Collins, & Koechlin, 2014). fNIRS has been used successfully for assessment of reward networks in prefrontal areas, particularly in substance abuse research (Bunce et al., 2012, 2013; Huhn et al., 2016).

The aim of our study was to assess reward perception by measuring the mPFC response during execution of three forms of visual self-expression. The main hypothesis guiding the study was that the free-drawing form of self-expression would evoke the most reward activation compared to the other two forms—coloring and doodling. We also hypothesized that the reward activation would be greater for artists compared to non-artists, given their familiarity with the art media. With the sequence of tasks from structured (coloring) to less structured (doodling in a circle) to unstructured (free drawing), it was also hypothesized that the participants would have improved self-perceptions of creativity at the end of the sessions compared with the beginning of the sessions.

Methods

The study used a pre–post quasi experimental design. The participants served as their own controls through the visual self-expression conditions (3 different art-making tasks) and control conditions (4 resting periods with eyes closed). The study was conducted with the approval of the university's institutional review board.

Sample

Participants were recruited through e-mail announcements and flyers posted around the campus. The recruitment announcements indicated that any healthy adult between the ages of 18 and 70 could participate in the study; an e-mail and phone number were included. Those who responded were told (1) the study involved brain imaging and drawing; and (2) no prior artistic experience was required. When potential participants contacted the study coordinator, they were asked whether they identified as artists (visual artists), their gender, and dominant hand use (right or left). Only right-handed participants were included to account for variations due to hand use. The session was then scheduled with the participant. When the participants came to the scheduled session, they completed informed-consent procedures that included understanding the purpose of the study and the steps involved in the use of the fNIRS technology.

Sequencing the study framework included a presession survey, three visual self-expression conditions, four rest conditions, and a postsession survey. The combined sequencing of these steps would take approximately 20 min; during that time the participant would wear the fNIRS band. See Fig. 1a for location of optodes on the PFC and Fig. 1b for the setup of the experimental conditions.

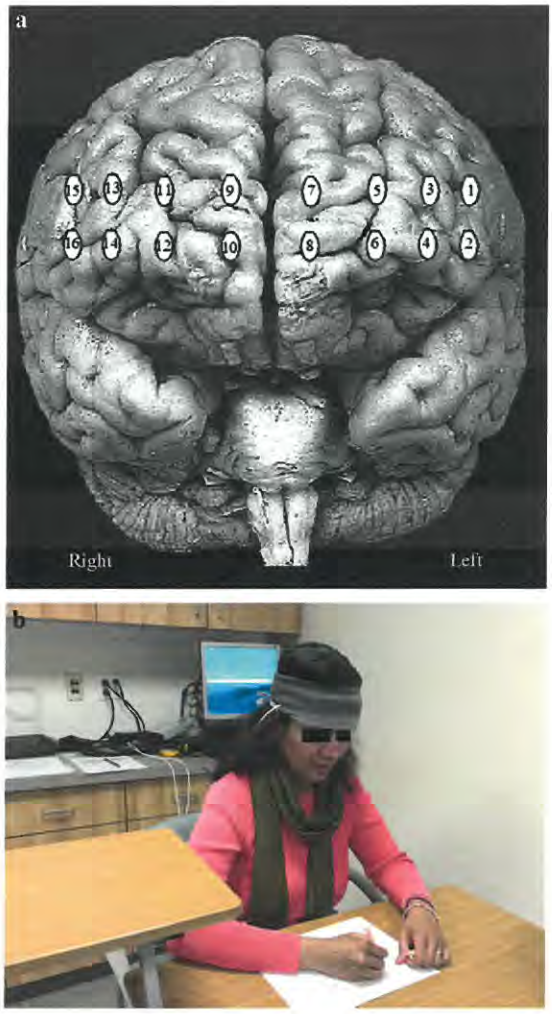

Fig. 1. (a) Location of functional near infrared-spectroscopy optodes on the prefrontal cortex (Ayaz et al., 2012). (b) Setup of the study with the functional near-infrared spectroscopy band.

Participants were told that they would engage in three different visual self-expression conditions: coloring, doodling, and free drawing. They would have 3 min for each of the three drawing conditions preceded and followed by 2 min of rest with their eyes closed. Prior to the start of the session, participants filled out a few questions on self-perceptions of creativity adapted from existing surveys (Beghetto, 2006; Tierney & Farmer, 2002). In addition, the participants were asked about their prior experience on a scale of 'limited,' 'somewhat,' or 'extensive.' At the end of the sessions, participants were again asked to complete the same survey questions on self-perceptions of creativity and to respond to an open-ended question about their experiences with these drawing conditions.

They were also given the opportunity to try out the art materials: three pieces of paper and a set of 12 fine-tipped color markers. Coloring was defined as coloring in the predrawn shape. Doodling was defined as a personalized doodle style that the participant might have used in the past. Free drawing was defined as any drawing the participant chose to create. Participants were offered a predrawn mandala and two pieces of paper with circles on the paper to be used for both the doodling and free-drawing conditions. See Figs. 2–4 for examples of the art materials.

After the participants completed the sequence of the study conditions, they were asked to complete the postsurvey on self-perceptions of creativity and to respond to a question about their

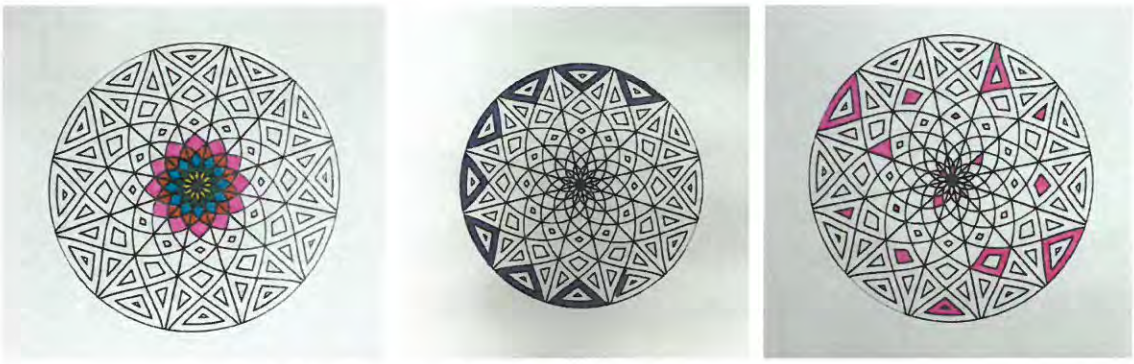

Fig. 2. Examples of coloring done on pre-drawn mandala designs.

Fig. 3. Examples of doodles using a circle.

experiences with the drawing conditions. They were then given the option of taking the drawings with them. With permission from the participants, photographs were taken to document the coloring, doodling, and free drawing art-making conditions. Participants were given $10 cash in compensation for participating in the study.

fNIRS data

We used a continuous wave fNIR device model 1000. This fNIR system (fNIR Devices LLC, Potomac, MD; www.fnirdevices.com) to obtain images of the cerebral hemodynamics of the PFC. After answering the presession survey, participants were connected to the fNIRS system and their baselines were taken while they visually fixated on a central cross presented on the computer screen. Activation of each participant's prefrontal cortex was monitored throughout the entire time the participants were engaged with the art-making and rest conditions. The sensor had a temporal resolution of 500 ms per scan with 2.5 cm source-detector separation allowing for approximately 1.25 cm penetration depth. The dual-wavelength LEDs were activated in turn, one light source and wavelength at a time, and the four surrounding photodetectors sampled around the active source. The positioning of the light source and detectors on the sensor pad yielded a total of 16 active optodes. COBI Studio software was used for data acquisition and visualization (Ayaz et al., 2011).

For each participant, raw fNIRS data (16 optodes × 2 wavelengths) were low-pass filtered with a finite impulse response, linear phase filter with order 20 and cut-off frequency of 0.1 Hz to attenuate the high-frequency noise, respiration, and cardiac cycle effects (Ayaz et al., 2011). Each participant's data were checked for any (1) potential saturation (when light intensity at the detector was higher than the analog-to-digital converter limit); and (2) motion artifact contamination by means of a coefficient of variation-based assessment (Ayaz et al., 2010). fNIRS data for each condition block were extracted using time synchronization markers indicating onset and completion of each condition. Hemo-

Fig. 4. Examples of free drawings.

dynamic changes for each of the 16 optodes during each condition block were calculated separately using the modified Beer-Lambert law. The hemodynamic response at each optode was averaged across time for each condition block to provide a mean hemodynamic response at each optode for each block. The final output of each optode was the average oxygenated hemoglobin level for each condition (Ayaz et al., 2012). The differences were first compared between creative visual self-expression and rest conditions and then compared across conditions and across artistic skill using a two-way repeated measures ANOVA, with gender and age included as covariates. The fNIRS data analysis focused on optode 7, which represented activation of the left dorsomedial PFC.

Self-perceptions of creativity

Five questions from Beghetto's (2006) and Tierney and Farmer's (2002) surveys on creative self-efficacy were adapted for use in this study and were used as both a presession and a postsession instrument. This five-item questionnaire asked participants to rate their perceptions of their abilities to (1) have new ideas; (2) have good ideas; (3) have a good imagination; (4) have novel ideas; and (5) solve problems. The survey data were compared using the paired samples *t* tests.

In addition to the questions on self-perceptions of creativity, participants were asked two additional questions. Before the session, they were asked to rate their prior experience with visual self-expression or art making. They were provided with a single question with three choices: limited, some, extensive. After the study session and the completion of the postsurvey, participants were asked to respond to an open-ended question related to their experiences with these art-making activities. The narrative responses about their experiences with the visual self-expression conditions were summarized using thematic analysis (Riessman, 2008), and the recurring themes were tabulated with representative examples.

Results

Study participants

The study sample comprised 26 participants: 11 artists (4 men, 7 women) and 15 non-artists (7 men, 8 women). Participants ranged in age from 20 to 60 years ($M = 32.46$, SD = 11.03). All participants were right-handed and reported being healthy (not unwell or undergoing any medical treatments) at the time of their participation in the study.

Table 1
Mean activation levels and mean change in activation across conditions for optode 7 ($N = 26$).

Condition	Mean	SE	95% CI	Mean change	*p*-value
Baseline	.047	.094	−.149 to .243	–	–
Coloring	.388	.114	.151 to .626	.341*	.023
Rest	.027	.092	−.166 to .219	−.362*	.033
Doodling	.548	.162	.209 to .887	.521*	.021
Rest	−.297	.165	−.640 to .047	−.845*	.005
Free-drawing	.473	.165	.128 to .817	.769*	.011
Rest	.044	.131	−.229 to .316	−.429	.103

CI: confidence interval; SE: standard error.
* $p < .05$.

Findings

fNIRS

We first compared whether there was higher activation of the reward pathway as demonstrated through optode 7 (associated with the left mPFC) during the visual self-expression conditions compared to the rest conditions. A repeated measures ANOVA showed differences in activation across the four rest and three visual self-expression conditions: $F(6,120) = 4.729$, $p < .001$. Results of post hoc comparisons across all intervals are presented in Table 1. As indicated in Table 1, activation levels rose with each of the creative self-expression conditions compared to the rest conditions and returned to baseline levels during the rests. A paired *t* test confirmed that activation on optode 7 was higher during the creative self-expression conditions ($M = 0.46$, SD = 0.68) compared to the rest conditions ($M = -0.03$, SD = 0.30, $t[23] = -2.74$, $p = .012$).

Results of the repeated measures ANOVA allowed us to compare activation on optode 7 across the creative self-expression conditions as well. As shown in Table 1 and Fig. 5, the doodling condition resulted in the most blood oxygenation (activation of PFC) compared with the coloring and free-drawing conditions for optode 7. However, post hoc comparisons indicated that differences in acti-

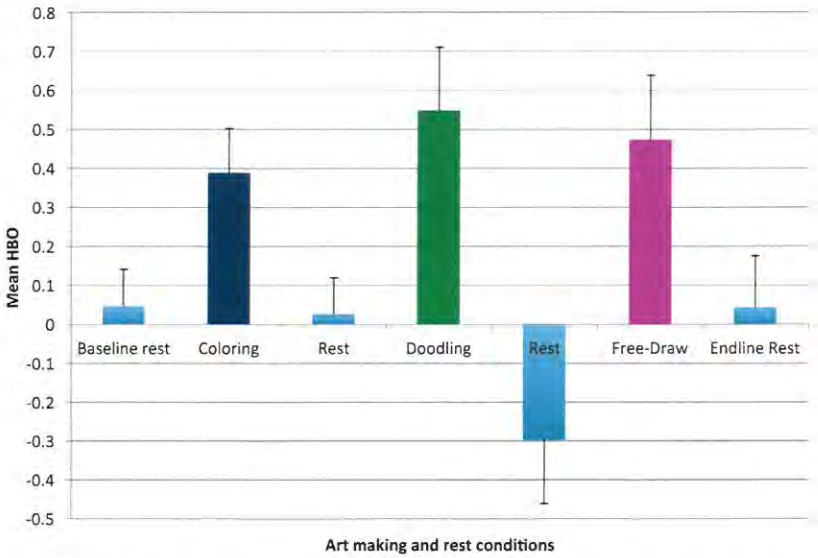

Fig. 5. Mean levels of oxygenation (activation of the medial prefrontal cortex) for each condition.

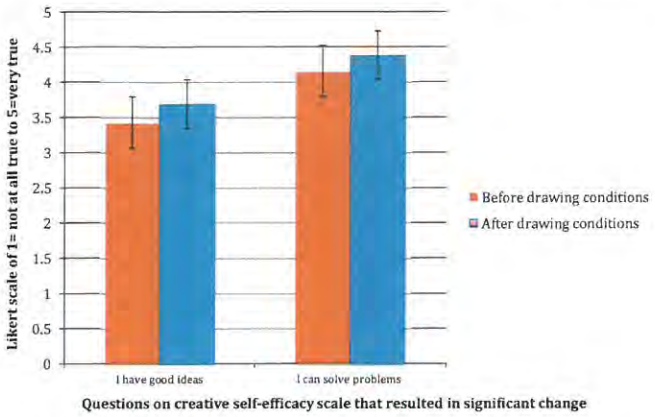

Fig. 6. Changes in self-perceptions of creativity among participants before and after the seven art-making and rest conditions ($p < 0.05$).

vation across the three art-making conditions were not statistically significant ($p = .38–.69$).

The results point toward a possible difference between artists and non-artists related to the reward perception of the coloring condition; however, this difference was not evident in the doodling or free-drawing conditions. In fact, doodling seemed to evoke more brain activation (HbO or oxygenated hemoglobin) in the artists, whereas both artists and non-artists had similar levels of brain activation in the free-drawing condition. The coloring condition resulted in negative brain activation for artists compared with the other two conditions, whereas changes in oxygenation increased brain activation in the coloring condition. For all participants, regardless of skill level, doodling, and free drawing resulted in increased brain activation compared with the coloring condition. The interaction between artist/non-artist and the condition was not significant ($F[6,114] = 1.51$, $p = .18$), perhaps because the study was underpowered to detect the effects of interaction.

Self-perceptions of creativity

This category was assessed using an adapted survey that included five questions asking participants to rate perceptions of their abilities to have new ideas, good ideas, a good imagination, and novel ideas and about their ability to solve problems. Overall, participants' responses to the 5-item survey improved after they completed the three art-making and four rest conditions ($M = .85$, $SD = 1.78$, $t[25] = 4.42$, $p = .02$). Self-perceptions significantly increased following the session conditions specifically for the questions of 'I have good ideas' ($M = -.269$, $SD = .667$, $t[25] = -.059$, $p = .050$) and 'I can solve problems' ($M = -.231$, $SD = .514$, $t[25] = -2.287$, $p = .031$). See Fig. 6.

Experience with session

In their narrative responses about the experience of the art-making conditions, the most common responses referred to enjoyment or relaxation ($n = 16$). Eight individuals mentioned the fact that the experience was fun or enjoyable ('Coloring with markers was fun! Enjoyable & relaxing'), and eight mentioned the relaxing nature of drawing ('Overall it was a very relaxing experience'). In addition, 11 participants described aspects of the experience that they found limiting, such as the time constraints ('The 3-min interval was short, and I was unable to come to a stopping point with my art'), the structure provided ('The circles on the paper for the free drawing were kind of odd in that they were almost in the way'), or the materials that were provided ("markers don't have a lot of control. I usually draw w/pen or colored pencils").

Discussion and implications

The results of this pilot study indicate that all three creative self-expression conditions activated the mPFC and the reward pathway in a way that was significantly different from the rest conditions. The doodling condition evoked the most activation; however, the differences from coloring and free drawing were not statistically significant. There were some indications that there might be differences between artists and non-artists; however, the sample was too small to draw any definitive conclusions. The hypothesis that free drawing would evoke the most activation was not supported. All conditions activated the reward pathway. The hypothesis that self-perceptions of creativity would improve following the sequence of drawing tasks was supported, indicating that even a short series of creative self-expression or art-making tasks completed in approximately 15–20 min can result in individuals perceiving themselves as having good ideas and being able to solve problems. These findings have useful implications in empowering individuals to shift self-perceptions of creative abilities and creative problem solving. These differences were not seen to be related to artistic skills, age, or gender, indicating that all participants, regardless of demographic background, could potentially see such changes. The sample used in this pilot study is small, and any conclusions must be drawn with caution. In addition, Dietrich and Kanso (2010) highlight the challenges of defining and assessing creativity as any one single construct. It is to be noted that we did not ask participants to define creativity or to assess the creative qualities of their artwork in any way; rather we asked them their self-perceptions of having novel ideas, being imaginative, and coming up with good ideas and solutions to problems. These self-perceptions are valuable and warrant further study in terms of what exactly changed for the participants and how they perceived these changes to manifest in their lives.

The instructions for the drawing conditions might also have affected the results. For example, in a previous study, Andrade (2010) found that doodling helped improve memory and retention. The doodling condition in that study was similar to the coloring condition in our study. Participants in Andrade's (2010) study colored in blank squares as part of the doodling condition. In our study, however, we asked participants to engage in doodling with only the frame of a circle provided on an empty page. Moreover, when we invited participants to engage in doodling, it was operationalized for this study as a personalized activity, and almost everyone had a doodling style. Some participants said that they did not doodle much since they used digital devices rather than paper and pencil/pen. Our participants, however, had a style that they identified as their preferred doodling style, which helped them participate in the doodling condition. This preference could be equated to esthetic judgment (Ishizu & Zeki, 2013), leading to increased reward perception and pleasure from creating and viewing the doodle. Rather than serving as a distraction or containing activity that coloring seems to serve, doodling might be a way to engage the reward perception mechanism in an accessible way for artists and non-artists alike. The free-drawing condition, however, did not evoke a distinct response. This finding could have been based on the fact that the free-drawing condition followed the two other conditions in the study sequence and could thus be embedding experiences of the other conditions. In addition, for some participants, free drawing was intimidating, whereas for others, the paper, circle format, and media were restrictive. All of these factors together might explain the indistinct responses to the free-drawing condition.

Bolwerk et al. (2014) highlighted the positive outcomes of art-making versus simply viewing artwork. We have built on this work and have demonstrated the perception of reward generated by art-making through a range of creative self-expression options. We have also provided evidence for a shift in an individual's self-perceptions of his or her creativity in just 15 min of a sequence

of art-making tasks. Given that the narratives also corroborated the enjoyable aspects of art-making regardless of gender or age, these are valuable findings for further study. We recognize that the mPFC has multiple roles, including emotion processing, long-term memory processing, and social cognition (Euston et al., 2012; Grossmann, 2013). These roles might also be in play for the drawing tasks, especially the fact that doodling might evoke memories and free drawing might involve making connections between long-term memories and spatiotemporal regions to generate an image. As seen from the narrative responses, drawing itself evokes memories for participants of early school experiences as well as individual differences in whether these memories elicited positive emotions or negative emotions. Further research is needed to better understand the interaction of emotion, reward perception, and visual self-expression.

Because this endeavor is a pilot study, further research is needed to make conclusive clinical recommendations. We can, however, highlight some emergent directions for clinical applications for art therapists. For example, participants reported more improvements in self-perceptions of creativity and problem solving at the end of the three art-making conditions, indicating a simple way to enhance perceptions of creativity in individuals. The potential differences in activation of the reward pathways differed for artists and non-artists, which suggests that it might be valuable for art therapists to consider some sensitivity around the reward pathways. The narrative feedback also indicates differences in participant experiences with the choices of creative self-expression and media. Because no therapists facilitated the art-making conditions, these results further highlight the potential differences based on the opportunity for self-expression and processing the experience. The finding that all drawing conditions activated the mPFC and the related reward pathway in the brain indicates that artistic expression can be a positive experience even if it is practiced for a short time. We did not find any significant differences between artists and non-artists, which also indicates the potential for all participants to enjoy positive experiences from visual self-expression. Art therapists could cite this result as evidence to encourage participants/clients who might be intimidated by drawing tasks and perceive themselves as unskilled in the visual arts. Furthermore, the fact that art can evoke reward pathways indicates that it could potentially be a replacement for other activities that are known to activate these pathways such as addictive behaviors, eating disorders, and mood disorders. Further research is needed to examine the potential of visual self-expression to replace other reward-seeking behaviors like addictions and loss of pleasure conditions like anhedonia (Huhn et al., 2016). In addition, given the evidence that impulse control disorders like attention-deficit/hyperactivity disorder and borderline personality disorder exhibit disturbed functioning in the mPFC, we might explore the role of art-making in addressing these symptoms (Sebastian et al., 2014).

This study has several limitations. It was a pilot study that tested three creative self-expression conditions set up in a sequence from structured to unstructured tasks (coloring in predrawn shapes to doodling to free drawing). It was set up to mimic art therapy practice, which has traditionally helped clients move from structured to more unstructured activities of self-expression. The setup is also, therefore, one of the main limitations of the study, because the creative self-expression conditions were implemented in the same sequence across all participants, and there was only one iteration with each participant. We did not control for the order effect. The participants served as their own controls, and we did not have separate groups for each of the drawing conditions. Moreover, the number of participants is small, and the sample size is further reduced when comparing participant characteristics such as gender, age, and artistic skill levels. It is also possible that any "making" or "doing" task involving the hands might have evoked the mPFC, but we did not test for this. In addition, fNIRS only measures PFC activation, and we did not account for other mechanisms of inner brain structures that might have offered more insight into the experiences of reward perception. In the narrative responses, several participants spoke about not having enough time to complete the tasks. Some participants felt restricted in their creative self-expression by the limited time (3 min) to complete each condition, and others felt constrained by the media choices and the circle shape for the free-drawing condition. The 3-minute time frame was set to accommodate the technology, because the fNIRS band sits snugly on the participant's forehead and might feel uncomfortable beyond 20 min of wear. These short-duration experiences might have affected the reward perception of each drawing condition. Further research might examine how brain activation varies by the creative self-expression condition when participants are given a longer time and different media choices. Newer fNIRS detection technology allows for longer wear, which may also facilitate further study.

Conclusions

This pilot study examined brain activation measured by fNIRS for three creative self-expression conditions—coloring, doodling, and free drawing. The study provided initial findings to indicate that all three art-making conditions activated the mPFC and that this activation was significantly higher than that obtained during the rest condition. Of the three art-making conditions, doodling resulted in maximum mPFC activation compared with the coloring and free-drawing conditions; however, these differences were not statistically significant. Some clinical implications include: the recognition that art-making evokes reward pathways, that even short spans of artistic activity can improve self perceptions of creative abilities, and, art-making could be a way to regulate mood, addictive behaviors and evoke a sense of pleasure. Further study is needed to better understand the specific ways in which art-making is perceived, including expressive activities and aesthetic perceptions of the art product, reward pathways related to art making, art media choices, time on task, identification as an artist/non-artist, and the intersection of emotions and self expression to art making.

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References

Andrade, J. (2010). What does doodling do? *Applied Cognitive Psychology, 24*, 100–106. http://dx.doi.org/10.1002/acp.1561

Arnsten, A. F. (2009). Stress signaling pathways that impair prefrontal cortex structure and function. *Nature Reviews Neuroscience, 10*(6), 410–422. http://dx.doi.org/10.1038/nrn2648

Ayaz, H., Izzetoglu, M., Platek, S. M., Bunce, S., Izzetoglu, K., Pourrezaei, K., et al. (2006, August). Registering fNIR data to brain surface image using MRI templates. In *Conference proceedings of the IEEE engineering in medicine and biology society*. pp. 2671–2674. http://dx.doi.org/10.1109/IEMBS.260835

Ayaz, H., Izzetoglu, M., Shewokis, P. A., & Onaral, B. (2010). Sliding-window motion artifact rejection for functional near-infrared spectroscopy. In *Conference proceedings of the IEEE engineering in medicine and biology society* (pp. 6567–6570).

Ayaz, H., Onaral, B., Izzetoglu, K., Shwokis, P. A., McKendrick, R., & Parasuraman, R. (2013). Continuous monitoring of brain dynamics with functional near infrared spectroscopy as a tool for neuroergonomic research: Empirical examples and a technological development. *Frontiers in Human Neuroscience, 7*, 1–13. http://dx.doi.org/10.3389/fnhum.2013.00871

Ayaz, H., Shewokis, P. A., Bunce, K. I., Bunce, S., Izzetoglu, K., Willems, B., et al. (2012). Optical brain monitoring for operator training and mental workload assessment. *Neuroimage*, *59*, 36–47. http://dx.doi.org/10.1016/j.neuroimage.2011.06.023

Ayaz, H., Shewokis, P. A., Curtin, A., Izzetoglu, M., Izzetoglu, K., & Onaral, B. (2011). Using MazeSuite and functional near infrared spectroscopy to study learning in spatial navigation. *Journal of Visualized Experiments*, *8*(October (56)), e3443. http://dx.doi.org/10.3791/3443

Ayaz, H., Shewokis, P. A., Scull, L., Libon, D. J., Feldman, S., Eppig, J., et al. (2014). Assessment of prefrontal cortex activity in amyotrophic lateral sclerosis patients with functional near infrared spectroscopy. *Journal of Neuroscience and Neuroengineering*, *3*(1), 41–51. http://dx.doi.org/10.1166/jnsne.2014.1095

Babouchkina, A., & Robbins, S. J. (2015). Reducing negative mood through mandala creation: A randomized controlled trial. *Art Therapy: Journal of the American Art Therapy Association*, *32*(1), 34–39. http://dx.doi.org/10.1080/07421656.2015.994428

Baeken, C., De Raedt, R., van Schuerbeek, P., De Mey, J., Bossuyt, A., & Luypaert, R. (2012). The influence of emotional priming on the neural substrates of memory: A prospective fMRI study using portrait art stimuli. *NeuroImage*, *61*, 876–883. http://dx.doi.org/10.1016/j.neuroimage.2012.03.043

Beghetto, R. A. (2006). Creative self-efficacy: Correlates in middle and secondary students. *Creativity Research Journal*, *18*, 447–457. http://dx.doi.org/10.1207/s15326934crj1804.4

Belkofer, C. M., Van Hecke, A. V., & Konopka, L. M. (2014). Effects of drawing on alpha activity: A quantitative EEG study with implications for art therapy. *Art Therapy: Journal of the American Art Therapy Association*, *31*(2), 61–68. http://dx.doi.org/10.1080/07421656.2014

Bolwerk, A., Mack-Andrick, J., Lang, F. R., Dörfler, A., & Maihöfner, C. (2014). How art changes your brain: Differential effects of visual art production and cognitive art evaluation on functional brain connectivity. *PLoS ONE*, *9*(7), e101035. http://dx.doi.org/10.1371/journal.pone.0101035

Bunce, S., Harris, J., Izzetoglu, K., Ayaz, H., Izzetoglu, M., Pourrezaei, K., et al. (2013). Functional near-infrared spectroscopy in addiction treatment: Preliminary evidence as a biomarker of treatment response. In D. Schmorrow, & C. Fidopiastis (Eds.), *Foundations of augmented cognition* (Vol. 8027) (pp. 250–258). Berlin/Heidelberg: Springer.

Bunce, S., Izzetoglu, K., Izzetoglu, M., Ayaz, H., Pourrezaei, K., & Onaral, B. (2012). Treatment status predicts differential prefrontal cortical responses to alcohol and natural reinforcer cues among alcohol dependent individuals. In H. Zhang, A. Hussain, D. Liu, & Z. Wang (Eds.), *Advances in brain inspired cognitive systems* (Vol. 7366) (pp. 183–191). Berlin/Heidelberg: Springer.

Chamberlain, R., McManus, C. I., Brunswick, N., Rankin, Q., Riley, H., & Kanai, R. (2014). Drawing on the right side of the brain: A voxel based morphometry analysis of observational drawing. *NeuroImage*, *96*, 167–173. http://dx.doi.org/10.1016/j.neuroimage.2014.03.062

Chatterjee, A., & Vartanian, O. (2014). Neuroaesthetics. *Trends in Cognitive Sciences*, *18*(7), 370–375. http://dx.doi.org/10.1016/j.tics.2014.03.003

Cui, X., Bray, S., Bryant, D. M., Glover, G. H., & Reiss, A. L. (2010). A quantitative comparison of NIRS and fMRI across multiple cognitive tasks. *NeuroImage*, *54*(4), 2808–2821. http://dx.doi.org/10.1016/j.neuroimage.2010.10/069

Curry, N. A., & Kasser, T. (2005). Can coloring mandalas reduce anxiety? *Art Therapy: Journal of the American Art Therapy Association*, *22*(2), 81–85. http://dx.doi.org/10.1080/07421656.2005.10129441

Damasio, A. R., Everitt, B. J., & Bishop, D. (1996). The somatic marker hypothesis and the possible functions of the prefrontal cortex [and discussion]. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *351*(1346), 1413–1420. http://dx.doi.org/10.1098/rstb.1996.0125

Dietrich, A., & Kanso, R. (2010). A review of EEG ERP, and neuroimaging studies of creativity and insight. *Psychological Bulletin*, *136*(5), 822–848. http://dx.doi.org/10.1037/a0019749

Donoso, M., Collins, A. G. E., & Koechlin, E. (2014). Foundations of human reasoning in the prefrontal cortex. *Science*, *344*(6191), 1481–1486. http://dx.doi.org/10.1126/science.1252254

Drake, C. R., Searight, H. R., & Olson-Pupek, K. (2014). The influence of art-making on negative mood states in university students. *American Journal of Applied Psychology*, *2*(3), 69–72. http://dx.doi.org/10.12691/ajap-2-3-3

Ehlis, A. C., Ringel, T. M., Plichta, M. M., Richter, M. M., Herrmann, M. J., & Fallgatter, A. J. (2009). Cortical correlates of auditory sensory gating: A simultaneous near-infrared spectroscopy event-related potential study. *Neuroscience*, *159*, 1032–1043. http://dx.doi.org/10.1016/j.neuroscience.2009.01.015

Euston, D. R., Gruber, A. J., & McNaughton, B. L. (2012). The role of medial prefrontal cortex in memory and decision making. *Neuron*, *76*(6), 1057–1070. http://dx.doi.org/10.1016/j.neuron.2012.12.002

Ferrari, M., & Quaresima, V. (2012). A brief review on the history of human functional near-infrared spectroscopy (fNIRS) development and fields of application. *NeuroImage*, *63*, 921–935. http://dx.doi.org/10.1016/j.neuroimage.2012.03.049

Grossmann, T. (2013). The role of medial prefrontal cortex in early social cognition. *Frontiers in Human Neuroscience*, *7*, 340. http://dx.doi.org/10.3389/fnhum.2013.00340

Herrmann, M. J., Huter, T., Plichta, M. M., Ehlis, A. C., Alpers, G. W., Mühlberger, A., et al. (2008). Enhancement of activity of the primary visual cortex during processing of emotional stimuli as measured with event-related functional near-infrared spectroscopy and event-related potentials. *Human Brain Mapping*, *29*, 28–35. http://dx.doi.org/10.1002/hbm.20368

Huhn, A. S., Meyer, R. E., Harris, J. D., Ayaz, H., Deneke, E., Stankoski, D. M., et al. (2016). Evidence of anhedonia and differential reward processing in prefrontal cortex among post-withdrawal patients with prescription opiate dependence. *Brain Research Bulletin*, *123*, 102–109. http://dx.doi.org/10.1016/j.brainresbull.2015.12.004

Irani, F., Platek, S. M., Bunce, S., Ruocco, A. C., & Chute, D. (2007). Functional near infrared spectroscopy (fNIRS): An emerging neuroimaging technology with important applications for the study of brain disorders. *The Clinical Neuropsychologist*, *21*(1), 9–37. http://dx.doi.org/10.1080/13854040600910018

Ishizu, T., & Zeki, S. (2013). The brain's specialized systems for aesthetic and perceptual judgment. *Cognitive Neuroscience*, *13*, 1413–1420. http://dx.doi.org/10.1038/nn.2659

Izzetoglu, K., Ayaz, H., Merzagora, A., Izzetoglu, M., Shewokis, P. A., Bunce, S. C., et al. (2011). The evolution of field deployable fNIR spectroscopy from bench to clinical settings. *Journal of Innovative Optical Health Sciences*, *4*(3), 1–12. http://dx.doi.org/10.1142/S1793545811001587

Jöbsis, F. F. (1977). Noninvasive, infrared monitoring of cerebral and myocardial oxygen sufficiency and circulatory parameters. *Science*, *198*, 1264–1267.

Kaimal, G., & Ray, K. (2017). Free art-making in an art therapy open studio: Changes in affect and self-efficacy. *Arts and Health*, *9*(2), 154–166. http://dx.doi.org/10.1080/17533015.2016.1217248

Kaimal, G., Ray, K., & Muniz, J. M. (2016). Reduction of cortisol levels and participants' responses following artmaking. *Art Therapy: Journal of the American Art Therapy Association*, *33*(2), 74–80. http://dx.doi.org/10.1080/07421656.2016.1166832

Kruk, K. A., Aravich, P. F., Deaver, S. P., & deBeus, R. (2014). Comparison of brain activity during drawing and clay sculpting: A preliminary qEEG study. *Art Therapy: Journal of the American Art Therapy Association*, *31*(2), 52–60. http://dx.doi.org/10.1080/07421656.2014.911027

Lacey, S., Hagtvedt, H., Patrick, V. M., Anderson, A., Stilla, R., Deshpande, G., et al. (2011). Art for reward's sake: Visual art recruits the ventral striatum. *NeuroImage*, *55*(1), 420–433. http://dx.doi.org/10.1016/j.neuroimage.2010.11.027

Miall, R. C., Nam, S., & Tchalenko, J. (2014). The influence of stimulus format on drawing—A functional imaging study of decision making in portrait drawing. *NeuroImage*, *102*, 608–619. http://dx.doi.org/10.1016/j.neuroimage.2014.08.015

O'Reilly, R. C. (2010). The what and how of prefrontal cortical organization. *Trends in Euroscience*, *33*(8), 355–361. http://dx.doi.org/10.1016/j.tins.2010.05.002

Ramnani, N., & Owen, A. M. (2004). Anterior prefrontal cortex: Insights into function from anatomy and neuroimaging. *Nature Reviews Neuroscience*, *5*(3), 184–194. http://dx.doi.org/10.1038/nrn1343

Riessman, C. K. (2008). *Narrative methods for the human sciences*. New York: Sage.

Ruocco, A. C., Rodrigo, A. H., McMain, S. F., Page-Gould, E., Ayaz, H., & Links, P. S. (2016). Predicting treatment outcomes from prefrontal cortex activation for self-harming patients with borderline personality disorder: A preliminary study. *Frontiers in Human Neuroscience*, *10*, 220. http://dx.doi.org/10.3389/fnhum.2016.00220

Russo, J. S., & Nestler, J. E. (2013). The brain reward circuitry in mood disorders. *Nature Reviews Neuroscience*, *14*, 609–625. http://dx.doi.org/10.1038/nrn3381

Schlegel, A., Alexander, P., Fogelson, S. V., Li, X., Lu, Z., Kohler, P. J., et al. (2015). The artist emerges: Visual art learning alters neural structure and function. *NeuroImage*, *105*, 440–451. http://dx.doi.org/10.1016/j.neuroimage.2014.11.014

Schott, G. D. (2011). Doodling and the default network of the brain. *The Lancet*, *378*(9797), 133–1134.

Sebastian, A., Jung, P., Krause-Utz, A., Lieb, K., Schmahl, C., & Tuscher, O. (2014). Frontal dysfunctions of impulse control – A systematic review in borderline personality disorder and attention deficit/hyperactivity disorder. *Frontiers in Human Neuroscience*, *8*, 698–715. http://dx.doi.org/10.3389/fnhum.2014.00698

Smolarski, K., Leone, K., & Robbins, S. J. (2015). Reducing negative mood through drawing: Comparing venting, positive expression, and tracing. *Art Therapy: Journal of the American Art Therapy Association*, *32*(4), 197–201. http://dx.doi.org/10.1080/07421656.2015.1092697

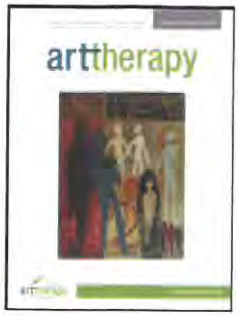
Teo, W. P., Muthalib, M., Yamin, S., Hendy, A. M., Bramstedt, K., Kotsopoulos, E., et al. (2016). Does a combination of virtual reality, neuromodulation and neuroimaging provide a comprehensive platform for neurorehabilitation? – A narrative review of the literature. *Frontiers in Human Neuroscience*, *10*, 284. http://dx.doi.org/10.3389/fnhum.2016.00284

Tierney, P., & Farmer, S. M. (2002). Creative self-efficacy: Its potential antecedents and relationship to creative performance. *Academy of Management Journal*, *45*(6), 1137–1148.

Van Den Heuvel, M. P., & Pol, H. E. H. (2010). Exploring the brain network: A review on resting-state fMRI functional connectivity. *European Neuropsychopharmacology*, *20*(8), 519–534. http://dx.doi.org/10.1016/j.euroneuro.2010.03.008

Van der Vennet, R., & Serice, S. (2012). Can coloring mandalas reduce anxiety? A replication study. *Art Therapy*, *29*(2), 87–92. http://dx.doi.org/10.1080/07421656.2012.680047

Wood, J. N., & Grafman, J. (2003). Human prefrontal cortex: Processing and representational perspectives. *Nature Reviews Neuroscience*, *4*(2), 139–147. http://dx.doi.org/10.1038/nrn10331038/nrn1033



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Humor, Self-Attitude, Emotions, and Cognitions in Group Art Therapy With War Veterans

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Abstract

This article presents findings from a study of the therapeutic effects of group art therapy in a psychotherapy unit of a Russian hospital for war veterans. The researchers randomly assigned 112 veterans being treated for stress-related disorders to an experimental group (art therapy) and a control group. The emphasis was on the use of humor in the Draw A Story assessment and the Silver Drawing Test with respect to cognition, emotions, creativity, and self-image. Findings included a high frequency of humorous responses in both groups, and an increase of humor in the art therapy group post treatment. Results suggest that image formation and artistic activity foster cognitive and creative problem solving and increased self-esteem, and that humor serves as an important therapeutic function in this population.

Introduction

War veterans are among the many client groups in which art therapy is used to reduce stress-related symptoms and to improve social adaptation. In the Russian Federation many combat veterans of military campaigns in different regions of the country and abroad suffer from mental disorders as a result of their service. Given the increasing need for quality medical and psychosocial support, it is important to develop and research cost-effective treatment. Art therapy can be regarded as one such treatment.

Although the value of art therapy with war veterans who have suffered psychological trauma has been studied (Foa, Keane, & Friedman, 2004; Golub, 1984; Haeseler, 1998), little research that is grounded in specific "rules of evidence" (Goldner & Bilsker, 1995) has been conducted to support the multifaceted effects of art therapy. Further clarification of intra- and interpersonal dynamic factors also is needed in order to understand the specific benefits of art therapy with this population, taking into account the clinical nature of stress-related disorders and the culture and personal characteristics of war veterans. Combat veterans have been identified with having high levels of emotional tension and instability, low impulse control, difficulties in interpersonal relations, distorted reactions to others, ambivalent and inadequate self-perception, and difficulties in securing existential meaning (Apchel & Tsygan, 1999; Kolov, Ostapenko, & Krivtsov, 2005). They may have a retrospective orientation toward life, or they may organize their lives around those values and norms that were acceptable in combat situations while feeling themselves to be lonely and unsafe in civilian life (Apchel & Tsygan, 1999; Kolov et al., 2005).

Foa et al. (2004) found that different interventions were helpful, depending upon the goals and conditions of treatment. Interventions may be aimed at: (a) uncovering and working through traumatic material while avoiding reactions, (b) reducing restlessness through relaxation and withdrawal of attention, (c) improving communication skills and reducing agoraphobic reactions through group interaction, and (d) improving self-esteem by stimulating creativity. Foa et al. suggested that as a treatment modality for war veterans and other traumatized persons art therapy may help reduce symptoms and promote other positive effects, such as improved impulse control and interpersonal skills and alleviation of dissociation, anxiety, night fears, and distortions in perception. Artistic activity also may have a positive effect on a client's social functioning, which in turn can lead to better self-esteem, sense of hope, socially adaptive behavior, and decreased feelings of shame. Foa et al. suggested that these positive effects may be the result of a combination of general psychological processes (e.g., relaxation and cognitive working-through) with nonverbal and creative processes.

Art therapists have reported on the difficulty of establishing therapeutic relations with male war veterans due to a resistant and strongly masculine culture within the military (Haeseler, 1998; Lebedev, 2006). Haeseler (1998) found, however, that such resistance could be slowly overcome in the creative atmosphere of the art therapy group. She described how the men's art and verbal commentaries, which were full of self-irony and humor, helped to release tension and express powerful feelings. Lebedev (2006) offered numerous examples of humor expressed in the art of war veterans who participated in art therapy treatment. Although some therapeutic and regulative functions of humor and its representations in art, psychoanalytic therapy, and art therapy have been discussed in the literature (Clay, 1997;

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Eric, 1998; Fabian, 1998; Jakab, 1998; Mango & Richman, 1990; Roux & Laharie, 1998; Silver, 2002, 2010; Verdeau-Pailles, 1998; Ziv, 1984), no systematic studies have been conducted on the nature and role of humor in art therapy with war veterans. As a therapeutic or adaptive factor in treatment, thus, an in-depth study of the manifestations of humor in clinical and nonclinical populations is needed.

Humor is a complex psychological and interpersonal phenomenon involving emotions and cognitions, conscious and unconscious minds, and also the human body. There are many different types of humor, including wit, jokes, clowning, irony, sarcasm, and cynicism. All have common attributes but there are important differences among them as well. Jakab (1998) observed the similarity of humor to metaphor, noting that both have "disguised, but understandable meaning" (p. 16). Although humor is a state of mind, it shares a tendency with metaphor to reveal hidden meanings in a situation and to connect to repressed emotions and concepts, "transforming them into acceptable, liberating presentations" (Jakab, 1998, p. 16). Jakab noted as well the similarities between jokes and dreams, explaining that each involves condensation, displacement, and indirect representation.

It can be difficult to differentiate between healthy and pathological or morbid humor due to the significant role that context plays. Nonetheless, the distinction is important if we are to predict humor's effects on individuals and groups and use its therapeutic and regulative power properly. Nagy (1998) believed that constructive humor helps make "the borders of the self flexible in fighting problematic inner or outer situations," whereas destructive humor is "correlated with destructive aggression, with the lack of contact-making ability, and the rigidity of the borders of the ego" (p. 257). Some types of humor are openly sexual and provide some liberation of instinctual drives; other forms may express disagreement or even aggression against other persons or institutions. Very often humor helps to defuse anxiety and suffering. According to Provine (as cited in Clay, 1997), humor and laughter may be involved when people are dealing with social power. In these situations humor may signal dominance or submission, rejection or acceptance. Collective laughter helps build contact-making ability; it contains group-building power.

According to Ziv (1984), humor is closely connected with the following functions: (a) expressing aggression and sexuality, (b) providing defense, (c) supporting the intellectual digesting of information, and (d) promoting inclusion in the social context. Psychological integration is an additional significant function of humor when deployed in therapy. Humor allows a person to tolerate ambivalence and see the positive and negative sides of a situation. As Jakab (1998) observed, humor helps to overcome inner splits within an individual, both "the difficulty (dark side) and the possible solution (light side)" in order to grapple with "the complexity of human existence" and "to transfer repressed feelings and ideas into acceptable properties of the self" without overtly identifying with them (pp. 17–18).

In her assessment of humor as expressed in drawings and stories, Silver (2002, 2007) identified several distinct types: (a) lethal and morbid humor, (b) lethal but not morbid humor, (c) disparaging humor, (d) self-disparaging humor, (e) ambiguous or ambivalent (neutral) humor, (f) resilient humor, and (g) playful humor. Silver gave no suggestions as to what role these distinct types of humor play in therapy or how they may be related to mental disorders. However, in a U.S. sample of 888 participants from different age and gender groups, she found that humor was predominantly negative: 69% of all humorous responses were identified as lethal, morbid, or disparaging humor, compared to only 22% positive (resilient or playful) responses (Silver, 2007). In addition, negative humor appeared significantly more often in male than female drawing responses (Silver, 2007).

The goal of the present study was to assess the therapeutic effects of brief group art therapy with patients being treated in a specialized psychotherapy unit for war veterans. The focus was on the patients' use of humor in particular and its connection with creativity, self-image, cognitions, and emotions during the course of treatment. Hypotheses of the study were as follows:

1. Group interactive art therapy is an effective intervention, which can be used with war veterans to reduce symptoms and improve personality functioning and quality of life. These effects will be more apparent in the experimental group than in the control group.
2. Humor is an important personal characteristic of war veterans, which may be connected to their coping skills and identification with "male culture." Therefore, numerous humorous responses throughout treatment can be expected.
3. Humor serves as one of the therapeutic factors linked to the creative and cognitive resources of war veterans.

Method

Location

The study took place in a specialized psychotherapy department within a regional clinical hospital for war veterans. The hospital is administered by the Ministry of Public Health and offers complex treatment for war veterans. The psychotherapy department was established in 1997 to provide quality medical and psychosocial support to war veterans residing in the Volgograd region of the Russian Federation who were involved in military campaigns in Northern Caucasus, Afghanistan, and other geopolitical "hot points." All of the patients experienced emotional disorders that, due to their severity, could not be treated outside the hospital setting.

The staff of the psychotherapy department includes psychiatrists, psychotherapists, clinical psychologists, and nurses. The treatment emphasis combines medical and psychosocial interventions and includes occupational therapy, counseling, individual and group verbal therapy, and group interactive art therapy. The general goal is not only to reduce the clients' symptoms but to enable personality reconstruction and social integration as well.

Participants

Male and female patients of different ages comprised the experimental (Group 1) and control (Group 2) groups (for more demographic information, see Table 1). The inclusion criteria were that participants had been diagnosed with having nonpsychotic mental disorders and had been involved in military campaigns either in the Russian Federation or abroad. Patients were excluded from the study if they experienced severe mental disorders and were older than 55 years.

A total of 112 patients were enrolled in the study. The department chief randomly assigned participants to the experimental group (Group 1; $n = 62$) or the control group (Group 2; $n = 50$). From the complete list of patients being treated in the department, every second patient was referred to group art therapy and every first patient was referred to occupational therapy, the standard treatment that served as the control condition. Patients in both groups continued to receive psychopharmacological treatment and physiotherapy.

The participant ages in the groups varied from 25 to 53 years; participant mean age in Group 1 was 38 years and the mean age in Group 2 was 35 years. Most patients in both groups were diagnosed as having stress-related and somatoform disorders, affective disorders, and organic disorders (Table 1). The main presenting problem was a decreased or unstable mood that was often associated with anxiety, irritation, difficulties in relationships, low impulse control, absence of interest in life, tiredness, apathy, poor sleep, and feelings of pain and discomfort in the body. A majority of the participants were involved in local military campaigns, whereas 75 had fought in Afghanistan or the Northern Caucasus. The average length of stay in the hospital was one month.

Table 1 Participant Demographics and Diagnoses

Variable	Group 1 ($n = 62$)	Group 2 ($n = 50$)
Demographic		
Male	57 (92%)	45 (90%)
Female	5 (8%)	5 (10%)
Age 20–29 years	15 (29%)	13 (26%)
Age 30–39 years	29 (47%)	23 (47%)
Age 40–49 years	10 (16%)	9 (18%)
Age 50+ years	8 (13%)	5 (10%)
Diagnoses (ICD-10)[a]		
Neurotic, stress-related, and somatoform disorders[b]	17 (24%)	14 (28%)
Affective disorders (depression)[c]	10 (16%)	7 (14%)
Organic mental disorders[d]	35 (60%)	29 (58%)

[a]International Statistical Classification of Diseases and Related Health Problems (ICD-10), World Health Organization, 1992.
[b]ICD-10 codes F43.22, F45.3, F48.0, and F43.23.
[c]ICD-10 codes F32.0, F32.10, F32.11, and F33.01.
[d]ICD-10 codes F06.6, F06.4, F06.3, F06.2, and F07.0.

Written consent was obtained from patients upon their admission to the department and additional consent was obtained from them to be included in art therapy. The study was reviewed and approved by the head of the department as well as the institution's internal research review board. Additionally, the study was reviewed by the research review board of the Psychotherapy Department at the Bekhterev Scientific–Research Psychoneurological Institute of St. Petersburg, Russian Federation.

Measures

The instruments were chosen to assess symptomatic improvement in the participants' conditions and changes in their self-perception, cognitive functioning, and quality of life. The second author assessed group interaction and artistic expression as well. To assess symptomatic improvement, the following tools were used: Symptomatic Checklists, SCL-90 (Derogatis, 1983); Questionnaire of Depressive Conditions (Bespalko, 2004), and the Integrative Anxiety Test (Bizyuk, Wasserman, & Iovlev, 2005). The Questionnaire of Depressive Conditions is a quantitative tool that measures the absence or presence of depressive symptoms, according to its first scale, and distinguishing endogenous and neurotic depression, according to its second scale. The Integrative Anxiety Test provides a general index and measure for personality and situational anxiety, as well as specific scales for both these types of anxiety, such as Emotional Discomfort, Asthenic Component, Phobic Component, Perception of Perspectives, and Social Phobic Reactions.

To assess changes in personality functioning, self-perception, cognitive skills, and quality of life, the following instruments were used: the self-report General Condition-Activity-Mood Test (Doskin, Lavrenteva, Miroshnikov, & Sharay, 1973); the Silver Drawing Test (SDT) and Draw A Story assessment (DAS; Silver, 2002, 2010); and the World Health Organization Quality of Life Questionnaire (Burkovskij, Kotsubinskij, Levchenko, & Lomachenkov, 1998; Kuyken, Orley, Hudelson, & Sartorius, 1994; World Health Organization Group, 1998).

In order to study the role of humor throughout treatment, and to see whether it is indeed an important personal characteristic of war veterans, drawing responses to the SDT and DAS tasks from both groups were scored on the Humor scale (Silver, 2002, 2010). To study the connection between a sense of humor and the creative and cognitive resources of war veterans, humorous responses in these assessments were scored on Silver's cognitive scale (Ability to Represent) and compared with non-humorous responses.

All the measures were taken before and after treatment: at the beginning of treatment in the hospital, and again after one month and not long before the participants' discharge (usually during the 12th and 13th sessions). To compare statistical differences between pre- and post-test results in the two groups, the researchers used *t*-test, Mann-Whitney, and

chi-square measures. The t test enabled a statistical comparison of pre-test and post-test results in the groups, whereas the Mann-Whitney measure compared Group 1 and Group 2 data. The chi-square measure compared different kinds of humor between groups and pre-test and post-test frequencies of humorous responses.

Art Therapy Intervention

Participants in Group 1 took part in group art therapy three times per week in after-lunch sessions that lasted 2.5 hours. Group sessions usually consisted of 5 to 8 patients. The course of art therapy lasted one month and included 12 to 14 sessions that were facilitated by the second author, who is a psychiatrist and trained art therapist. Each session was structured with warm-up activities, a main art-based activity with discussion, and closure. Basic art materials were available, such as crayons and pastels, colored pencils, gouache and acrylic paints, and white paper of different sizes.

Group art therapy involved various art-based activities that corresponded with appropriate stages of treatment and group dynamics aimed at different therapeutic targets. For example, participants created individual and group squiggle drawings that encouraged warming up, creative stimulation, and the safe release of emotions and stimulation, and also presented their current emotional state through drawing. Drawing tasks and themes were introduced to allow participants to develop interpersonal skills and mindfulness; to express and understand their own self-perception; to perceive their attitude to others and their position in a group, their disease, and their resources; and to gain perspective on their past and present life situations. Directives included "realistic and metaphoric self-portrait," "my life line," "positive and negative feelings," "my resources in the past and present," "challenging life situations and how I overcome them," "personal coat of arms," "my life achievements and goals," and "presents I give myself and others." Issues that arose from group dynamics also were worked through using art-based activities and discussion.

Results

Therapeutic Effects

The pre-treatment measures resulted in no significant overall difference ($p > .05$) in patients' scores at the start of treatment between those who received art therapy and those who did not receive art therapy. However, significant differences ($p < .05$) were found after one month between the groups in mean scores on several measures.

As for SCL-90 Symptom Checklists, there was a statistically significant difference between Group 1's post-test scores ($M = 0.47$, $SD = 0.07$) and Group 2's post-test scores ($M = 0.67$, $SD = 0.10$) on the Depression Scale, $t = -1.62$, $p < .05$, and between Group 1's post-test scores ($M = 0.45$, $SD = 0.07$) and Group 2's post-test scores ($M = 0.73$, $SD = 0.13$) on the Hostility Scale, $t = -1.91$, $p < .05$. Statistical significance was in favor of the experimental (art therapy) condition. The difference between the groups on other scales was insignificant at the end of treatment (Table 2).

Comparison of post-test scores in the experimental and control groups for the Questionnaire of Depressive Conditions indicated a lower level on the Depression–No Depression Scale in the experimental group as compared to the control group, and no significant difference on the Endogenous–Neurotic Depression Scale between groups. There was a statistically significant difference between Group 1's post-test scores ($M = 66.18$, $SD = 2.69$) as compared to Group 2's post-test scores ($M = 73.69$, $SD = 3.05$) on the Depression–No Depression Scale, $t = -2.11$, $p < .05$, and no significant difference on the Endogenous–Neurotic Depression Scale between groups, $t = .59$, $p > .05$ (Table 2).

Comparison of mean pre-test and post-test scores in the experimental group for the Integrative Anxiety Test indicated a significant decrease in General Indices and most Scales of Personality and Conditional Anxiety ($p < .05$), whereas a decrease in scores was less evident in the control group. There was a statistically significant difference between Group 1's post-test scores ($M = 4.44$, $SD = 0.38$) and Group 2's post-test scores ($M = 6.56$, $SD = 0.36$) on the General Index of Personality Anxiety Scale, $t = -3.16$, $p < .005$, and between Group 1's post-test scores ($M = 3.58$, $SD = 0.35$) and Group 2's post-test scores ($M = 5.28$, $SD = 0.46$) on the General Index of Situational Anxiety Scale, $t = -2.39$, $p < .05$, in favor of the experimental group (Table 2).

General Condition-Activity-Mood Test scores showed a statistically significant difference between Group 1's post-test scores ($M = 5.39$, $SD = 0.11$) and Group 2's post-test scores ($M = 5.01$, $SD = 0.14$) on the General Condition Scale, $t = 2.55$, $p < .05$, between Group 1's post-test scores ($M = 5.22$, $SD = 0.12$) and Group 2's post-test scores ($M = 4.54$, $SD = 0.17$) on the Activity Scale, $t = 4.08$, $p < .001$, and between Group 1's post-test scores ($M = 5.48$, $SD = 0.12$) and Group 2's post-test scores ($M = 4.77$, $SD = 0.18$) on the Mood Scale, $t = 3.47$, $p < .001$, in favor of the experimental group (Table 2).

Comparison of the experimental and control groups' mean post-test scores for the Draw A Story assessment and the Silver Drawing Test indicated a more significant increase in scores on the Emotional Content and Self-Image scales and on three cognitive scales in the experimental group as compared to the control group. There was a statistically significant difference between Group 1's post-test scores ($M = 3.42$, $SD = 0.13$) and Group 2's post-test scores ($M = 3.05$, $SD = 0.19$) on the Emotional Content Scale, $t = 1.91$, $p < .05$; between Group 1's post-test scores ($M = 3.56$, $SD = 0.09$) and Group 2's post-test scores ($M = 3.23$, $SD = 0.16$) on the Self-Image Scale, $t = 2.08$, $p < .05$; and between Group 1's post-test scores ($M = 13.82$, $SD = 0.16$) and Group 2's post-test scores ($M = 12.68$, $SD = 0.31$), $t = 4.46$, $p < .001$, for the total in cognitive scales, all in favor of the experimental group (Table 2). The increased scores on the cognitive scales are indicative of such improvements as the ability to select, combine ideas, and represent a story. These and other abilities are basic for effective cognitive functioning and creativity (Bruner, Olver, & Greenfield, 1966; Piaget & Inhelder, 1967; Zeki, 1999).

Table 2 Pre- and Post-Test Results on Assessment Instruments

Assessment Instrument and Scales	Group 1 $M \pm SD$ ($n = 62$) Pre	Group 1 $M \pm SD$ ($n = 62$) Post	Group 2 $M \pm SD$ ($n = 50$) Pre	Group 2 $M \pm SD$ ($n = 50$) Post
SCL-90				
Somatization	1.11 ± .09	.56 ± .07	1.10 ± .09	.62 ± .08
Obsessive-compulsivity	1.21 ± .19	.63 ± .08	1.18 ± .10	.79 ± .10
Interpersonal sensitivity	1.04 ± .10	.55 ± .07	1.02 ± .10	.70 ± .11
Depression	1.05 ± .10	.47 ± .07	1.00 ± .09	.67 ± .10*
Anxiety	1.06 ± .10	.44 ± .07	1.07 ± .12	.61 ± .10
Hostility	1.09 ± .11	.45 ± .07	1.17 ± .13	.73 ± .13*
Phobic anxiety	.56 ± .09	.28 ± .07	.56 ± .08	.34 ± .08
Paranoid ideation	.83 ± .10	.51 ± .07	.94 ± .12	.61 ± .11
Psychotism	.60 ± .08	.26 ± .06	.56 ± .08	.40 ± .08
Additional scales	1.20 ± .11	.58 ± .10	1.23 ± .11	.66 ± .09
Global severity index	.99 ± .08	.48 ± .06	.99 ± .08	.62 ± .09
Personality severity index	49.74 ± 2.86	31.26 ± 3.13	53.91 ± 3.32	38.41 ± 4.44
Positive symptom distress index	1.71 ± .07	1.29 ± .04	1.60 ± .06	1.32 ± .05
Questionnaire of Depressive Conditions				
Depression–no depression scale	79.76 ± 3.07	66.18 ± 2.59	81.32 ± 3.51	73.69 ± 3.05*
Endogenous–neurotic depression scale	40.73 ± 1.50	47.12 ± 1.46	42.52 ± 1.96	45.22 ± 2.03
Integrative Anxiety Test				
Personality anxiety				
General index	7.57 ± .23	4.44 ± .38	7.48 ± .24	6.56 ± .36**
Emotional discomfort	7.74 ± .19	4.88 ± .32	7.56 ± .27	6.38 ± .37*
Asthenic component	7.29 ± .25	4.96 ± .35	7.67 ± .34	6.59 ± .36*
Phobic component	5.95 ± .29	3.54 ± .37	5.30 ± .44	5.31 ± .37***
Perception of perspectives	7.40 ± .27	5.00 ± .36	7.41 ± .24	6.34 ± .36*
Social phobic reactions	5.00 ± .40	4.00 ± .42	4.96 ± .47	4.31 ± .44*
Situational anxiety				
General index	6.64 ± .31	3.58 ± .35	6.33 ± .44	5.28 ± .46*
Emotional discomfort	5.88 ± .35	3.50 ± .30	5.67 ± .48	4.91 ± .44*
Asthenic component	6.76 ± .34	4.10 ± .34	6.93 ± .40	5.34 ± .43*
Phobic component	5.05 ± .39	3.04 ± .34	5.30 ± .42	4.34 ± .46*
Perception of perspectives	7.19 ± .32	4.82 ± .38	6.48 ± .41	5.88 ± .41
Social phobic reactions	5.29 ± .40	4.16 ± .36	5.52 ± .43	5.16 ± .41
General Condition–Activity–Mood Test				
General condition	3.75 ± .15	5.39 ± .11	3.77 ± .20	5.01 ± .14*
Activity	3.82 ± .13	5.22 ± .12	3.94 ± .19	4.54 ± .17***
Mood	4.13 ± .15	5.48 ± .12	4.14 ± .21	4.77 ± .18***
Silver Drawing Test				
Emotional content scale	2.89 ± .22	3.42 ± .13	2.60 ± .76	3.05 ± .19*
Self-image scale	3.26 ± .17	3.56 ± .09	3.20 ± .65	3.23 ± .16*
Ability to select	3.67 ± .08	4.49 ± .07	4.00 ± .13	4.05 ± .14***
Ability to combine	4.22 ± .1	4.69 ± .08	4.50 ± .14	4.45 ± .13***
Ability to represent	3.69 ± .12	4.62 ± .07	4.09 ± .16	4.14 ± .16***
Total in cognitive scales	11.69 ± .23	13.82 ± .16	12.55 ± .33	12.68 ± .31***

*$p < .05$. **$p < .005$. ***$p < .001$.

Comparison of the experimental and control groups' post-test scores on the World Health Organization Quality of Life Questionnaire indicated that participants in the art therapy group had significantly higher scores on the General Quality of Life and Health Index ($M = 14.3$, $SD = 0.51$) as compared to participants in the control group ($M = 11.86$, $SD = 1.07$), $t = 3.24$, $p < .05$. Mean post-test scores also were significantly higher in the experimental group ($M = 88.98$, $SD = 1.93$) as compared with the control group ($M = 78.95$, $SD = 4.48$), $t = 4.12$, $p <$

.05, in the sub-spheres of Life Activity/Energy/Fatigue (F2; I Physical Sphere) ($M = 14.43$, $SD = 0.46$ and $M = 12.14$, $SD = 0.92$, accordingly), $t = 2.04$, $p < .05$, Cognition/Memory/Concentration (F5; II Psychological Sphere) ($M = 14.77$, $SD = 0.39$ and $M = 12.5$, $SD = 0.95$, accordingly), $t = 2.94$, $p < .05$, Mobility (F9; III Level of Independence) ($M = 17.1$, $SD = 0.59$ and $M = 14.12$, $SD = 1.11$, accordingly), $t = 3.21$, $p < .05$, Physical Safety and Protection (F16) ($M = 15.5$, $SD = 0.54$ and $M = 12.43$, $SD = 0.73$, accordingly), $t = 3.39$, $p < .05$, Medical and Social Aid (F19; V Environment) ($M = 14.5$, $SD = 0.50$ and $M = 12.36$, $SD = 0.73$, accordingly), $t = 2.75$, $p < .05$, and Spirituality/Religion/Personal Values (F24; VI Spiritual Sphere) ($M = 16.03$, $SD = 0.48$ and $M = 13.0$, $SD = 0.90$, accordingly), $t = 4.12$, $p < .05$.

The Use of Humor

Using Silver's (2002) guidelines for scoring humor in participant responses to the SDT, DAS, and specifically the Drawing from Imagination task, we found high percentages of expressions of humor pre- and post-treatment (ranging from 38% to 45%) in both the experimental and the control groups. This frequency of humorous responses was significantly greater than Silver's (2002) findings from a U.S. sample. Silver identified humorous responses in 9% of drawings from children (aged 9–12 years), 19% of drawings and stories from adolescents (aged 13–19 years), 21% of drawings and stories from adults (aged 20–65 years) and 19% of drawings and stories from older adults (65 years and older). The average percentage of responses in the Drawing from Imagination task that were considered humorous responses was only 18% in her study.

According to Silver (2002), men in her sample produced more humorous responses than women (24% and 13%, accordingly) and this gender difference was highly significant (chi-square = 37.3, $p < .01$). In addition, men tended to produce more negative humor than women. For comparison, the percentages of different kinds of humor in the Drawing from Imagination task for both groups in our study are shown in Table 3.

Our results, thus, support the second hypothesis that humor may be an important personal characteristic of war veterans and of a particular "male culture" based on the high frequency (38% to 45%) of humorous responses on the Silver drawing assessment tasks. Although the number of humorous responses increased throughout the course of treatment in both groups (with a more considerable increase in the art therapy group), the difference between pre-test and post-test rates in both groups and between groups was insignificant ($p > .05$) according to the chi-square criterion. Thus, the correlation between humorous responses and overall therapeutic dynamics seems to be not as strong and needs further clarification.

As for the presence of different types of humor, ambivalent or ambiguous humor was most common (from 11% to 17%), whereas lethal, morbid humor was least common (from 0 to 3%). These kinds of humor also differed in frequency when compared to Silver's (2002) U.S. study. Silver reported that disparaging and self-disparaging humor were most common in her sample of adults (aged 20–65 years), and that the expression of playful humor was also comparatively common (ranging from 4% to 6%). When averaging the total of all humorous responses, she found that negative humor prevailed over positive humor (68% versus 24%, respectively). This tendency was not observed to the same degree in our study. When averaging all humorous responses, we found only 24% to 27% were negative as compared to 34% to 44% that were positive, depending on the group and stage of treatment.

Table 3 Kinds of Humor in Pre- and Post-Treatment Responses to Drawing From Imagination Task

Kinds of Humor (Humor Scale Score)	Group 1 ($n = 62$)		Group 2 ($n = 50$)	
	Pre	Post	Pre	Post
Lethal and morbid (1 point)	2	3	1	0
Lethal but not morbid (1.5 points)	5	7	6	5
Disparaging (2 points)	6	4	4	5
Self-disparaging (2.5 points)	5	6	3	5
Ambivalent or ambiguous (3 points)	11	14	15	17
Resilient, moderately positive (4 points)	4	5	7	7
Playful, strongly positive (5 points)	5	6	5	4
Total (all kinds)	38	45	41	43

Examples of Humorous Responses

One example of lethal but not morbid humor (receiving a score of 1.5 points on the Humor scale) can be seen in a drawing entitled *Big Mishap* depicting a cat encountering a snake (Figure 1). This drawing was created by a 38-year-old war veteran. For the story response, he related, "Why did the cat go for a walk? It would be better for her just to sleep on a windowsill." The drawing received a score of 3 on the Self-Image scale, as suggested by the respondent's identification with a snake, and a score of 2 on Emotional Content, due to the suggestion of a hostile relationship depicted.

As for disparaging humor, one example is a drawing entitled *Surprise* (Figure 2), created by a war veteran aged 45. He related, "The cat was pursuing the mouse and drove it into forest. Suddenly the dinosaur appeared in front of the cat. It was afraid and decided that it cannot catch the mouse and must run away." This response was scored 2 points for humor, 3 points for self-image as indicated by the

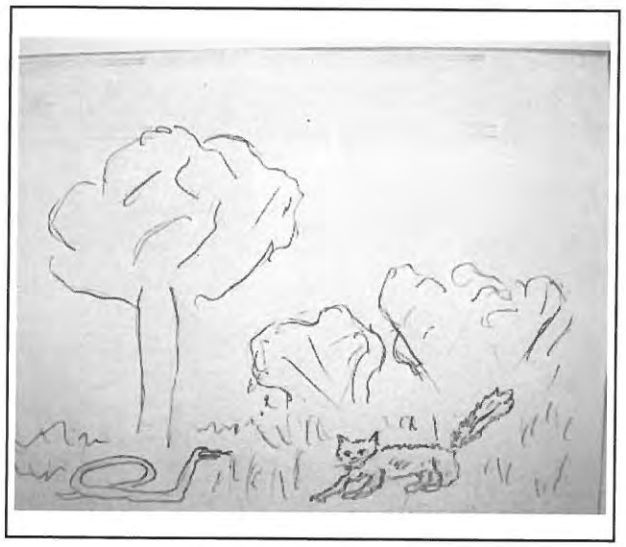


Figure 1 *Big Mishap*

respondent's identification with the dinosaur, and 1 point for emotional content for the depiction of an apparently assaultive relationship.

Figure 3 is an example of self-disparaging humor, created by a war veteran aged 42, who titled it *Unsuccessful Jumps*. He related, "Once a parachutist landed on a haystack and nearly killed my cat. Later he landed on a house and tipped over a plate with milk. I don't want to tolerate him anymore." The drawing was scored 2.5 points for humor, and 2 points for self-image as the respondent seems to identify with a frustrated owner of the house. Emotional content

Figure 3 *Unsuccessful Jumps*

received a score of 2 points for the depiction of an apparently stressful relationship.

Ambiguous humor (score of 3 points) is seen in Figure 4, which was created by a war veteran aged 35, who entitled it *Married by Love*. He told this story about it: "A young commando's wife was very jealous. She pursued

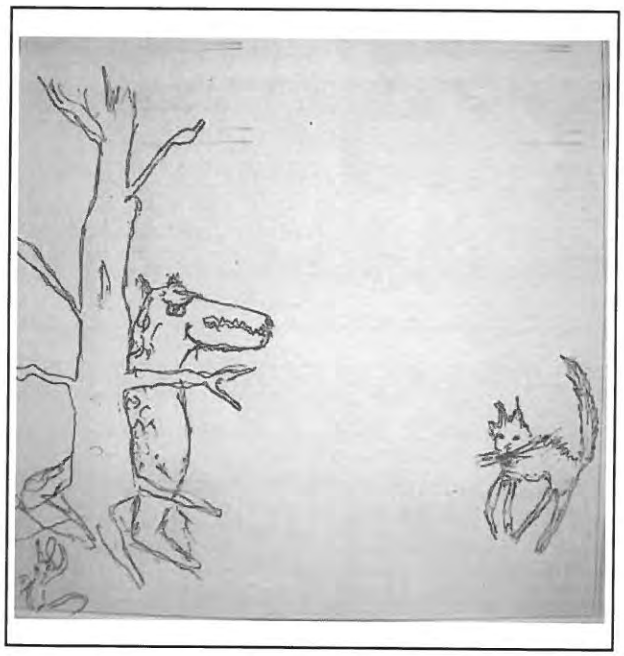


Figure 2 *Surprise*

Figure 4 *Married by Love*

Figure 5 *Serious Talk*

him even during his parachute jumps." The response received a score of 3 points for self-image due to the respondent seeming to identify with the narrator, and 3 points for emotional content that depicts an apparently ambiguous relationship.

Finally, Figure 5, entitled *Serious Talk* by a war veteran aged 43, scored 5 points for playful humor. His story was simply the statement "meeting friends and discussing life matters." The respondent seems to identify with one of the animals in the drawing, which received a score of 5 points for both self-image and emotional content that depicts a friendly and happy subject.

Relationship of Humor to Cognitive and Creative Resources

In order to explore the relationship between the presence of humor in the drawings and the participants' creative and cognitive abilities, we compared a subset of 50 participant drawings having humorous responses with 50 participant drawings having non-humorous responses and calculated mean scores on the Ability to Represent scale (Silver, 2002) in both subsets. The mean score for the humorous set was 4.79 points ($SD = .08$), whereas the mean score in the non-humorous set was 4.32 ($SD = .11$). Comparison of mean scores with the t test showed significant difference, $t = 3.64$, $p < .05$. This suggests that a connection exists between the SDT and DAS Drawing from Imagination humorous responses and the participants' creative and cognitive abilities. Therefore our third hypothesis, that humor serves as one of the therapeutic factors linked to creative and cognitive resources, was confirmed.

Discussion

Throughout the course of group art therapy, we observed that certain patients demonstrated a sense of humor on a regular basis. Humorous responses in various creative tasks seemed to be more reflective of the patients' personal characteristics than the stage of group therapy process. Our conclusion is that art therapy does not necessarily develop one's sense of humor as much as it enables a considerable number of war veterans to more freely express humor in their art and verbal communications during sessions.

Various manifestations of humor were connected to certain degrees to group dynamics and the group culture that developed in art therapy. We found that the group culture of these war veterans typically induced and supported the expression of humor, which served as an element of the patients' self-identification. Humorous responses were observable in SDT and DAS tasks as well as in many other creative activities in art therapy.

Humorous responses not only seemed to characterize the group culture and emotional sphere of the participants but also their cognition as well. Both emotions and cognitive processes are involved in processing and integrating information, and personal experience in particular, when image formation takes place. Our findings support Newman's assertion (as cited in Clay, 1997) that people may use humor to cope with stress and that humor may foster cognitive restructuring of complex information. Jakab (1998) also emphasized, "it requires adequate intellectual capacity and the flexibility of thought to understand and to produce humor" (p. 18).

The high frequency of participant humor in our study provokes several questions. We note that the sample was comprised of comparatively young men who primarily presented with nonpsychotic stress-related disorders. To what a degree does the frequency of humor in their responses reflect social-demographic, cultural, and clinical characteristics? Are such humorous responses typical for members of the military, perhaps indicative of a need for certain strategies and defenses to cope with high stress?

It is possible that the participants' frequent use of humor is connected to the high resistance many patients have to art therapy. Most of these war veterans reported that they considered art therapy to be a "childish" activity or that by participating they were "doing nothing." Many thought that expressing their emotions and problems, especially through art, was "not men's business." In this situation humor could be deployed to exert a heightened self-control while at the same time enabling a more secure emotional self-expression in the group. This interpretation aligns with Jakab's (1998) assertion that "the patient's humor in therapy may be a sign of desiring emotional control of the therapy without too much open aggression" (p. 19). Humor in therapy also may be a sign of high cognitive activity and resistance to regressive states (Jakab, 1998).

The specific nature of the mental disorders that prevailed in our sample of war veterans also should be taken into account. For instance, in some clinical syndromes, an escape from traumatic material is a characteristic feature.

Pessimism, lack of trust, interpersonal distance, sensitivity to emotional stress, high levels of anxiety, depression, and aggression can also explain the patients' difficulties in openly expressing their emotions as well as their disposition toward veiling such difficulties with humor and irony.

One of the limitations of the study was that patients with more severe stress-related conditions, such as posttraumatic stress disorder, were absent both in Group 1 and Group 2 because few of them were hospitalized in the department over the course of study. This category of patients in particular should be studied further regarding art therapy efficacy and the role of humor in their treatment. Possible bias in how the drawings in this study were scored, given that there was no test-retest analysis and no interrater measure, also should be taken into account. Finally, the sample in Silver's (2002) study, which we used as a basis for comparison for our results, did not include war veterans and was not normative. Therefore, the high percentage of humorous responses in drawings of war veterans in our study should be further compared with those obtained in other populations. Cultural factors as they may impact humorous responses should be further studied as well.

Conclusion

Results of the study indicate that, when used as a brief intervention, group art therapy may exert a positive influence on war veterans and particularly on their symptomatic status, personality functioning, cognitive abilities and creativity, and quality of life. Although these positive effects also were observed in the control group, they were less evident than in the experimental group. Scores on the DAS and SDT for emotional content, self-image, and cognition significantly increased for the experimental group after one month of art therapy; such increases were absent in the control group. These findings support the idea that image formation and artistic activity serve important roles in developing capacity for cognitive and creative problem solving and improved self-esteem (Calvin, 1996; Horowitz, 1983; Solso, 1994).

The study findings also showed very high rates of humorous responses in both groups before and after treatment, with considerable increase in such responses in the art therapy group. Humor appeared far more frequently in drawing task responses in this study than was reported by Silver (2002) in her U.S. study involving males and females of different ages. We suggest that humor is an important personal characteristic of war veterans and may be reflective of the "male culture" to which these individuals subscribe.

Finally, by comparing subsets of participants' humorous and non-humorous responses in the drawing measures, we found a significant difference between the experimental group and the control group, which is indicative of the connection between humorous responses and the participants' creative and cognitive abilities. Therefore we conclude that humor serves as one of the therapeutic factors linked to creative and cognitive resources for war veterans.

References

Apchel, V. Y., & Tsygan, V. N. (1999). *Stryess i stryessooostoychivostj chyelovyeka* [Stress and coping with stress]. St. Petersburg, Russia: Peter.

Bespalko, I. G. (2004). *Shkala dlya psikhologichyeskoy ekspryess-diagnostiki slabostrooktoorirovannikh dyepryessivnikh rasstroystv: Posobiye dlya vrachyey i psikhologov* [The scale for quick psychological measurement of unstructured depressive disorders: The manual for doctors and psychologists]. St. Petersburg, Russia: Psychoneurological Research Institute.

Bizyuk, A. P., Wasserman, L. I., & Iovlev, B. V. (2005). *Primyenyeniye intyegrativnogo tyesta tryevoznosti (ITT): Myetodichyeskiye ryekomyendatzii* [The use of Integrative Anxiety Test (ITT): The manual]. St. Petersburg, Russia: Psychoneurological Research Institute.

Bruner, J. S., Olver, R. R., & Greenfield, P. M. (Eds.). (1966). *Studies in cognitive growth*. New York, NY: Wiley.

Burkovskij, G. V., Kotsubinskij, A. P., Levchenko, E. V., & Lomachenkov, A. S. (1998). *Ispoljzovaniye oprosnika kachyestvazizni (vyersiya VOZ) v psikhiatrichyeskoy praktikye (posobiye dlya vrachyey i psikhologov)* [The use of the Questionnaire of Quality of Life (World Health Organization) in psychiatric practice: The manual for doctors and psychologists]. St. Petersburg, Russia: Psychoneurological Research Institute.

Calvin, W. H. (1996). *How brains think: Evolving intelligence, then and now*. New York, NY: Basic Books.

Clay, R. A. (1997). Researchers harness the power of humor. *Monitor on Psychology, 28*(9), 1–8.

Derogatis, L. R. (1983). *The Symptomatic Checklists (SCL-90-R) administration, scoring and procedures manual-II*. Towson, MD: Clinical Psychometric Research.

Doskin, V.A., Lavrenteva, N. A., Miroshnikov, M. P., & Sharay, V. B. (1973). Tyest diffyeryentzialjnoy samootzyenki foonktzionaljnogo sostoyaniya [Test for differential self-measuring of the functional state]. *Voprosy Psihologii, 6*, 141–145.

Eric, L. (1998). Humor in the struggle against a totalitarian regime. In G. Roux & M. Laharie (Eds.), *L'humour: Histoire, culture et psychologie* [Humor: History, culture, and psychology] (pp. 123–126). Paris, France: Société Internationale de Psychothérapie de l'Expression et d'Art-Thérapie.

Fabian, E. (1998). Concretism and identity aspects in the Jewish joke. In G. Roux & M. Laharie (Eds.), *L'humour: Histoire, culture et psychologie* [Humor: History, culture, and psychology] (pp. 97–100). Paris, France: Société Internationale de Psychothérapie de l'Expression et d'Art-Thérapie.

Foa, E. B., Keane, T. M., & Friedman, M. J. (Eds.). (2004). *Effective therapy of PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.

Goldner, E. M., & Bilsker, D. (1995). Evidence-based psychiatry. *Canadian Journal of Psychiatry, 40*(2), 97–101.

Golub, D. (1984). Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. *The Arts in Psychotherapy, 12,* 285–296.

Haeseler, M. P. (1998). Crossing the border: Cultural implications of entering a new art therapy workplace. In A. R. Hiscox & A. C. Calisch (Eds.), *Tapestry of cultural issues in art therapy* (pp. 327–346). London, England: Jessica Kingsley.

Horowitz, M. J. (1983). *Image formation and psychotherapy.* New York, NY: Jason Aronson.

Jakab, I. (1998). Humor and psychoanalysis. In G. Roux & M Laharie (Eds.), *L'humour: Histoire, culture et psychologie* [Humor: History, culture, and psychology] (pp. 15–22). Paris, France: Société Internationale de Psychothérapie de l'Expression et d'Art-Thérapie.

Kolov, S. A., Ostapenko, A. V., & Krivtsov, A. G. (2005). Psikhologichyeskiye isslyedovaniya pri posttravmatichyeskom stryessovom rasstroystvye [Psychological study of the posttraumatic stress disorder]. *Vyestnik Psikhotyerapii, 13,* 23–35.

Kuyken, W., Orley, J., Hudelson, P., & Sartorius, N. (1994). Quality of life assessment across cultures. *International Journal of Mental Health, 23*(2), 5–27.

Lebedev, A. (2006). Primyenyeniye grooppovoy intyeraktivnoy art-tyerapii v psikhotyerapyevtichyeskom otdyelyenii gospitalya vyetyeranov voyn [The use of group interactive art therapy in the psychotherapy department of the hospital of war veterans]. In A. Kopytin (Ed.), *Praktichyeskaya art-tyerapiya: Lyechyeniye, ryeabilitatziya, tryening* [Practical art therapy: Treatment, rehabilitation, training] (pp. 105–132). Moscow, Russia: Cogito-Centre.

Mango, C. R., & Richman, J. (1990). Humor and art therapy. *American Journal of Art Therapy, 28*(4), 111–114.

Nagy, J. (1998). Anxiety, depression and humor. In G. Roux & M Laharie (Eds.), *L'humour: Histoire, culture et psychologie* [Humor: History, culture, and psychology] (pp. 255–257). Paris, France: Société Internationale de Psychothérapie de l'Expression et d'Art-Thérapie.

Piaget, J., & Inhelder, B. (1967). *The child's conception of space.* New York, NY: Norton.

Roux, G., & Laharie, M. (Eds.). (1998). *L'humour: Histoire, culture et psychologie* [Humor: History, culture, and psychology]. Paris, France: Société Internationale de Psychothérapie de l'Expression et d'Art-Thérapie.

Silver, R. (2002). *Three art assessments: The Silver Drawing Test of cognition and emotion; Draw A Story: screening for depression; and stimulus drawings and techniques.* New York, NY: Brunner-Routledge.

Silver, R. (2007). *The Silver Drawing Test and Draw A Story: Assessing depression, aggression, and cognitive skills* (2nd ed.). New York, NY: Routledge.

Silver, R. (2010). *Identifying risks for aggression and depression through metaphors: The mouse, the bride and the use of humor.* Dewitt, NY: Purple Finch Press.

Solso, R. L. (1994). *Cognition and the visual arts.* Cambridge, MA: Massachusetts Institute of Technology Press.

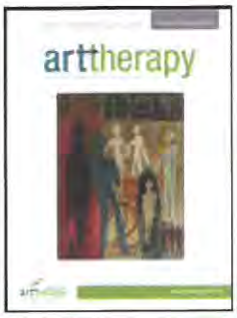
Verdeau-Pailles, J. (1998). L'humour en psychiatrie et en psychopathologie [Humor in psychiatry and psychopathology]. In G. Roux & M. Laharie (Eds.), *L'humour: Histoire, culture et psychologie* [Humor: History, culture, and psychology] (pp. 31–41). Paris, France: Société Internationale de Psychothérapie de l'Expression et d'Art-Thérapie.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* Geneva, Switzerland: Author.

World Health Organization Group. (1998). The World Health Organization quality of life assessment (WHOQOL): Development and general psychometric properties. *Social Science and Medicine, 46*(12), 1569–1589. doi:10.1016/S0277-9536(98)00009-4

Zeki, S. (1999). *Inner vision: An exploration of art and the brain.* Oxford, England: Oxford University Press.

Ziv, A. (1984). *Personality and sense of humor.* New York, NY: Springer.



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Effect of Art Production on Negative Mood and Anxiety for Adults in Treatment for Substance Abuse

Mattye Laurer and Renée van der Vennet

Abstract

This study investigated whether art production or viewing and sorting art reproductions would be more effective in reducing negative mood and anxiety for 28 adults with substance use disorders. Participants were randomly assigned to one of two groups and completed pre- and posttest measures of negative mood and anxiety The hypothesis that art production would have a greater reduction in negative mood and anxiety was initially supported by the mean scores and t-test analyses; however, it was not supported by two of three ANOVAs, which indicated that time over treatment made a difference rather than the intervention.

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 22.2 million people in the United States have substance abuse or dependence diagnoses (SAMHSA, 2009). This number has been stable from 2002 through 2008 (SAMHSA, 2009). In 2008, of these 22.2 million people, only 2.3 million obtained treatment (SAMHSA, 2009). Approximately 20 million people in the United States have a diagnosable substance abuse or dependence problem and have not received treatment (SAMHSA, 2009). Mark et al. (2008) estimated the cost of mental health and substance abuse in the United States for the year 2003 to be over $121 billion for all age groups. Of that total, $21 billion was spent on substance abuse treatment.

For clients with substance use disorders, the probability of relapse increases for those who also have psychiatric problems (Carroll, Power, Bryant, & Rounsaville, 1993). Mood and anxiety disorders are two common comorbid diagnoses for clients with substance use disorders (Carroll et al., 1993; Doughty & Hunt, 1991; Ellason, Ross, Sainton, & Mayran, 1996). There is a relationship between coping styles, substance abuse, and mood and anxiety disorders (Franken, Hendriks, Haffmans, & van der Meer, 2001). The more adaptive the coping style, the better the client will deal with stress and negative emotions and the less likely they will abuse substances (Franken et al., 2001). Thus, mood and anxiety symptoms affect clients with substance use disorders in treatment. Franken et al. (2001) investigated the effects of mood and anxiety disorders on changes in coping styles of clients with substance abuse receiving cognitive behavioral therapy and found that the mood disorder had no effect on changes in coping styles. The anxiety disorder had a negative effect on improvement of coping style. Franken et al. recommended that to improve coping, more focus is needed on treating the anxiety disorders for these individuals.

Psychotherapy is noted to be an important aspect of a combination of effective interventions for comorbid treatment for substance use disorders (Kelly, Daley, & Douaihy, 2012). Specific effective psychotherapy interventions include cognitive behavioral treatment and motivational interviewing (Kelly et al., 2012). Because mood and anxiety symptoms affect clients with substance use disorders in treatment, Franken et al. (2001) recommended more focus on treating anxiety for this population.

There is little in the literature on art therapy and substance abuse that addresses reducing anxiety and negative mood. Much of what literature exists is qualitative and relates to the benefits of art therapy for this population. It focuses on models and protocols applied to treatment programs (Allen, 1985; Feen-Calligan, 1995; Holt & Kaiser, 2009; Horay, 2006; Johnson, 1990; Matto, Corcoran, & Fassler, 2003) as well as the use of specific techniques (Cox & Price, 1990; Hanes, 2007). For example, Holt and Kaiser (2009) and Horay (2006) discussed the use of art therapy protocols based on motivational interviewing grounded in the stages-of-change model. The protocols target the clients' issues of denial and defenses in accepting that they have a problem and need to change. Holt and Kaiser (2009) provided examples of five art therapy directives that illustrate their First Step Series protocol. Horay (2006) presented a case example of how individual art therapy works at building a therapeutic alliance with a specific client and encourages self-efficacy to affect change.

Although the literature describes how art therapy can be effective when working with clients with substance abuse, the research is sparse. Quantitative art therapy research in this area is limited to the study of artwork. Dickman, Dunn, and Wolf (1996) and Francis, Kaiser, and Deaver (2003) evaluated artwork of those with substance

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abuse disorders to determine if there were specific drawing indicators characteristic of these clients. Taylor, Kymissis, and Pressman (1998) studied adolescents Projective Kinetic Family Drawings and concluded these drawings assisted the therapist in providing treatment because they helped in understanding a client's feelings, perceptions, relationships, and fears.

Julliard (1994) used a single subject, multiple measure A–B design and interviews to look at the effects of art therapy interventions on participants' belief in Step One of the Twelve Steps. The art therapy interventions involved multimedia collage and role-playing. He concluded that the art therapy intervention used along with role-play affected clients' belief in Step One. Unfortunately, the size of the sample he studied was quite small ($N = 6$).

It is a common assumption that the production of art can have stress-reducing or relaxing effects (Kramer, 1971, 1973; Rubin, 1999). In a Delphi study, outcome research testing the effectiveness of art therapy was found to be the most important area of research needed in art therapy (Kaiser & Deaver, 2013). Various studies support the use of creating art to reduce anxiety (e.g., Bell & Robbins, 2007; Sandmire, Gorham, Rankin, & Grimm, 2012). This basic claim was supported by one randomized controlled trial by Bell and Robbins (2007), who measured changes in mood and anxiety of college students using the Profile of Mood States (POMS; McNair, Lorr, & Droppleman, 1971) and the State-Trait Anxiety Inventory (STAI; Spielberger, 1983). Their study tested whether the production of art reduces negative mood and anxiety more than the exposure to art. Bell and Robbins (2007) stated, "People commonly associate the viewing of art with relaxation and stress-relief" (p. 72). Their results supported the hypothesis that the production of art does reduce negative mood and anxiety more than viewing art.

The purpose of our study was to extend the research by Bell and Robbins (2007) in order to provide more empirical data on the effectiveness of art therapy with a population that displays clinically significant symptoms and impairment: adults with substance use disorders. In addition, because mood and anxiety symptoms affect clients with substance use disorders in treatment and Franken et al. (2001) recommended an increased focus on treating anxiety in treatment for this population, we decided to explore art interventions and their effect on mood and anxiety symptoms for this population, compared to a control intervention. The hypothesis we tested was that art production would result in a greater reduction in negative mood states and anxiety than viewing and sorting art.

Method

Participants

Participants were 28 adults (11 women and 17 men) who were diagnosed with an Axis I substance abuse or dependence disorder and were receiving outpatient treatment. Individuals known to have mood-related disorders were excluded. Participant ages ranged from 18 to 54 years ($M = 30.5$, $SD = 10.0$); 25 (89%) identified as White and 3 (11%) as African American.

Procedures

The college Institutional Review Board and the chemical dependency center study site approved the study. Participants were recruited through their primary therapists and assigned to conditions without regard to prior experience with art therapy or training in art. Two groups viewed and sorted art (Group View) and served as the control groups. Two experimental groups produced art (Group Produce). There were two groups in each category because the treatment provided at the center was in gender-specific groups. By having two groups in the control and experimental categories, we were able to have both women and men participate. We randomly assigned two groups as experimental and two as control by flipping a coin. There were 14 total participants in the two groups that viewed art, one group of men and one of women, and the same configuration in the groups that made art.

All study processes took place in two sessions in the respective groups. In an initial meeting, the participants completed consent forms. On the day of the study, one week later, participants completed the demographic form, wrote a 10-item to-do list of their most pressing concerns or worries, and then completed two standardized mood assessments: the Profile of Mood States (McNair et al., 1971) and the State-Trait Anxiety Inventory (Spielberger, 1983). Participants were told that the to-do list was for their private use and that it would not be collected at the end of the study. The purpose of the to-do list was to produce a baseline level of mild negative mood and anxiety against which the study manipulations could be assessed.

The participants in the experimental groups, Group Produce, were given 20 minutes to complete a free art task. All individuals were given blank sheets of 8.5″ × 11″ off-white paper and their choice of colored pencils, charcoal pencils, oil pastels, chalk pastels, or watercolor paint. They were asked to draw whatever they liked using as many sheets of paper as they desired during the 20 minutes.

The participants in the control groups, Group View, viewed and sorted sixty classical art prints, which depict famous paintings. Participants were asked to view the prints and then categorize them into groups based on their perceptions of the pictorial content. The intention was to create a condition in which participants were viewing art rather than producing it with a similar level of freedom to approach the task at their own pace and to make whatever judgments they chose. The individuals were asked to sort the prints rather than simply view them for two reasons. The first was to verify that they were actually looking at the prints as instructed; compliance in Group Produce was easily verifiable by the presence of a drawing at the end of 20 minutes. Secondly, it was important that the control group experienced a time-limited task to match the task demands placed on Group Produce.

Following the interventions, participants again completed the POMS and STAI assessments. Then they were

asked to make a list of their ten happiest or most favorable memories in order to reduce anxiety that may have resulted from completing the to-do list. A verbal and written debriefing was provided and participants received a list of resources that could be used if any adverse psychological reactions occurred. They were also directed to their primary therapist if they felt it necessary.

Instruments

The Profile of Mood States (McNair et al., 1971) and the State-Trait Anxiety Inventory (Spielberger, 1983) were used to replicate Bell and Robbins's (2007) protocol. Both are commonly used to assess mood and anxiety in experimental settings, have demonstrated validity and reliability, and can be easily self-administered (Bowling, 2001; McNair & Heuchert, 2005; Spielberger, 1983).

The POMS is used to assess changes in mood states, especially in the short term (Bowling, 2001; McNair & Heuchert, 2005). It has been used to assess mood for those who abuse substances (Howland et al., 2010; Karlsgodt, Lukas, & Elman, 2003; Lex, Griffin, Mello, & Mendelson, 1989). The POMS is a 65-question inventory that measures mood with a list of adjectives that are grouped into six subscales: tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia, and confusion-bewilderment (McNair et al., 1971). Each adjective is rated with a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). Internal consistency reliabilities for the mood subscales are reported to be near .90 or higher (McNair & Heuchert, 2005). Test–retest reliabilities range from .43 to .53 for the six subscales. Such low test–retest reliabilities are expected for mood states that fluctuate over time. Validity studies have been conducted on a variety of populations, specifically for substance use (McMahon & Davidson, 2003; McNair & Heuchert, 2005).

The STAI was developed to measure anxiety in two forms (Spielberger, 1983). State anxiety measures transitory feelings of fear and worry and trait anxiety measures the stable tendency of responding to anxious or stressful situations. The STAI consists of 40 items; 20 measure state anxiety (S-Anxiety) and 20 measure trait anxiety (T-Anxiety). Each state anxiety question is rated on a 4-point Likert scale ranging from *not at all* to *very much so*. The scores for each scale range from 20 to 80, with higher scores indicating higher anxiety. Construct validity has been determined for measuring the anxiety of clients who misuse alcohol (Donham, Ludenia, Sands, & Holzer, 1984). Internal consistency reliability for state and trait anxiety are $r = .93$ and $r = .90$, respectively (Bowling, 2001). Test–retest reliabilities over 104 days for college students range from .31 to .33 and .73 to .77 for the state and trait anxiety, respectively (Spielberger, 1983). The test–retest reliability results for state anxiety reflect that it should fluctuate over time.

Results

Data were analyzed using SPSS and Excel. Table 1 summarizes the mean scores and standard deviations for the pre- and posttest results of all three measures by condition. Paired sample t tests were used to test significance (Table 2). Then 2×2 ANOVAs were calculated to examine the effects of time (pre- and posttest) and group (Produce and View) on scores (Table 3). Finally, Cohen's d was used to calculate effect size. The alpha level of .05 was used for all statistical tests.

Table 2 summarizes the results of the paired sample t tests to compare the mean pre- and posttest scores. For Group Produce the POMS pre- and posttest mean scores were 28.4 ($SD = 35.9$) and 13.6 ($SD = 23.4$), respectively. A significant decrease from pre- to posttest was found, $t(13) = 2.5$, $p < .05$. For Group Produce the S-Anxiety pre- and posttest mean scores were 38.8 ($SD = 12.9$) and 33.9 ($SD = 9.7$), respectively. A significant decrease from pre- to posttest was found, $t(13) = 2.6$, $p < .05$. Lastly, Group Produce's T-Anxiety pre- and posttest mean scores were 44.1($SD = 11.4$) and 40.0 ($SD = 11.4$), respectively. A significant decrease from pre- to posttest was found, $t(13) = 3.2$, $p < .05$. The paired sample t-test results were significant for producing art. Producing art reduced negative mood and state and trait anxiety.

A paired sample t test was calculated to compare the pre- and posttest mean scores of Group View. The POMS pre- and posttest mean scores were 47.7 ($SD = 45.8$) and 36.4 ($SD = 39.9$), respectively. A significant decrease from pre- to posttest was not found, $t(13) = 1.1$, $p > .05$. For

Table 1. Descriptive Statistics for the POMS and STAI

Group	Measure	Time 1		Time 2	
		M	*SD*	*M*	*SD*
Group Produce ($n = 14$)					
	POMS	28.4	35.9	13.6	23.4
	STAI: State	38.8	12.9	33.9	9.7
	STAI: Trait	44.1	11.4	40.0	11.2
Group View ($n = 14$)					
	POMS	47.7	45.8	36.4	39.9
	STAI: State	43.8	17.2	43.4	14.8
	STAI: Trait	47.4	13.1	47.9	12.4

Table 2. Paired Sample *t*-Test Results ($N = 28$)

Measure	*t*	*df*	*p*	95% *CI*	
				LL	*UL*
Group Produce					
POMS	2.5	13	0.024*	2.2	27.2
STAI: State	2.6	13	0.024*	0.7	9.1
STAI: Trait	3.2	13	0.008*	1.2	6.8
Group View					
POMS	1.1	13	0.259	−9.4	32.1
STAI: State	0.2	13	0.829	−3.7	4.6
STAI:Trait	−0.4	13	0.674	−3.0	2.0

Note. *CI* = confidence interval; *df* = degrees of freedom; *LL* = lower limit; *UL* = upper limit.
*$p < .05$, two-tailed.

Group View the S-Anxiety pre- and posttest mean scores were 43.8 ($SD = 17.2$) and 43.4 ($SD = 14.8$), respectively. A significant decrease from pre- to posttest was not found, $t(13) = 0.2$, $p > .05$. Finally, Group View's T-Anxiety pre- and posttest mean scores were 47.4 ($SD = 13.1$) and 47.9 ($SD = 12.4$), respectively. A significant decrease from pre- to posttest was not found, $t(13) = -0.4$, $p > .05$. The paired sample *t*-test results were not significant for viewing and sorting art. Decreased mood and state and trait anxiety were not significant for viewing and sorting art.

As seen in Table 1, Group Produce appeared to exhibit a greater reduction in negative mood on all three measures. In each case Group Produce demonstrated a substantial decrease in negative mood score, whereas Group View showed lesser or minimal change. However, this impression was not fully supported by the ANOVAs (Table 3). In two out of the three measures there was not a significant Group × Time interaction (POMS: $F(1, 26) = 0.09$, $p > .05$; S-Anxiety: $F(1, 26) = 2.69$, $p > .05$). The only significant Group × Time interaction was for T-Anxiety, $F(1, 26) = 6.93$, $p < .05$. Therefore, due to the amount of insignificant interactions, we are unable to document a greater reduction in negative mood state and anxiety in the art production groups as compared to the art viewing groups as measured by POMS and S-Anxiety.

The two-factor ANOVA for the POMS revealed that the main effect for time was significant, $F(1, 26) = 5.39$, $p < .05$. The S-Anxiety ANOVA revealed that the main effect for time approached significance at $p = .061$.These findings indicated that time made a difference, not the intervention or group. The *t* tests and mean score results support this because they show significant decreases for Group Produce. Therefore, the POMS and S-Anxiety scores decreased due to the amount of time that elapsed between the pre- and posttest measures.

The T-Anxiety ANOVA revealed that the main effect for Group × Time was significant, $F(1, 26) = 6.93$,

Table 3. 2×2 ANOVA Results ($N = 28$)

Group	*df*	Mean square	*F*	Sig
POMS				
Time	1	2379.01	5.39	0.028*
Group × Time	1	39.45	0.09	0.767
Group	1	6195.02	2.67	0.115
STAI: State				
Time	1	100.45	3.82	0.061
Group × Time	1	70.87	2.69	0.113
Group	1	735.87	2.04	0.165
STAI: Trait				
Time	1	44.64	4.23	0.05*
Group × Time	1	73.14	6.93	0.014*
Group	1	281.04	1.59	0.219

*$p < .05$.

$p < .05$. Also, the main effect for time was significant, $F(1, 26) = 4.23$, $p < .05$. These findings indicate that the intervention, art production, did make a difference for each group, between groups, and the amount of time elapsed also effected mean scores. Both the *t*-test results and the mean score decreases support this finding for Group Produce. The three analyses show a greater reduction in negative mood states and anxiety in the art production group as compared to the art viewing group as measured by T-Anxiety.

Cohen's *d* was used to calculate the effect size for the posttest measurements of POMS, S-Anxiety, and T-Anxiety comparing Group Produce with Group View. The Cohen's *d* for POMS, S-Anxiety, and T-Anxiety were .697, .759, and .669, respectively. These values reflect a medium to large effect size, supporting the idea that the results are important (Cronk, 2012).

Discussion

We tested the hypothesis that art production of clients in treatment for substance abuse would produce a greater reduction in negative mood states and anxiety than viewing and sorting art. Paired sample *t* tests showed a reduction in all three measures for the groups producing art. They showed no significant reduction in negative mood for the groups merely viewing art. These results support our hypotheses. However, these results were not fully supported by additional ANOVA tests. We found one significant Group × Time interaction for trait anxiety, and saw a significant decrease in mean scores and significant *t*-test scores for the group producing art (POMS: $t(13) = 2.5$, $p < .05$; S-Anxiety: $t(13) = 2.6$, $p < .05$; T-Anxiety: $t(13) = 3.2$, $p < .05$), suggesting that creating art improved mood and reduced anxiety more than viewing art. Therefore, the question that remains is what caused the change in mean scores on the POMS and the S-Anxiety if it was not the main effect of Group × Time interaction?

The two-factor ANOVA for the POMS results revealed that the main effect for time was significant, $F(1, 26) = 5.39$, $p < .05$, and the ANOVA for S-Anxiety revealed that the main effect for time was not significant at $p = .061$. We conclude that even though those making art appeared to have a greater reduction in negative mood on the POMS and S-Anxiety, these reductions were not due to producing art. These reductions were due to the amount of time elapsed as supported by the POMS and S-Anxiety two-factor ANOVA.

The ANOVA results for trait anxiety revealed significant results for the main effects for Group × Time, as well as the effect for time. The group making art had a greater reduction in anxiety on the trait anxiety measure and according to the ANOVA this reduction can be attributed to the intervention of producing art. The reduction in anxiety due to the production of art has the potential to address Franken et al.'s (2001) directive to focus on anxiety interventions for this population and is consistent with Bell and Robbins's (2007) findings. Bell and Robbins's results demonstrated greater improvements in mood and decreases in anxiety for all three measures for individuals who were allowed to freely create art compared to those who viewed and sorted art prints.

There were some differences between the current study and the one by Bell and Robbins (2007) that may explain why our results diverged. These differences were sample size, the collection of data, and the nature of our clinical sample. Bell and Robbins had a sample of 50 participants whereas we had 28. Although we used the same analyses, the smaller sample size may have led to different results. However, the effect size (Cohen's *d*) that we calculated for the three measures ranged from .669 to .759 and this is considered a medium to large effect size (Cronk, 2012). This medium to large effect size suggests that the results for this small sample were significantly different between the experimental and control groups.

Another difference lies in how we used preexisting groups for data collection. Bell and Robbins (2007) collected data from 50 participants all at once. Participants in their control group and experimental group were in the same room at the same time and this may have impacted their results. The participants in our study were seen in four preexisting treatment groups where only one intervention occurred in a specific group at a specific time and these four groups were also gender-specific.

One important difference between the two studies is that ours was conducted with individuals with a clinical condition, that is, an Axis I substance-related diagnosis, whereas Bell and Robbins (2007) studied a convenience sample of college students. Therefore, their results did not directly speak to the use of art making with individuals with clinical conditions. This difference may have affected the research in a number of ways. The first is that Bell and Robbins concluded that viewing art would be considered relaxing and the act of sorting art prints could have been viewed as test-like in a way they had not intended. In our sample of individuals with an Axis I substance-related diagnosis, whose treatment to improve coping skills may be negatively influenced by anxiety (Franken et al., 2001), these assumptions may not have applied. Therefore, if the interventions in the control group were perceived as test-like procedures they could have induced more negative emotional states and anxiety.

The lack of greater reductions in negative mood and anxiety in our study suggests that the participants might not have had adequately high baseline levels of anxiety. Simply making a to-do list may not have been enough to create sufficiently high levels of negative mood and anxiety for the intervention to have had an effect. Perhaps making this kind of list to induce negative mood and anxiety was more appropriate for college students than for individuals in a substance abuse treatment center. The lack of Group × Time interactions may justify this concern. Judging by what was observed in the groups, in that participants responded to making the list with humorous comments, we think that there may be a need for a different manipulation that would have the potential to increase baseline levels of negative mood and

anxiety enough for a greater improvement to occur following the intervention.

We also excluded people with mood-related disorders from this study. While implementing the study, we found that there were participants at the treatment center with a comorbid mood-related disorder and could not be included because we excluded them. Mood disorders are common comorbid diagnoses for clients with substance use disorders (Carroll et al., 1993; Doughty & Hunt, 1991; Ellason et al., 1996). We were fortunate to have four groups of individuals available who were not diagnosed with mood-related disorders who could participate. However, after recognizing the number of individuals suffering from mood-related disorders at the center, it would not be surprising to learn that some of our participants had an underlying, undiagnosed mood disturbance that affected results.

To further test whether the production of art has anxiety reducing and therapeutic effects for clinical populations, we recommend that future studies replicate this study with a larger sample and varied populations. We also recommend including a survey of participants to explore whether the negative mood manipulation played a role in elevating baseline negative mood states and anxiety and to clarify whether the test-like qualities of viewing and sorting art escalated negative mood and anxiety. In addition, we recommend evaluating whether the to-do list induces a large enough increase in negative mood and anxiety for participants with clinical symptoms. Other ways of inducing higher negative mood states may need to be explored. We also wonder if the exclusion criterion for mood disorders is needed, especially because mood and anxiety disorders are two common comorbid diagnoses for clients with substance use disorders (Carroll et al., 1993; Doughty & Hunt, 1991; Ellason et al., 1996).

The purpose of this study was to test whether art production would result in a greater reduction in negative mood states and anxiety than viewing and sorting art for clients in treatment for substance abuse. The paired sample *t* tests provide promising evidence for increasing positive mood and reducing both trait and state anxiety for this clinical population producing art compared to viewing art. The ANOVAs showed some support that these results could be attributed to the production of art. The results of this study suggest that art making shows promise for reducing negative mood states and anxiety for clients struggling with substance abuse. More research needs to be done to demonstrate that the production of art has anxiety reducing and therapeutic effects for clients.

References

Allen, P. B. (1985). Integrating art therapy into an alcoholism treatment program. *American Journal of Art Therapy, 24*(1), 10–12.

Bell, C. E., & Robbins, S. J. (2007). Effect of art production on negative mood: A randomized, controlled trial. *Art Therapy: Journal of the American Art Therapy Association, 24*(2), 71–75. doi:10.1080/07421656.2007.10129589

Bowling, A. (2001). *Measuring disease* (2nd ed.). Philadelphia, PA: Open University Press.

Carroll, K. M., Power, M., Bryant, K. J., & Rounsaville, B. J. (1993). One-year follow-up status of treatment-seeking cocaine abusers: Psychopathology and dependence severity as predictors of outcome. *Journal of Nervous & Mental Disease, 181*(2), 71–79.

Cox, K., & Price, K. (1990). Breaking through: Incident Drawings with adolescent substance users. *The Arts in Psychotherapy, 17*, 333–337. doi:10.1016/0197-4556(90)90053-S

Cronk, B. C. (2012). *How to use SPSS: A step-by-step guide to analysis and interpretation* (7th ed.). Glendale, CA: Pyrczak Publishing.

Dickman, S. B., Dunn, J. E., & Wolf, A. W. (1996). The use of art therapy as a predictor of relapse in chemical dependency treatment. *Art Therapy: Journal of the American Art Therapy Association, 13*(4), 232–237.

Donham, G. W., Ludenia, K., Sands, M. M., & Holzer, P. D. (1984). Cross-validation of the State-Trait Anxiety Inventory with an alcoholic population. *Journal of Clinical Psychology, 40*(2), 629–631. doi:10.1002/1097-4679(198403)40:2<629::AID-JCLP2270400244>3.0.CO;2-A

Doughty, J. D., & Hunt, B. (1991). Counseling clients with dual disorders: Information for rehabilitation counselors. *Journal of Applied Rehabilitation Counseling, 30*(3), 3–10.

Ellason, J. W., Ross, C. A., Sainton, K., & Mayran, L. W. (1996). Axis I and II comormidity and childhood trauma history in chemical dependency. *Bulletin of the Menninger Clinic, 60*(1), 39–51.

Feen-Calligan, H. (1995). The use of art therapy in treatment programs to promote spiritual recovery from addiction. *Art Therapy: Journal of the American Art Therapy Association, 12*(1), 46–50.

Francis, D., Kaiser, D., & Deaver, S. P. (2003). Representations of attachment security in the Bird's Nest Drawings of clients with substance abuse disorders. *Art Therapy: Journal of the American Art Therapy Association, 20*(3), 125–137. doi:10.1080/07421656.2003.10129571

Franken, I. H. A., Hendriks, V. M., Haffmans, P. M. J., & van der Meer, C. W. (2001). Coping styles of substance-abuse patients: Effects of anxiety and mood disorders on coping change. *Journal of Clinical Psychology, 59*(10), 1125–1132. doi:10.1002/jclp.10205

Hanes, M. J. (2007). "Face-to-face" with addiction: The spontaneous production of self-portraits in art therapy. *Art Therapy: Journal of the American Art Therapy Association, 24*(1), 33–36. doi:10.1080/07421656.2007.10129365

Holt, E., & Kaiser, D. H. (2009). The First Step Series: Art therapy for early substance abuse treatment. *The Arts in Psychotherapy, 36*(4), 245–250. doi:10.1016/j.aip.2009.05.004

Horay, B. J. (2006). Moving towards the gray: Art therapy and ambivalence in substance abuse treatment. *Art Therapy: Journal of the American Art Therapy Association, 23*(1), 14–22. doi:10.1080/07421656.2006.10129528

Howland, J., Rohsenow, D. J., Greece, J. A., Littlefield, A. A., Almeida, A., Heeren, T., ... Hermos, J. (2010). The effect of binge drinking on college students' next-day academic test-taking performance and mood state. *Addictions, 105*, 655–665. doi:10.1111/j.1360-0443.2009.02880.x

Johnson, L. (1990). Creative therapies in the treatment of addictions: The art of transforming shame. *Arts in Psychotherapy, 17*(4), 299–308.

Julliard, K. (1994). Increasing chemically dependent patients' belief in Step One through expressive arts. *American Journal of Art Therapy, 33*(4), 110–119.

Kaiser, D., & Deaver, S. (2013). Establishing a research agenda for art therapy: A Delphi study. *Art Therapy: Journal of the American Art Therapy Association, 30*(3), 114–121. doi:10.1080/07421656.2013.819281

Karlsgodt, K. H., Lukas, S. E., & Elman, I. (2003). Psychosocial stress and the duration of cocaine use in non-treatment seeking individuals with cocaine dependence. *The American Journal of Drug and Alcohol Abuse, 29*(3), 539–551. doi:10.1081/ADA-120023457

Kelly, T. M., Daley, D. C., & Douaihy, A. B. (2012). Treatment of substance abusing patients with comormid psychiatric disorders. *Addictive Behaviors, 37*(1), 11–24. doi:10.1016/j.addbeh.2011.09.010

Kramer, E. (1971). *Art as therapy with children*. New York, NY: Schocken Books.

Kramer, E. (1973). *Art as therapy in a children's community*. Springfield, IL: Charles C Thomas.

Lex, B. W., Griffin, M. L., Mello, N. K., & Mendelson, J. H. (1989). Alcohol, marijuana, and mood states in young women. *International Journal of the Addictions, 24*(5), 405–424.

Mark, T. L., Harwood, H. J., McKusick, D. C., King, E. C., Vandivort-Warren, R., & Buck, J. A. (2008). Mental health and substance abuse spending by age, 2003. *Journal of Behavioral Health Science & Research, 34*(3), 279–289. doi:10.1007/s11414-008-9118-2

Matto, H., Corcoran, J., & Fassler, A. (2003). Integrating solution-focused and art therapies for substance abuse treatment. *The Arts in Psychotherapy, 30*(5), 265–272. doi:10.1016/j.aip.2003.08.003

McMahon, R. C., & Davidson, R. S. (2003). Patterns of stability and change in mood states of alcoholics in inpatient treatment. *International Journal of Addictions, 21*(8), 923–927.

McNair, D. M., & Heuchert, J. W. P. (2005). *Profile of Mood States: Technical update*. North Tonawanda, NY: Multi-Health Systems.

McNair, D. M., Lorr, M., & Droppleman, L. E. (1971). *The Profile of Mood States*. San Diego, CA: Educational and Industrial Testing Service.

Rubin, J. (1999). *Art therapy: An introduction*. Philadelphia, PA: Brunner/Mazel.

Sandmire, D. A., Gorham, S. R., Rankin, N. E., & Grimm, D. R. (2012). The influence of art making on anxiety: A pilot study. *Art Therapy: Journal of the American Art Therapy Association, 29*(2), 68–73. doi:10.1080/07421656.2012.683748

Spielberger, C. D. (1983). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Counseling Psychologists.

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 national survey on drug use and health: National findings* (NSDUH Series H-36, HHS Publication No. SMA 09-44340). Rockville, MD: Office of Applied Studies.

Taylor, S. A., Kymissis, P., & Pressman, M. (1998). Prospective Kinetic Family Drawings and adolescent mentally ill chemical abusers. *The Arts in Psychotherapy, 25*(2), 115–124. doi:10.1016/S0197-4556(97)00100-7

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Group art therapy with sexually abused girls

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The psychological impact of child sexual abuse has been widely researched. The purpose of this study was to evaluate a group art therapy intervention designed by the authors aimed at reducing depression, anxiety, sexual trauma and low self-esteem among 25 sexually abused girls aged 8–11 years. The programme was based on existential-humanistic, Gestalt, client-centred and abuse-focused principles. The Solomon four-group design was used to investigate the efficacy of the intervention, and the Trauma Symptom Checklist for Children and Human Figure Drawing were used as measures for assessing symptom change. The results indicated that the experimental groups improved significantly compared to the control groups with regard to anxiety and depression. The study adds to the literature on therapeutic approaches that can be applied to sexually abused children and on the use of group art therapy as an intervention technique.

Keywords: anxiety; art therapy; depression; group therapy; group art therapy; sexual abuse; South Africa

Child sexual abuse (CSA) is recognised as a traumatic experience that can have a number of adverse effects (Bohn, 2003; Diehl, 2002). Sexually abused children generally reveal significant problems in diverse areas of functioning including those of affect, behaviour, cognition and interpersonal relationships (Browne & Finkelhor, 1986; Freeman, Collier, & Parillo, 2002; Gardner, 2002; Mazza, 2003). Finkelhor and Browne (1986) developed a conceptual framework to organise the observed effects of CSA. They proposed an analysis of sexual abuse in terms of "four trauma-causing factors" labelled as the traumagenic dynamics (Finkelhor & Browne, 1986, p. 180). This umbrella term covers the concepts of traumatic sexualisation, stigmatisation, betrayal and powerlessness. Several psychological impacts and behavioural manifestations are associated with the four traumagenic dynamics. Psychological impacts include sexual pre-occupation, age-inappropriate sexual knowledge, depression, anxiety and feelings of isolation. Behavioural manifestations include recurring sexual behaviours, sexual aggression, self-destructive behaviours, and suicide (Finkelhor & Browne, 1986).

Sexually abused children have been found to suffer from anxiety, post-traumatic stress, guilt, depression and low self-esteem (Carr, 2000; Gardner, 2002; Wade, 2000). Common behavioural symptoms found include irritability, frequent soiling, nightmares, suicide attempts and confusion about sexual boundaries (Gardner, 2002; Mazza, 2003; Sacks, McKendrick, & Banks, 2008). Research suggests that children in South Africa are at high-risk for CSA. A recent meta-analysis on the prevalence of CSA revealed that South Africa appears to have the highest incidences of CSA globally (Pereda, Guilera, Forns, & Gómez-Benito, 2009). For example, Madu and Peltzer (2001) found that 60% of males (n = 193) and 53.2% of females (n = 216) in their sample of Grades 11 and 12 students in the Northern Province (Limpopo) reported some form of sexual abuse against them as a child. The South African Police Services Annual Report (2008) also indicates that there were approximately 16,000 reported cases of rape against children (children defined between 0–18) between 2007 and 2008. A need therefore exists for effective treatment in counselling children who have experienced CSA. The purpose of this study was accordingly to evaluate a group art therapy programme — developed by the authors — for sexually abused girls in South Africa.

PSYCHOTHERAPY

Many different interventions and treatment modalities are used when counselling children who have

experienced sexual abuse (Cohen, Mannarino, & Knudsen, 2005; Lev-Wiesel, 2008; see the National Crime Victims Research and Treatment Centre & Centre for Sexual Assault and Traumatic Stress (NSVRC), 2004, for an overview of the various intervention techniques). Although sound empirical evidence exists for the efficacy of a number of interventions, various other techniques are undocumented, have not received empirical evaluation or are not suitable for the treatment of CSA (Lev-Wiesel, 2008; NSVRC, 2004).

Treatment modalities used in CSA include individual, family and group therapies (Lev-Wiesel, 2008; Tourigny, Hébert, Daigneault, & Simoneau, 2005). Trauma-focused cognitive behavioural therapy (TF-CBT) has emerged as a highly effective and widely used treatment for CSA (Chaffin & Friedrich, 2004; Cohen & Mannarino, 2008; Cohen, Mannarino, & Deblinger, 2006; Lev-Wiesel, 2008). TF-CBT is an evidence-based treatment model that is designed to reduce the emotional and behavioural sequelae attributed to traumatic events (Cohen *et al.*, 2005; 2006; Lev-Wiesel, 2008). However, TF-CBT is not an optimal solution for children with problems unrelated to trauma thus necessitating participation in other evidence-based treatments (Cohen & Mannarino, 2008).

GROUP THERAPY AND ART THERAPY AS INTERVENTION

The literature indicates that group psychotherapy may be useful as a treatment modality for sexually abused children (Aldridge & Hastilow, 2001; Brown & Latimir, 2001; Buckland & Murphy, 2001). According to Killian and Brakarsh (2004), group therapy can ameliorate difficulties encountered in the use of individual therapies with sexually abused children, including an inherent distrust of adults, fear of intimacy with and disclosure to adults, secrecy and defensive behaviour (Killian & Brakarsh, 2004). Group therapy also offers children the opportunity to realise that they are not alone in their experiences and that other children have had similar experiences (Freyd, 2002; Murphy, 2001; Yalom, 1998). This realisation may be a great source of relief that helps reduce the sense of isolation (Gallo-Lopez, 2000; Killian & Brakarsh, 2004; Yalom, 1998).

Various studies have demonstrated the efficacy of art therapy with children (Carolan, 2001; Douglass, 2001; Gilroy, 2006; Snyder, 1997; Waller, 2006). Art therapy involves a holistic approach in that it not only addresses emotional and cognitive issues but also enhances social, physical and developmental growth (Carolan, 2001; Snyder, 1997). Art therapy appears to help with the immediate discharge of tension and simultaneously minimize anxiety levels (Dwivedi, 1993; Naitove, 1986). Dwivedi (1993) and Snyder (1997) contend that the act of external expression provides a means for dealing with difficult and negative life experiences. Art therapy, therefore, not only assists with tension reduction but also with working through issues thereby leading to greater understanding (Naitove, 1986).

Children may experience difficulties integrating the experience of abuse and processing it emotionally and cognitively due to their developmental immaturity (Ryan, 1996). Difficulties associated with the treatment of sexually abused children relate to their inability to verbalize their emotions and thoughts generated by the abuse (Zinni, 1997). Children also tend to feel overwhelmed and intimidated by the verbal expression of their experience (Killian & Brakarsh, 2004; Pifalo, 2002). Art therapy is consequently perceived as a successful alternative to conventional psychotherapy for this population group (Bissonnet, 2001; Case & Dalley, 1990; Murphy, 2001).

GROUP ART THERAPY

Although the combination of group and art therapy has not been widely researched, research results indicate the effectiveness of this type of intervention with sexually abused children (Brown & Latimir, 2001; Corder, Haizlip, & De Boer, 1990; Delson & Clark, 1981; Meekums, 1999; Murphy, 2001; Rust & Troupe, 1991). The combination of group and art therapy has the advantage of treating the 'whole' child, and, consequently, this intervention technique adopts a holistic approach whereby diverse levels of functioning can be dealt with (Crafford, 1985) besides answering the child's need for group interaction, thus addressing social aspects of functioning (Dwivedi, 1993; Killian &

Brakarsh, 2004). Group art therapy further acknowledges the concrete thinking style (Brainerd, 1978) of latency-aged children and accordingly provides an opportunity for non-verbal communication (Case & Dalley, 1990; Murphy, 2001). Contact with group members may also decrease sexual and abusive behaviours toward others (Naitove, 1986; Yalom, 1998).

AIM OF THE STUDY

The study aimed to evaluate a group art therapy programme — as developed by the authors — for sexually abused girls in respect to reducing depression, anxiety, sexual trauma and low self-esteem, by using the Solomon-four group design. In order to evaluate the effectiveness of the programme, the following four factors were explored.

1. Difference in pre- and post-test scores for the first experimental group (Group 1).
2. Differences in pre- and post-test scores for the first control group (Group 2).
3. Differences in pre- and post-test scores between the first experimental group (Group 1) and the first control group (Group 2).
4. Differences in post-test scores between all four groups.

METHOD

Participants

Purposive sampling was used to select the participants (Neumann, 2000). The criterion for selection were that participants were girls, aged between 8 to 11 years, had a history of sexual abuse, were living with a non-offending caretaker and were predominantly English-speaking. These criteria were based on suggestions in extant research indicating that the therapist be the same gender as the participants (Kitchur & Bell, 1989; Murphy, 2001) and that participants in a group setting be of similar chronological age (Berliner & Ernst, 1984; Finkelhor & Berliner, 1995).

The sample, obtained from children's homes in the Gauteng area, consisted of 25 sexually abused girls aged from 8 to 11 years (M = 9.6). This age group was appropriate as research suggests that children aged between 7 and 13 are most at-risk for adverse impacts from the abuse (Diehl, 2002; Kitchur & Bell, 1989). The ethnic distribution was six black African girls, two coloured girls and 17 white girls. The sample was divided into four groups. Three groups consisted of six girls and one control group consisted of seven girls. As the participants were recruited from various children's homes in the Gauteng Area, each group consisted of girls from a particular home. This decision was made on the practical considerations of a) the difficulty in obtaining participants for the study, and b) the inability of the children's homes to transport the participants to a central location for each session.

Instruments

The Trauma Symptom Checklist for Children (TSCC) developed by Briere (1996) was used to assess levels of depression, anxiety and sexual trauma. Reliability alphas for the TSCC are in the mid to high 0.80s for all scales except Sexual Concerns, which has been found to be in the 0.70s (Briere, 1996). Research has indicated that reliability and validity of this instrument (Sadowski & Friedrich, 2000; Singer, Anglin, Song, & Lunghofer, 1995).

The Human Figure Drawing (HFD) proposed by Koppitz (1968) was used as a measure of self-esteem and as an additional measure of depression, anxiety and sexual trauma. The instrument has been validated internationally (Groth-Marnat, 2003; Koppitz, 1968). Research indicates the effectiveness of using drawings as emotional indicators with children in South Africa (Rudenberg, Jansen, & Fridjhon, 2001; Skybo, Ryan-Wenger, & Su, 2007).

Procedure

The study made use of the Solomon four-group design (Braver & Braver, 1988). It is important from the outset to indicate that the non-random assignment of participants violates the assumptions of the Solomon design. The limited sample size (n = 25) also limits the application of the design. The results

of the study should therefore be interpreted with caution as the groups were non-equivalent. It is possible that these limitations compromised the internal validity of the study (Rosnow & Rosenthal, 2008). Although this is not the ideal, Hirschi and Läge (2008, p. 100) state that this approach "is frequently applied in field research because the groups already existed before the research began". The Solomon four-group design was used as it is a combination of the pre-test/post-test control group design and the post-test only control group design. This provided an indication of whether differences already existed prior to the treatment (pre-test scores) or whether symptom change could be attributed to the art therapy programme (post-test scores) (Kazdin, 1998).

The study used a quasi-experimental research design with non-equivalent groups (Rosnow & Rosenthal, 2008). The two experimental groups were subjected to the intervention whereas the two control groups were not. The first experimental group (Group 1) was assessed on the TSCC and HFD prior to and after the treatment. The first control group (Group 2) was assessed on the pre- and post-test in the absence of the intervention. The second experimental group (Group 3) was assessed only on the post-test after the intervention whereas the second control group (Group 4) was assessed only on the post-test in the absence of the intervention. An independent psychologist with no knowledge of the groups scored all the tests.

Ethical considerations

Permission was obtained from the Higher Degree's Ethics Committee of the University of Johannesburg to conduct this study. It was emphasised that participation was voluntary and confidential. Informed consent was obtained from the children's caretaker(s) and/or social worker(s) who were debriefed following the intervention by way of a confidential written and verbal report on each child's progress. Informed consent (assent) was also obtained from each child prior to participation. The researchers provided the proposal of the research to the children's homes prior to them agreeing to allow the research to be conducted. Both control groups received treatment following the post-test. The researcher administering the treatment was also provided with regular supervision in order to ensure that the children received optimal treatment.

Data analysis

Analyses were conducted using the SPSS statistical package. Parametric as well as non-parametric tests were used to establish treatment efficacy and between and within group variance (Pallant, 2007). The Paired Samples *t* test and the Wilcoxon Signed Rank Test were used to compare the pre- and post-test scores of the first experimental group and the pre- and post-test scores of the first control group. The differences in pre- and post-test scores between the first experimental and first control group were examined using the Independent Samples t-test and the Mann-Whitney Test. One-way ANOVA and the Kruskal-Wallis Test were used to establish the differences in intervention effect regarding the four groups (Pallant, 2007). The results of the analyses were considered at the 0.05 and 0.01 significant levels.

INTERVENTION

The foundation of the structured group art therapy programme was based on the existential-humanistic perspective, and incorporated principles from Gestalt therapy (Naranjo, 2000; Perls, 1990), the Client-centred approach (Rogers, 1967; Du Toit, Grobler, & Schenck, 1998) and the Abuse-focused approach (Briere, 1992). The programme consisted of four themes with eight sessions (for the purpose of space each theme is succinctly discussed). The themes of the programme included the following:

Establishing group cohesion and fostering trust

This theme focused on promoting positive relationships between group members and encouraging the process of disclosure. The programme was outlined to the participants where after the participants

introduced themselves to the other group members in the form of an animal which best represented them. This was followed by a group painting task and a discussion with the children about the activity.

Group norms and boundaries were then established. To initiate introspection and minimize anxiety a relaxation exercise (in the form of a guided fantasy) using clay was conducted. After this a story with anatomically correct dolls was made; each child was asked whether the story was similar to their own lives in any way.

Exploration of feelings associated with the abuse

This theme focused on exploring feelings associated with the abuse. The children were asked to draw and discuss different feelings. They were then asked to draw or paint a 'happy box' and an 'unhappy box' in which their feelings could be stored. Hereafter the children drew the person who abused them (as an animal, shape or colour) and their feelings toward the perpetrator.

In order to further address any unfinished business regarding the abuser, the girls were given the opportunity to verbally or physically express their feelings, which could then be placed in the happy or unhappy box. This was followed by a discussion on how it felt to express these feelings.

Sexual behaviour and prevention of revictimisation

This theme aimed to explore awareness of sexual behaviour and boundaries, and trust and prevention of further abuse. Various forms of touch were role-played and a discussion held on the meaning of different touches. Physical boundaries were then explored through role-plays.

The meaning and aim of sexualized behaviour, as well as age-appropriate ways of gaining rewards and having needs fulfilled was explored using mutual storytelling. Different scenarios similar to those in which sexual abuse might occur were selected and the children were given the opportunity to role-play these situations. These role-plays were discussed in terms of appropriateness of behaviour and possible alternative behaviours.

Group separation

The last theme was used to conclude the programme and help the children to reflect on the learning that took place. The children were asked to think about what they liked and disliked about the programme, and anything that was very special for them. Members then painted, drew or sculpted their feelings associated with leaving the group.

RESULTS

The parametric and non-parametric analyses yielded similar results, and, consequently, the results of the non-parametric statistics are not reported here. A Paired Samples *t* test was conducted to evaluate the impact of the intervention on girls' pre- and post-test scores for Group 1. **The results for Aim 1 indicated a significant improvement in depression (as measured by the TSCC) (pre-test $M = 75$, $SD = 11.576$; post-test $M = 52.33$, $SD = 18.206$; $p = 0.046$) and anxiety (as measured by the HFD) (pre-test $M = 2.5$, $SD = 0.548$; post-test $M = 1.17$, $SD = 0.753$; $p = 0.025$).** A Paired Samples *t* test was conducted to determine the results of Aim 2. The results indicated that Group 2 did not show any significant changes from the pre- to the post-test scores on the variables with the exception of a deterioration in the depression (as measured by the TSCC) variable with the mean score for depression increasing from pre- to post-test (pre-test $M = 54.17$, $SD = 12.254$; post-test $M = 65.17$, $SD = 5.742$; $p = 0.041$).

Aim 3 was concerned with the difference in pre- and post-test scores between the experimental group (Group 1) and the control group (Group 2). Comparison of the pre-test scores between Group 1 and Group 2 was done by means of an Independent Samples t-test. The analysis indicated similar results for anxiety (Group 1 $M = 2.5$, $SD = 0.548$; Group 2 $M = 3.17$, $SD = 1.169$; $t(10) = -1.265$) and depression (Group 1 $M = 1.33$, $SD = 1.033$; Group 2 $M = 1.83$, $SD = 0.753$; $t(10) = -0.958$) as

measured by the HFD. However, statistically significant differences were found in anxiety (Group 1 $M = 77.5$, $SD = 10.252$; Group 2 $M = 55$, $SD = 14.394$; $t(10) = 3.119$; $p = 0.011$) and depression (Group 1 $M = 75$, $SD = 11.576$; Group 2 $M = 54.17$, $SD = 12.254$; $t(10) = 3.027$; $p = 0.013$) pre-test scores as measured by the TSCC. This implies that Group 1 and Group 2 were not similar to begin with. In order to conduct an Independent Samples t test on the post-test scores of the two groups, the differences in scores between the pre- and post-test scores for Group 1 and Group 2 (post-test scores minus pre-test scores) were first determined. The results indicated statistically significant differences between the pre- and post-test scores of the first experimental group and the first control group on depression (Group 1 $M = -1.1667$, $SD = 1.16905$; Group 2 $M = 0.1667$, $SD = 0.75277$; $t(10) = -2.349$, $p = 0.41$) and anxiety (Group 1 $M = -1.3334$, $SD = 1.0328$; Group 2 $M = 0.5$, $SD = 0.54772$; $t(10) = -3.481$, $p = 0.003$) as measured by the HFD. A significant difference was also found on depression (Group 1 $M = -22.667$, $SD = 21.0776$; Group 2 $M = 11$, $SD = 9.85901$; $t(10) = -3.544$, $p = 0.005$), anxiety (Group 1 $M = -12.334$, $SD = 12.5486$; Group 2 $M = 7.8347$, $SD = 7.985$; $t(10) = -3.321$, $p = 0.008$) and sexual trauma (Group 1 $M = -11.834$, $SD = 17.76982$; Group 2 $M = 11.1667$, $SD = 17.475$; $t(10) = -2.261$, $p = 0.047$) as measured by the TSCC.

The difference in post-test scores between all four groups was determined by means of ANOVA. The analyses show that the two experimental groups yielded similar results on the post-test for all variables (Table 1). Group 1 and Group 4 obtained significantly different post-test scores for depression ($p = 0.001$) and anxiety ($p = 0.000$) on the HFD. Group 1 showed significantly lower scores compared to Group 4 (Table 2). Group 2 showed significantly higher scores in anxiety ($p = 0.009$) and depression ($p = 0.002$) on the HFD compared to Group 3 (Table 3). No difference in post-test scores was indicated between the two control groups (Table 4). Group 3 and Group 4 differed significantly regarding anxiety ($p = 0.000$) and depression ($p = 0.001$) as measured by the HFD. Group 3 showed significantly lower post-test scores than Group 4 (Table 5).

Table 1. Significance of difference between post-test scores for Group 1 and Group 3

Variables	Mean difference (Group 1 – Group 3)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	0.00	1.000	–1.19	1.19
Anxiety (HFD)	–0.50	0.818	–2.07	1.07
Low self-esteem (HFD)	0.33	0.820	–0.72	1.39
Depression (TSCC)	–12.83	0.557	–39.55	13.88
Anxiety (TSCC)	–3.00	0.968	–21.16	15.16
Sexual trauma (TSCC)	–14.33	0.648	–47.94	19.27

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist

Table 2. Significance of difference between post-test scores for Group 1 and Group 4

Variables	Mean difference (Group 1 – Group 4)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	–1.83	0.001**	–2.98	–0.69
Anxiety (HFD)	–3.12	0.000**	–4.64	–1.60
Low self-esteem (HFD)	–0.38	0.732	–1.40	0.63
Depression (TSCC)	–17.67	0.257	–43.41	8.07
Anxiety (TSCC)	–1.55	0.995	–19.05	15.95
Sexual trauma (TSCC)	–0.14	1.000	–32.52	32.24

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist
* $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed)

Table 3. Significance of difference between post-test scores for Group 3 and Group 2

Variables	Mean difference (Group 3 – Group 2)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	–1.83	0.002**	–3.02	–0.64
Anxiety (HFD)	–2.00	0.009**	–3.57	–0.43
Low self-esteem (HFD)	–0.83	0.157	–1.89	0.22
Depression (TSCC)	0.00	1.000	–26.71	26.71
Anxiety (TSCC)	5.33	0.850	–12.83	23.496
Sexual trauma (TSCC)	8.33	0.903	–25.27	41.94

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist
* $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed)

Table 4. Significance of difference between post-test scores for Group 2 and Group 4

Variables	Mean difference (Group 2 – Group 4)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	0.00	1.000	–1.15	1.15
Anxiety (HFD)	–0.62	0.678	–2.14	0.90
Low self-esteem (HFD)	0.12	0.988	–0.90	1.13
Depression (TSCC)	–4.83	0.954	–30.57	20.91
Anxiety (TSCC)	–3.88	0.928	–21.38	13.62
Sexual trauma (TSCC)	5.86	0.959	–26.52	38.24

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist

Table 5. Significance of difference between post-test scores for Group 3 and Group 4

Variables	Mean difference (Group 3 – Group 4)	Sig.	95% confidence interval	
			Lower	Upper
Depression (HFD)	–1.83	0.001**	–2.98	–0.69
Anxiety (HFD)	–2.62	0.000**	–4.14	–1.10
Low self-esteem (HFD)	–0.71	0.239	–1.73	0.30
Depression (TSCC)	–4.83	0.954	–30.57	20.91
Anxiety (TSCC)	1.45	0.996	–16.05	18.95
Sexual trauma (TSCC)	14.19	0.628	–18.19	46.57

Note. HFD = Human Figure Drawing; TSCC = Trauma Symptom Checklist
* $p < 0.05$ (2-tailed); ** $p < 0.01$ (2-tailed)

DISCUSSION

Regarding Aim 1, a decrease in depression was found in the first experimental group. The results of Aim 2 indicated that depression increased from pre- to post-test in the absence of intervention in the first control group. This may be explained in terms of the girls' demonstration of a desperate need for treatment. Events outside the therapy may also have contributed to an increase in symptoms. However, because the two experimental groups yielded similar results, and the two control groups yielded similar results, the implication is that history and maturation effects were not present.

Differences in the pre-test scores existed between Group 1 and Group 2. For this reason, the scores between these two groups were calculated. The results indicated that depression, anxiety and

sexual trauma improved significantly for Group 1 from pre- to post-test as opposed to Group 2 whose members did not receive the intervention. These findings appear to be consistent with the results of previous research. Burke (1988) and Lindon and Nourse (1994) found a significant reduction in anxiety and depression following group therapy, and Kelley (1984) found a significant decrease in sexual trauma following art therapy. Low self-esteem was the only variable that remained stable from pre- to post-test for both Group 1 and Group 2. These results are inconsistent with findings by Kelley (1984), Lindon and Nourse (1994), Reeker and Ensing (1998), Corder *et al.* (1990) and Rust and Troupe (1991) who found that low self-esteem reduced significantly after group and/or art therapy.

The findings of the present study suggest that the programme does not target low self-esteem as successfully as depression and anxiety. Alternatively, the findings may reveal that the HFD is not sensitive to changes in self-esteem symptoms. The HFD did not indicate any sexual trauma symptoms among the groups in this study. Possibly, the HFD is not as sensitive as the TSCC in tapping symptoms associated with sexual trauma.

The results associated with Aim 4 indicate similar scores for the two experimental groups and for the two control groups. The experimental groups differed significantly in post-test scores from the control groups. The findings reveal that following the intervention, the experimental groups demonstrated improvement in depression, anxiety and sexual trauma as compared to the control groups.

LIMITATIONS AND RECOMMENDATIONS

The research was subject to many limitations. The small sample size (n = 25) is a significant weakness of this study. The limited number of participants assigned to each group is likely to have an adverse impact on the validity of the obtained results. The results must therefore be viewed with caution. Future studies should address this weakness and explore the usefulness of this therapeutic approach with different samples (both in terms of ethnicity and size). Because each group originated from a different children's home, it is not clear whether the difference in environments can be linked to the variability found among the groups and whether this may have influenced the findings of the study.

Grouping the participants from different children's homes may be useful in reducing the confounding variables that were present in the study (i.e. use random assignment of participants to groups). This also raises the questions as to whether certain homes receive children with more or less severe symptoms than other homes and whether particular homes exacerbate or improve symptoms. The improvement in symptoms could also be attributed to the therapist as only one therapist conducted the treatment programme .

CONCLUSION

The study aimed at contributing to the CSA intervention literature by applying and evaluating a newly designed group art therapy intervention with sexually abused girls. The results suggest that this group art therapy programme may ameliorate symptoms of depression and anxiety. This study is another building block in the literature on sexual abuse intervention and it is hoped that future studies on the effectiveness of this programme for sexually abused children are performed.

REFERENCES

Aldridge, F., & Hastilow, S. (2001). Is it safe to keep a secret? A sibling group in art therapy. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 167-183). East Sussex: Brunner-Routledge.

Berliner, L., & Ernst, E. (1984). Group work with preadolescent sexual assault victims. In I.R. Stuart & J.G. Greer (Eds), *Victims of sexual aggression: treatment of children, women, and men.* New York: Van Nostrand Reinhold Company.

Bissonnet, J. (2001). Tell me your story so far: A developmental approach to art therapy. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: lost for words* (pp. 126-139). East Sussex:

Brunner-Routledge.
Bohn, D.K. (2003). Lifetime physical and sexual abuse, substance abuse, depression and suicide attempts among Native American women. *Issues in Mental Health Nursing, 24*, 333-352.
Brainerd, C.J. (1978). *Piaget's theory of intelligence*. Englewood Cliffs, NJ: Prentice-Hall.
Braver, M.C.W., & Braver, S.L. (1988). Statistical treatment of the Solomon Four-Group design: A meta-analytic approach. *Psychological Bulletin, 104*, 150-154.
Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. California: SAGE Publications.
Briere, J. (1996). Psychometric review of the Trauma Symptom Checklist for Children. In B.H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation*. Lutherville, MD: Sidran Press
Brown, A.M., & Latimir, M. (2001). Between images and thoughts: An art psychotherapy group for sexually abused adolescent girls. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 184-200). East Sussex: Brunner-Routledge.
Browne, A., & Finkelhor, D. (1986). Initial and long-term effects: A review of the research. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse*. Beverly Hills: SAGE Publications.
Buckland, R., & Murphy, J. (2001). Jumping over it: Group therapy with young girls. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (143-166). East Sussex: Brunner-Routledge.
Burke, M. (1988). Short term group therapy for sexually abused girls. *Dissertation Abstract International, 49*, (5-B).
Carr, A. (2000). *Family therapy: Concepts, process and practice*. Chichester: John Wiley and Sons.
Carolan, R. (2001). Models and paradigms of art therapy research. Art Therapy: *Journal of the American Art Therapy Association, 18*, 190-206.
Case, C., & Dalley, T. (1990). *Working with children in art therapy*. London: Tavistock/Routledge.
Chaffin, M., & Friedrich, B. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review, 26*, 1097-1113.
Cohen, J.A., & Mannarino, A.P. (2008). Trauma-focused cognitive behavioural therapy for children and parents. *Child and Adolescent Mental Health, 13*, 158-162.
Cohen, J.A. Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.
Cohen, J.A., Mannarino, A.P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29*, 135-145.
Corder, B.F., Haizlip, T., & De Boer, P. (1990). A pilot study for a structured time-limited therapy group for sexually abused pre-adolescent children. *Child Abuse & Neglect, 14*, 243-251.
Crafford, W. (1985). *Hulpverlening in die voorligtingsielkunde: 'n Funksionele integrasie* [Assistance in counselling psychology: A functional integration]. Ongepubliseerde meestersverhandeling, Rand Afrikaanse Universiteit, Johannesburg.
Delson, N., & Clark, M. (1981). Group therapy with sexually molested children. *Child Welfare, 60*, 175-182.
Diehl, A.S. (2002). Self-efficacy and learned optimism: The treatment of post-traumatic stress disorder in children. *Dissertation-Abstracts International, Sciences and Engineering, 62*, 5369.
Douglass, L. (2001). Nobody hears: How assessment using art as well as play therapy can help children disclose past and present sexual abuse. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: Lost for words* (pp. 50-65). East Sussex: Brunner-Routledge.
Du Toit, A.S., Grobler, H.D., & Schenck, C.J. (1998). *Person-centered communication: Theory and practice*. Johannesburg: International Thomson Publishing.
Dwivedi, K.N. (1993). *Group work with children and adolescents: A handbook*. London: Jessica Kingsley Publishers.
Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: a review and recommendation. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 1408-1423.
Finkelhor, D., & Browne, A. (1986). Initial and long-term effects: A conceptual framework. In D. Finkelhor (Ed.), *A sourcebook on child sexual abuse*. Beverly Hills, CA: SAGE Publications.
Freeman, R.C., Collier, K., & Parillo, K.M. (2002). Early life sexual abuse as a risk factor for crack cocaine use in a sample of community recruited women at high risk for illicit drug use. *The American Journal of Drug and Alcohol Abuse, 28*, 109-131.
Freyd, J.J. (2002). Memory and dimensions of trauma: Terror may be "all-too well remembered" and

betrayal buried. In J.R. Conte (Ed.), *Critical issues in child sexual abuse: Historical, legal and psychological perspectives*. Thousand Oaks, CA: SAGE.

Gallo-Lopez, L. (2000). A creative play therapy approach to the group treatment of young sexually abused children. In H.G. Kaduson, & C.E. Schaefer (Eds.), *Short-term play therapy for children* (2nd ed.). New York: Guildford Press.

Gardner, R.A. (2002). *Sex abuse trauma?: Or trauma from other sources?*. New York: Creative Therapeutics.

Gilroy, A. (2006). *Art therapy, research and evidence-based practice*. London: SAGE Publications.

Groth-Marnat, G. (2003). *Handbook of psychological assessment*, 4th ed.. Hoboken, NJ: John Wiley and Sons.

Hirschi, A., & Läge, D. (2008). Increasing the career choice readiness of young adolescents: an evaluation study. *International Journal for Educational and Vocational Guidance, 8*, 95-110.

Kazdin, A.E. (1998). *Research design in clinical psychology*. Boston: Allyn and Bacon.

Kelley, S.J. (1984). The use of art therapy with sexually abused children. *Journal of Psychosocial Nursing & Mental Health Services, 22*, 12-18.

Killian, B., & Brakarsh, J. (2004). Therapeutic approaches to sexually abused children. In L. Richter, A. Dawes, & C. Higson-Smith (Eds), *Sexual abuse of young children in Southern Africa* (pp. 367-394). Cape Town: HSRC Press.

Kitchur, M., & Bell, R. (1989). Group psychotherapy with preadolescent sexual abuse victims: Literature review and description of an inner-city group. *International Journal of Group Psychotherapy, 39*, 285-310.

Koppitz, E. (1968). *Psychological evaluation of children's human figure drawings*. New York: Grune and Stratton.

Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review, 30*, 665-673.

Lindon, J., & Nourse, C.A. (1994). A multi-dimensional model of group work for adolescent girls who have been sexually abused. *Child Abuse and Neglect, 18*, 341-348.

Madu, S.N., & Peltzer, K. (2001). Prevalence and patterns of child sexual abuse and victim-perpetrator relationship among secondary school students in the Northern Province (South Africa). *Archives of Sexual Behavior, 30*, 311-321.

Mazza, D.L. (2003). Dangerous behavior in children and adolescents. *American Psychoanalytic Association Journal, 51*, 651-666.

Meekums, B. (1999). A creative model for recovery from child sexual abuse trauma. *The Arts in Psychotherapy, 26*, 247-259.

Murphy, J. (2001). Introduction. In J. Murphy (Ed.), *Art therapy with young survivors of sexual abuse: lost for words* (pp. 1-15). East Sussex: Brunner-Routledge.

Naitove, C.E. (1986). Arts therapy with sexually abused children. In S.M. Sgroi (Ed.), *Handbook of clinical intervention in child sexual abuse*. Canada: D.C. Health and Company.

Naranjo, C. (2000). *Gestalt therapy: The attitude and practice of a theoretical experientialism*. UK: Crown House Publishing.

National Crime Victims Research and Treatment Centre & Centre for Sexual Assault and Traumatic Stress. (2004). *Child physical and sexual abuse: Guidelines for treatment*. Retrieved March 8, 2008, from http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf

Neuman, W.L. (2000). *Social research methods: qualitative and quantitative approaches*, 4th ed. Boston: Allyn & Bacon.

Pallant, J. (2007). *SPSS survival manual*, 3rd ed. Berkshire: Open University Press.

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review, 29*, 328-228.

Perls, F.S. (1990). Gestalt therapy verbatim. In C. Hatcher, & P. Himelstein (Eds), *The handbook of Gestalt therapy*. New York: Jason Aronson.

Pifalo, T. (2002). Pulling out the thorns: Art therapy with sexually abused children and adolescents. *Journal of the American Art Therapy Association, 19*, 12-22.

Reeker, J. & Ensing, D. (1998). An evaluation of a group treatment for sexually abused young children. *Journal of Child Sexual Abuse, 7*, 65-85.

Rogers, C.R. (1967). *On becoming a person, a therapist's view of psychotherapy*. USA: Constable.

Rosnow, R.L., & Rosenthal, R. (2008). *Beginning behavioral research: A conceptual primer*, 6th ed. Upper

Saddle River, NJ: Pearson Education.
Rudenberg, S.L., Jansen, P., & Fridjhon, P. (2001). Living and coping with ongoing violence. *Childhood, 8*, 31-55.
Rust, J.O., & Troupe, P.A. (1991). Relationships of treatment of child sexual abuse with school achievement and self-concept. *Journal of Early Adolescence, 11*, 420-429.
Ryan, K. (1996). The chronically traumatized child. *Child and Adolescent Social Work Journal, 13*, 287-310.
Sacks, J., McKendrick, K., & Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of Substance Abuse Treatment, 34*, 90-100.
Sadowski, C.M., & Friedrich, W.N. (2000). Psychometric properties of the Trauma Symptom Checklist for Children (TSCC) with psychiatrically hospitalized adolescents. *Child Maltreatment, 5*, 364-372.
Singer, M.I., Anglin, T.M., Song, L.Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association, 273*, 477-482.
Skybo, T., Ryan-Wenger, N., & Su, Y. (2007). Human figure drawings as a measure of children's emotional status: Critical review for practice. *Journal of Pediatric Nursing, 22*, 15-28.
South African Police Services (SAPS). (2008). *Crime situation in South Africa 1 April 2007 to 31 March 2008. Trends, spatial distribution and interpretation.* Retrieved August 31, 2009, from http://www.saps.gov.za/statistics/reports/crimestats/2008/docs/
Snyder, B.A. (1997). Expressive art therapy techniques: Healing the soul through creativity. *Journal of Humanistic Education and Development, 36*, 74-82.
Tourigny, M., Hébert, M., Daigneault, I., & Simoneau, A.C. (2005). Efficacy of a group therapy for sexually abused adolescent girls. *Journal of Child Sexual Abuse, 14*, 71-93.
Wade, G. (2000). *Hurting and healing: How to overcome the trauma of sexual abuse and rape.* Shaftesbury: Element.
Waller, D. (2006). Art therapy for children: How it leads to change. *Clinical Child Psychology and Psychiatry, 11*, 271-282.
Yalom, I.D. (1998). *The Yalom reader*. New York: Basic Books.
Zinni, V.R. (1997). Differential aspects of sand play with 10- and 11-year-old children. *Child Abuse and Neglect, 21*, 657-668.

Laura Jackson

From: Paul Eldridge
Sent: Thursday, July 26, 2018 5:32 PM
To: laura.jackson@dhp.virginia.gov
Subject: PUBLIC COMMENT -- Art Therapy Licensure in Virginia

Dear Ms. Laura Jackson,

My name is Paul Eldridge and I am Technical Program Manager with Salesforce in Herndon, Virginia.

I'm writing you today to express my **full support towards the licensure efforts of art therapists in Virginia,** and advocate for the safety of Virginians by establishing a state art therapy license.

Art therapy is a **distinct** mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals.

Art therapists are **clinically** trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

There's several reasons Art Therapy needs its own license as a distinct field from the more general Licensed Professional Counselor (LPC) path,.

It's not just a "branch" of counseling, it takes years of unique study, and can have negative consequences if employed halfheartedly or incorrectly, without proper training and ethics. It's easy for untrained general professionals to claim something is "Art Therapy", while actually doing damage if employing the unique field's directives and methods the wrong way, in the wrong order, without years of training to build in the correct guardrails. Without a license, any random person can take a weekend workshop and claim their practice is legitimate "Art Therapy", while incorrectly assessing things and emotionally jerking the client around without realizing it.

A license provides the necessary minimum bar and rigor to *prove* to a layperson that Art Therapist's competency, just as the LPC provides.

Additionally, there may be negative existential consequences for the Art Therapy field in general if it continues to be viewed as an "offshoot" of the LPC counseling field. The licensure enshrines that legitimacy, providing a single goalpost for Art Therapist graduate students to pursue.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.

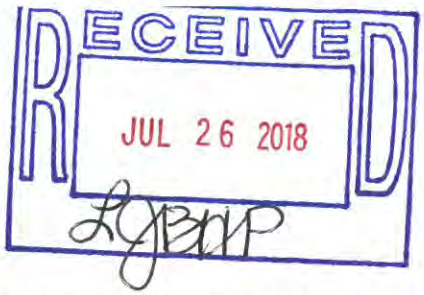
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

This is a **huge** opportunity to do good. Those are rare. Take this chance and thousands will benefit, on both sides of the therapist's drawing table.

Thank you again for your time, energy, and service to the residents of VA.

Sincerely,
Paul Eldridge
eldrake@gmail.com / 703-347-3208



To Whom it May Concern,

My name is Heather Stemas and I am writing to you as a resident from Arlington, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I have been an Art therapist in a large metropolitan pediatric medical center for over 15 years and have seen the multitude of benefits of Art therapy for children and teens with chronic illness and/or facing invasive and painful procedures. Many of the clients I have worked with want to continue with Art therapy services when they are discharged from the hospital. There are few options for them however as they have to deal with prohibitive cost (and no reimbursement) and a paucity of qualified and licensed providers I have supervised numerous graduate Art therapy interns who must complete comprehensive graduate level training completed with extensive supervision. Almost all of the staff that work with individuals in our facility (nurses, doctors, social workers, nursing assistants, etc.) must achieve and adhere to strict and rigorous training and licensure to ensure our vulnerable clients' safety, uniform regulatory policies and the highest ethical and most current delivery of care.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for *(but not limited to)*:

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Heather Stemas, MEd, ATR-BC, LCPAT
Art Therapist
hstemas@gmail.com
914 North Montana Street
Arlington, VA 22205

Laura Jackson

From: Joyce Vaughan
Sent: Thursday, July 26, 2018 8:34 PM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapist Licensure in Virginia

Dear Virginia Board of Health Professions,

My name is Joyce Vaughan and I am a retired science teacher in Fairfax County, Virginia. I am the proud mother of an art therapist who works at Loudoun County Mental Health in Northern Virginia. I fully support the licensure efforts of art therapists in Virginia and advocate for the safety of Virginians by establishing a state art therapy license. As an educator of special education students and a supporter of mental health professionals, I am dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist such as my daughter, uses art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

My daughter, Michelle works for Loudoun County Mental Health as an art therapist. She clinically assesses a client's mental health needs and determines which art media to use in order to support mental, emotional, physical, and spiritual goals for them. She works with people of all ages and backgrounds using visual arts to encourage healing and self-awareness which help a client achieve positive changes and personal growth. This enables Virginians with mental health issues to become stable and self- sufficient citizens of the state. Michelle has been trained (Supervision hours) and educated at the postgraduate level (Master's Degree from Eastern Virginia Medical School, Norfolk, Virginia) to carefully determine a client's needs. Among using art media, there are many other responsibilities of an art therapist such as writing reports and case notes, background checks and she is required to display the utmost confidentiality among her colleagues and clients. Making the wrong diagnosis or breaking confidentiality could be extremely dangerous to the mental wellbeing of the client.

Michelle assisted in designing and implementing a program at the Workhouse in Occoquan, Virginia where she worked with veterans, active duty military and their families who experienced PTSD among other mental health issues. This one on one or small group interaction cannot be successful through coloring books and colored pencils. It is a tedious process and one only a professionally trained art therapist should attempt to diagnose and treat. The art therapist's goal is not to create a famous artist, rather they implement different media of studio art, psychotherapy and counseling to guide their clients toward a healthier view of life. . I urge the movement for a state art therapy license to be required in Virginia for quality treatment. We are not talking about the latest craze in adult coloring books to support this profession. It goes far beyond this simple act.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.

- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.

- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for *(but not limited to)*:

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. I look forward to being in touch.

Sincerely,
Joyce Vaughan
Retired Teacher – Fairfax County Public Schools
58joyce@gmail.com 703-670-2894

Laura Jackson

From: Heather H. Montgomery
Sent: Friday, July 27, 2018 3:58 AM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapy licensure

Dear Laura L. Jackson,

My name is Heather Montgomery and I am a Library/Community Service Manager at Richmond Public Library in Richmond, Virginia. I have worked with art therapists at various agencies, most recently in the juvenile justice system. I fully support the licensure efforts of art therapists in Virginia and advocate for the safety of Virginians by establishing a state art therapy license. As a mental health professional, I am dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout Virginia. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

Protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.

Increase affordable access to mental health services by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
Attract and retain qualified art therapy professionals and art therapy students in Virginia.

Contribute to the economy of the state through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.
State licensure of professional art therapists will also support assessment and treatment for (but not limited to):

Veterans, active duty military, and their families who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.

The growing numbers of older adults suffering with dementia and depression.

People of all ages with cancer and other physical illnesses who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.

Individuals with developmental disabilities (i.e., autism) who need specially trained, qualified therapists.

Those experiencing trauma from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Anyone who is currently unable to express themselves sufficiently or directly analyze their thoughts and feelings verbally due to limited language skills or development.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. I look forward to being in touch.

Sincerely,
Heather Montgomery, Library/Community Services Manager
Hhmontgomery@gmail.com 804-393-6344

Laura Jackson

From:	Erica Wang
Sent:	Friday, July 27, 2018 10:45 AM
To:	laura.jackson@dhp.virginia.gov
Cc:	olson.carolann@gmail.com
Subject:	Feedback for the Regulation of the Practice of Art Therapy in Virginia

Dear Ms. Jackson,

I am writing in regards to my support for the regulation of the Art Therapy field in the state of Virginia.

With a MBA from the University of Cambridge and two decades of cross-sector professional experience, I have decided to transition my life journey towards making a positive societal contribution and pursue a Masters of Art Therapy and Counseling at the School of the Art Institute of Chicago. Upon completion of my degree, I plan on returning to the state of Virginia in order to SERVE the citizens of the state of Virginia.

As a sexual assault survivor and resident of NYC during 9/11, I know first hand about the debilitating, lifelong impact of traumatic experiences. From the turmoil that we are observing in American society today, it is imperative that we increase access to affordable and quality mental healthcare. Providing Licensed Art Therapists with the recognition, professional, and legal associations with the other mental health professions in Virginia will help support just that.

The NIH has funded and is currently searching for new research studies on the impact of creative arts therapies so that they can indeed release scientific evidence of positive impact on health and wellbeing. Several academic institutions have studies demonstrating improvements in the area of Alzheimer's, Parkinson's, and autism as well as its already well-know applications with trauma patients such as veterans.

At this juncture, I do not believe that the American Art Therapy Association represents my values, nor do I believe they reflect the majority of those in the field. However, until Art Therapy is considered with the other health professions, we are not able to refine or develop a new organization that represents a more holistic approach.

As I begin my three year intensive study and practice (over 1000 hours), I hope to return to Virginia with the ability to serve as many individuals and populations as possible.

Thank you kindly for your time and consideration,

Erica Wang
202.669.2691
(Formerly a resident of Fairfax County and Richmond, VA for 14 years)

July 27, 2018

To Whom it May Concern,

My name is Kimberly Faulkner, and I am writing to you as a resident and a person who works in the Prince William County area of Virginia. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I have over 13 years of experience working as an art therapist in New York, where I am licensed. I came to Virginia because my husband relocated for a better job. While he can maintain his career, I am struggling to re-establish my professional life and contribute to our family's income. While I have the years of experience to back up my qualifications (Registered and Board-Certified since 2008), clinics and other mental health agencies will not hire me because I do not have a license. With the appropriate state licensure in place, my service and expertise would compliment many forms of treatment, and countless people will have access to the care they deserve and are asking to receive. I would love to be able to take care of my family by providing the services I have been trained to administer and treat individuals who may not have the financial means or the insurance plans to receive art therapy treatment.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering from dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license are greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,

Kimberly Faulkner, ATR-BC, LCAT(NY) Art Therapist
faulknercat@gmail.com

July 26, 2018

Virginia Board of Health Professions
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463
Attention: Laura L. Jackson

Dear Ms. Jackson and To All To Whom it May Concern,

My name is Karen Montgomery and I am writing to you as a resident of and practicing Registered Art Therapist in Richmond, VA. I am also a current member and past president of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

I received my Masters in Counseling in 2003 in New York state, then returned to Virginia to be near family; however, have often regretted not remaining in NY due to their recognition of Art Therapy as a distinct mental health profession with licensure status. I've worked with clients in treatment facilities for adult mental illness, daycare for adults with disabilities, a residential treatment center for at-risk-youth, am now working for the Henrico County Public School system in Henrico Juvenile Detention Home, and have various individual clients, as well. Many of my clients have experienced severe trauma, from birth trauma and infant drug withdrawal to physical or sexual abuse and disaster trauma, and I want to stress that trauma-focused interventions represent an area of therapy in particular need of non-verbal approaches to both accessing and treating deep psychic pain and managing new and healthier life skills.

I want to reiterate on the many areas of focus that the Virginia Art Therapy Association has identified as crucial to ensure that only the most professional arts-based therapeutic interventions are used with clients in need of our services, for too many times I have been concerned about the appropriateness of art techniques used by those untrained to handle and unforeseen responses to the approach with struggling client. A short story of the importance of the urgency of supervised and responsible, clinical training: while in my first internship in graduate school, I used painting with a psychotic patient who reacted so strongly to the medium, due to sexual abuse, that she needed hospitalization afterwards – I was so grateful that I had the supervision during training to avoid more disastrous results with that very delicate client. Now I am fully aware of particular art therapy assessments, techniques, mediums, and tools to use and avoid with certain presenting behaviors!

<u>Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:</u>

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

<u>State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):</u>

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Karen Hope Montgomery, MS-ATR

Registered Art Therapist/Educator
Henrico Juvenile Detention Home
Henrico, Virginia
kamontgomery@henrico.k12.va.us
kinskimont@gmail.com
804-364-2469 cell

To Whom it May Concern,

My name is Leila Saadeh, LPC, ATR-BC and I am writing to you as a resident and employee of Richmond, VA. I am the Vice President of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal. In addition, I hold the LPC license in the state of VA.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I believe title protection is most necessary reason for art therapists to obtain their own licensure. There are unfortunately a great number of mental health professionals and artists out there in our state that claim they are doing "art therapy" recklessly and unethically without any proper training and education. This causes significant risks of harm to the population that need mental health treatment, and just because people can make art, does not mean they can administer art therapy. For example, because I can hold a blood pressure cuff and pump it doesn't mean I actually know how to effectively check a patient's blood pressure. Art media has significant effects on the brain and the unconscious. Certain media can invoke certain responses and if a person is unstable and has for example gone through a trauma, it can actually regress and cause harm to a patient when done without the proper facilitator who has had the extensive training and knowledge as art therapists have.

In addition, the need for other art therapists to have to go through another entire supervision and credentialing process as I did (to obtain my LPC) only to be recognized as a mental health professional ...is very unnecessary. The only reason I decided to go through with receiving my LPC after I became a Board-Certified and Registered Art Therapist (ATR-BC) is so I could be considered for mental health jobs in the state of VA that allow me to use my training and graduate education, and also to be reimbursed by insurance companies. As we all know, all of us who are mental health professionals ultimately at the foundation just want to help people in need. Most people "in need" have health insurance and cannot afford to self-pay, as they would have to in order to receive my services with solely my art therapy credentials. As our education and internship requirements are equal to the LPC education and internship requirements, there is no reason why art therapists should be not be able to be considered to obtain our own license under the Board of Counseling.

<u>Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:</u>

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Tennessee.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

<u>State licensure of professional art therapists will also support assessment and treatment for *(but not limited to)*:</u>

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.

- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Leila Saadeh LPC, ATR-BC
Art Therapist
saadehlc@gmail.com / 757-737-1875

AMERICAN arttherapy ASSOCIATION

July 27, 2018

Laura L. Jackson
Virginia Board of Health Professions,
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463.

Dear Ms. Jackson:

I am writing on behalf of the American Art Therapy Association (AATA) to express our Association's strong support for regulation and licensure of art therapists in Virginia. Our Association appreciates the considerable time and effort that the Board of Health Professions and Board staff have given to the study of the art therapy profession and its practice in Virginia, and we look forward to the Board's final report and recommendations.

The AATA is a national professional membership organization that represents over 5,000 practitioners, educators and researchers engaged in the art therapy profession. The Association works in concert with the Virginia Art Therapy Association and 40 other state and regional chapters to promote the highest standards of art therapy practice to the public.

Art therapy is a specialized, distinct mental health and behavioral science profession that offers a unique approach for assessing and treating a broad spectrum of mental health conditions. As noted in the Board's Preliminary Draft Report, art therapists have comparable training and a similar scope of practice as other master's level mental health professions currently licensed in Virginia. Lacking a separate license, many art therapists are licensed to practice in the state as professional counselors. Out of necessity, the graduate art therapy programs at Eastern Virginia Medical School (EVMS) in Norfolk and George Washington University in Alexandria have offered dual academic programs that include training in the theories and techniques of mental health counseling, as well as specialized training in theory, methods and clinical practice of art therapy, to qualify graduates for both state licensure and national credentials as art therapists.

While sharing important foundations and training with other mental health professions, art therapy is unique in its focus on non-verbal information processing. Where other master's-level mental health practitioners are trained to employ cognitive and verbal interventions, art therapists are trained in art-based interventions that stimulate the brain's tactile-haptic, visual, sensory, and perceptual channels to allow integrated verbal and non-verbal processing of emotions. Understanding of the potential for art-making to reveal emotions, along with the knowledge and skill to safely manage the reactions it may evoke in different clients, are competencies that are unique to art therapy master's education and that clearly distinguish art therapy as a separate profession.

American Art Therapy Association | 4875 Eisenhower Avenue, Suite 240, Alexandria, VA 22304
www.arttherapy.org | Phone (888) 290-0878 (703) 548-5860 | E-mail info@arttherapy.org

We support the Board's acknowledgement in the Preliminary Draft Report of the potential for harm that can be attributed to practice of art therapy without the necessary skills, specialized master's degree education, and supervised clinical training of credentialed art therapists. We further agree with the Report's recognition that the absence of laws or regulations defining art therapy and regulating art therapists in Virginia presents a potential for fraud and creates confusion for the public in determining who is qualified to practice art therapy. Growing public awareness of how the process of art-making can influence neural pathways and lead to improved physical and mental health has prompted other mental health practitioners to include art materials and art therapy methods within their practice and has also encouraged growing numbers of individuals with limited mental health training to represent themselves to the public as practicing art therapy. While documenting actual harm done to clients by these individuals has been difficult, the growing numbers of such untrained persons representing themselves as art therapists alone should be cause for concern. It also illustrates the confusion that exists within the public at large, and even among mental health professionals, about what constitutes competent and safe practice of art therapy.

While licensing of art therapists as professional counselors has been beneficial in providing a legal sanction for practice in the Commonwealth, it has also contributed to the public's confusion about what art therapy involves and the training required to practice it. It has additionally encouraged the misconception that counselors and other licensed mental health practitioners are qualified to practice art therapy with minimal additional training or credentials. Licensure as counselors also has failed to provide art therapists with a distinct professional identity with defined qualifications and scope of practice in state law that accurately reflect their specialized academic training and clinical practice.

Art therapists who reside or work in Virginia now consider separate regulation as an immediate need in light of continued action by the Virginia Board of Counseling to restrict future access to professional counseling licenses only to applicants with graduate degrees from CACREP-accredited counseling programs. We are aware that the regulatory proposal to implement a CACREP-only degree requirement for licensure has been withdrawn, at least temporarily, but our experience in other states provides ample reason to believe that the proposal will remain in the forefront of the Board's regulatory agenda well into the future. We also are aware of at least three recent George Washington University program graduates who have been denied licenses by the Board of Counseling for failing to meet current education requirements. This leads us to believe that the Board may already be implementing a more strict interpretation of what constitutes an equivalent course of study in counseling to that of CACREP-approved programs. This in turn may restrict future licensing of art therapists under counseling equivalency.

Virginia is now the only state in the Mid-Atlantic region that does not provide licensure for art therapists. Art therapists are licensed in Maryland, Delaware, Pennsylvania, New Jersey, and New York. Art therapists also are licensed in the state of Kentucky, and licensing bills are under consideration in the Tennessee legislature and the Council of the District of Columbia. With so many nearby alternatives, the lack of a Virginia license will continue to present an obstacle for art therapists seeking to return or relocate to practice in the state. In a recent survey of art therapy graduate students in the state, 78% of participants indicated that the lack of licensure in Virginia poses a barrier, with many participants reporting plans to move or work in Maryland (26%) or in Washington DC (23%).

The AATA strongly endorses continued licensure of art therapists in Virginia with a distinct professional art therapist license. We believe that licensure of art therapists can provide a reasonable and cost-effective approach for increasing the number of qualified and licensed professionals needed to meet Virginia's growing need for mental health and substance abuse services. Licensure also will benefit consumers by promoting competent and safe practice of art therapy, preserving Virginia's tradition of diversity and innovation in mental health services, and providing assurance that persons in need of art therapy services will be able to receive them from appropriately trained and credentialed mental health professionals.

Thank you for conducting this study into the need to regulate art therapy in Virginia and for the opportunity to submit comments. I am happy to answer any follow-up questions you may have.

Sincerely,

Christianne Strang, PhD, ATR-BC, CEDCAT-S
President, American Art Therapy Association

Laura Jackson

From: Laura Dobbs
Sent: Friday, July 27, 2018 3:18 PM
To: laura.jackson@dhp.virginia.gov
Subject: ***Urgent request to consider a state art therapy licensure!

Dear Ms. Jackson,

My name is Laura Dobbs and I am writing to you as a professional credentialed art therapist working in Virginia Beach, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I have been working in the mental health field for 16 years, since graduating with my master's degree in Art Therapy and Counseling at Eastern Virginia Medical School in 2002. It has been a long road for me as I have struggled to gain respect as a professional art therapist and am frequently educating others about how I am not the "art teacher." I recently left my job for personal reasons but have struggled to find another job as I am not licensed as a therapist and therefore am not billable for insurance companies. I am credentialed as a registered art therapist but this does not get me far in my job search. Therefore I am continuing to pursue my counseling licensure as an LPC in the state of Virginia.

In my previous job, there was another colleague in my department who was hired as an art therapist. This individual actually went to the same art therapy program I did, however she did not complete her thesis and therefore did not graduate from the program. Because there are no regulations for working as an art therapist in the state of Virginia, she was hired as an art therapist regardless and has been potentially misrepresenting our profession. Because she is not registered with the Art Therapy Credentials Board, she does not have to follow the ethics code the American Art Therapy Association enforces and there really is no legal action potential. She may not be aware of or required to do the continuing education of a registered art therapist. And yet because there are no state regulations or licensure she is free to work in a psychiatric setting misrepresenting our profession and potentially causing harm to the individuals she treats.

We need to protect the public by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements. By providing a state licensure for art therapists, we can increase affordable access to mental health services by providing a distinct service and reimbursement code under public and private insurance. A state art therapy licensure means employment opportunities would improve as well as the retention of qualified art therapy professionals in the state of Virginia. Recent research continues to show vast improvement in symptoms using art therapy with veterans, active duty military and their families. Living in a military town, I can't find a job providing art therapy, but through a state licensure I believe many more opportunities would become available. Creating a state art therapy licensure would also support assessment and treatment of the growing number of older adults, people of all ages with cancer or medical issues, individuals with developmental disabilities, those experiencing trauma or drug addiction. Licensure would also contribute to the economy of the state through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. I look forward to being in touch.

Sincerely,

Laura Dobbs, Registered Art Therapist
LauraDobbs@verizon.net
757-343-7151

Laura Jackson

From: Sarah Balascio
Sent: Friday, July 27, 2018 4:17 PM
To: laura.jackson@dhp.virginia.gov
Subject: Art Therapist Comment

To Whom it May Concern,

My name is Sarah Balascio and I am writing to you as a board certified art therapist that works in Williamsburg, VA. I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I was working in private practice as an art therapist until a complaint was filed against me by another therapist alleging that I was working as a counselor without a license. I had a thriving practice of 25 cases that I needed to close. This not only caused hardship on my family but these clients as well. This also showed me that there is clearly a need in the state of VA as most of my clients chose not to continue on with traditional therapy and there were minimal other registered art therapists to refer to. I feel and have seen proof from this experience that there is a clear distinction between traditional therapy and art therapy which needs to be clarified in our state as other stated have through licensing.

Credentialed art therapists, art therapy clients, and mental health colleagues in Virginia believe a state art therapy license through the VA Department of Health is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.

- ***Attract and retain qualified art therapy professionals and art therapy students***.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,
Sarah Balascio, Board Certified Registered Art Therapist
sarahbalascio@gmail.com
802-734-2537

Laura Jackson

From: Douglas, Eileen K.
Sent: Friday, July 27, 2018 4:28 PM
To: Laura.jackson@dhp.virginia.gov
Subject: Comment on Art Therapy

Dear Ms. Jackson:

My name is Eileen Douglas and I am writing to you as a resident of Norfolk, VA. I am also a member of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in VA – and believe a state art therapy license will help achieve this goal.

Art therapy is a distinct mental health profession in which clients, facilitated by a masters-level art therapist, use art media, the creative process, and the resulting artwork to achieve mental, emotional, physical, and spiritual goals. Art therapists are clinically trained to work with clients of all ages and are working in community, medical, and private settings throughout VA. Art therapy goals can range from coping with trauma and safe self-expression to enhancing cognitive and motor abilities and relieving stress and anxiety.

I have practiced art therapy for eight years and am currently teaching in the Graduate Art Therapy and Counseling Program at Eastern Virginia Medical School. As a practitioner, I have witnessed the benefits of art therapy in engaging and supporting positive growth among adolescents in juvenile detention as well as a quasi-military style program for at-risk youth. I have also provided art therapy services to students in a university counseling center. The citizens of Virginia would benefit greatly from the establishment of a state license for Professional Art Therapists. Licensure as Professional Art Therapists, along with title protection for the field of art therapy and equal third party reimbursement, is urgently needed to:

- ***Protect the public*** by ensuring that those in need of art therapy services receive them from qualified, trained professionals who meet the approved training, educational, and credentialing requirements.
- ***Increase affordable access to mental health services*** by providing a distinct service and reimbursement code under public and private insurance for licensed art therapists.
- ***Attract and retain qualified art therapy professionals and art therapy students*** in Virginia.
- ***Contribute to the economy of the state*** through expansion of art therapists' businesses and practices, increased employment, payment of taxes, and state licensure and renewal fees.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state.

Thank you again for your time, energy, and service to the residents of VA. We look forward to being in touch.

Sincerely,

Eileen Douglas, MS, LPC, ATR-BC
Assistant Professor
Graduate Art Therapy & Counseling Program
School of Health Professions
Eastern Virginia Medical School | Lester Hall | Room 301 |
☎: 757.446.5895 | 🖷: 757.446.6179 | ✉: douglaek@evms.edu

Shenandoah Art Therapy, LLC
P: (540) 255-1458 ~ F: (571) 482-6060 ~ A: 1600 N. Coalter St. Suite 8, Staunton, VA 24401

Laura L. Jackson
The Virginia Board of Health Professions
9960 Maryland Drive, Suite 300
Richmond, VA 23233-1463

July 26, 2018

Dear Laura Jackson,

Hello! I am a credentialed and Board-Certified art therapist and Certified trauma therapist who lives and works in Virginia. I am also the Delegate to the Assembly of Chapters on the board of the Virginia Art Therapy Association (VATA), with whom I'm working to raise awareness of art therapy, advocate for the safety of Virginians, and establish a state art therapy license in Virginia. We are dedicated to closing the current gap between mental health diagnoses and affordable, quality treatment in Virginia and believe a state art therapy license will help achieve this goal.

I am thrilled to have the opportunity to write to you in support of a license for art therapists. A license would allow Virginia to both ensure its residents receive art therapy services from trained and credentialed professionals and also expand access to art therapy services, which may be the most effective for a client's needs, but possibly unavailable in our current circumstance.

I personally saw the great need for access to art therapy services at the outpatient level in my community. As a result, I founded and manage a 2-art therapist private practice, which has stayed active despite the limitation of my client's not being able to use their insurance (due to lack of licensure). However, about 50% of the inquiries we get from our community are unable to access our services due to a need to go through their insurance company. In addition to lack of access, my secondary concern is that without title protection or a license, anyone can open a practice and claim to be providing art therapy services without the proper training, education and supervision. This, by default, puts the responsibility on clients to research and identify if their art therapist is properly trained and credentialed, which in my opinion is not fair to a population that may be vulnerable due to their mental or physical health and may not have the resources to protect themselves in this way.

I am attaching an article from the International Journal of Art Therapy that further outlines the potential for harm by illustrating an example of a client who was both severely physically and emotionally harmed in a session where art therapy techniques were implemented by a clinician with no art therapy training.

In the United Kingdom, the British Association of Art Therapists reported this year on a 20 year review of regulating art therapists. They found that in that 20 year span of time, 77 cases were brought to the Health and Care Professions Council (HCPC) and of those cases, 10 art therapists were no longer able to practice and 6 art therapists were restricted in their practice due to either inappropriate relationships with clients, fraud, accountability or health impairment. It would be helpful if we, too could protect our commonwealth from this malpractice.

My final attachment is a description provided by the Potomac Art Therapy Association to outline the comparison of art therapy programs to other mental health professions that are comparable. It helps to provide insight into the similarities that art therapists have in their training compared to other professions who are already licensed.

State licensure of professional art therapists will also support assessment and treatment for (*but not limited to*):

- ***Veterans, active duty military, and their families*** who are experiencing mental health problems, including PTSD, traumatic brain injury, depression, and increasing rates of suicide.
- ***The growing numbers of older adults*** suffering with dementia and depression.
- ***People of all ages with cancer*** who need complimentary therapies to increase quality of life and cope with the physical and emotional symptoms of diagnosis and treatment.
- ***Individuals with developmental disabilities (i.e., autism)*** who need specially trained, qualified therapists.
- ***Those experiencing trauma*** from natural disasters, abuse, drug dependency, or other mental health problems in the general population.

Your support and attention to a state art therapy license is greatly appreciated and vital for the health, safety, and well-being of Virginians across the state. Thank you again for your time, energy, and service to the residents of Virginia. We look forward to future contact.

Sincerely,

Laura Tuomisto, ATR-BC, CTT
Director/Art Therapist/Certified Trauma Therapist
Shenandoah Art Therapy, LLC
Greenbrier Office Park
1600 N. Coalter St., Suite 8
Staunton, VA 24401
540.255.1458
laura@shenarttherapy.com
www.shenarttherapy.com

Overview of Art Therapy Education Standards Compared to Other Mental Health Professions

(updated 12 December 2017)

Art Therapy (Accreditation Council for Art Therapy Education)	**Professional Counseling** (Counseling for Accreditation of Counseling and Related Educational Programs)	**Marriage and Family Therapy** (Commission on Accreditation for Marriage and Family Therapy Education)	**Social Work** (Council on Social Work Education)	**Psychology** (American Psychological Association – Commission on Accreditation)
Masters (60 credits)	**Masters (60 credits)**	**Masters (60 credits)**	**Masters (60 credits)**	**Doctorate (72 credits)**
a. History and theory of art therapy	1. Professional Counseling Orientation and Ethical Practice	FCA 1: Foundations of Relational/Systemic Practice, Theories & Model		Category 1: History and Systems of Psychology
b. Professional Orientation, Ethical, and Legal Issues	1. Professional Counseling Orientation and Ethical Practice	FCA 5: Professional Identity, Law, Ethics & Social Responsibility	Competency 1: Demonstrate Ethical and Professional Behavior	Profession-Wide Competencies: II. Ethical and legal standards IV. Professional values and attitudes VIII. Supervision
c. Materials and Techniques of Art Therapy Practice				
d. Creativity, Symbolism, and Metaphor				
e. Group Work	6. Group Counseling and Group Work	FCA 2: Clinical Treatment with Individuals, Couples and Families	Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities	Profession-Wide Competencies: VII. Intervention
f. Art Therapy Assessments	7. Assessment and Testing	FCA 7: Systemic/ Relational Assessment & Mental Health Diagnosis and Treatment	Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities	Category 4: Research Methods, Statistical Analysis, and Psychometrics
g. Thesis or Culminating Project				Profession-Wide Competencies: I. Research
h. Human Growth and Development	3. Human Growth and Development	FCA 6: Biopsychosocial Health & Development Across the Life Span	Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities	Category 2.4: Developmental Aspects of Behavior
i. Helping Relationships and Applications	5. Counseling and Helping Relationships	FCA 2: Clinical Treatment with Individuals, Couples and Families	Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities	Category 2: Basic Content Areas in Scientific Psychology Profession-Wide Competencies: V. Communication and interpersonal skills
j. Psychopathology and Diagnosis	7. Assessment and Testing	FCA 7: Systemic/ Relational Assessment & Mental Health Diagnosis and Treatment	Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities	Category 4: Research Methods, Statistical Analysis, and Psychometrics
k. Psychological and Counseling Theories	5. Counseling and Helping Relationships	FCA 1: Foundations of Relational/Systemic Practice, Theories & Model	Competency 6: Engage with Individuals, Families, Groups, Organizations, and Communities	Category 2: Basic Content Areas in Scientific Psychology Category 3: Advanced Integrative Knowledge in Scientific Psychology

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l. Appraisal and Evaluation	7. Assessment and Testing	FCA 7: Systemic/ Relational Assessment & Mental Health Diagnosis and Treatment	Competency 7: Assess Individuals, Families, Groups, Organizations, and Communities	Category 4: Research Methods, Statistical Analysis, and Psychometrics
m. Research	8. Research and Program Evaluation	FCA 4: Research & Evaluatio	Competency 4: Engage In Practice-informed Research and Research-informed Practice Competency 9: Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities	Category 4: Research Methods, Statistical Analysis, and Psychometrics
n. Cultural and Social Issues	2. Social and cultural diversity	FCA 3: Diverse, Multicultural and /or Underserved Communities	Competency 2: Engage Diversity and Difference in Practice Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice Competency 5: Engage in Policy Practice	Profession-Wide Competencies: III. Individual and cultural diversity
o. Studio art				
p. Specializations	5. Counseling and Helping Relationships	FCA 8: Contemporary Issues FCA 9: Community Intersections & Collaboration	Competency 8: Intervene with Individuals, Families, Groups, Organizations, and Communities	Profession-Wide Competencies: VII. Intervention
q. Career Development (optional)	4. Career Development			
Practicum/Internship	Practicum and internship	Practice Component	Field Education	Internship

Resources:

Accreditation Council for Art Therapy Education. (2016). Standards and Guidelines for the Accreditation of Educational Programs in Art Therapy. https://www.caahep.org/getattachment/About-CAAHEP/Committees-on-Accreditation/Art-Therapy/Art-Therapy-Standards-2017(1).pdf.aspx

American Psychological Association Commission on Accreditation. (2015). Implementing regulations Section C: IRs Related to the Standards of Accreditation. http://www.apa.org/ed/accreditation/section-c-soa.pdf

Commission on Accreditation for Marriage and Family Therapy Education. (2017). Accreditation Standards. http://dx5br1z4f6n0k.cloudfront.net/imis15/Documents/COAMFTE/Accreditation%20Resources/2018%20COAMFTE%20Accreditation%20Standards%20Version%2012.pdf

Council on Social Work Education. (2015). Educational Policy and Accreditation Standards. https://www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx

Counseling for Accreditation of Counseling and Related Educational Programs. (2015). 2016 CACREP Standards. http://www.cacrep.org/wp-content/uploads/2017/07/2016-Standards-with-Glossary-7.2017.pdf

APPENDIX 5 – AATA RECOMMENDED LEGISLATIVE PROVISIONS FOR DEFINING ART THERAPY AND THE SCOPE OF PRACTICE OF ART THERAPY IN STATE LICENSURE BILLS

The AATA provided the following information at the August 23, 2018 meeting to be included in the final report.

American Art Therapy Association

Recommended Legislative Provisions for Defining Art Therapy and the Scope of Practice of Art Therapy in State Licensure Bills

State licensing laws and legislative bills generally follow one of three approaches in describing health and mental health professions or specialties to be licensed and the professions' or specialties' approved scope of professional practice. Many states include these descriptions as one of more definitions in the "definitions" sections of licensure bills *(the Maryland and Kentucky art therapy licensing laws follow this approach).* A number of large states structure legislation to include this information in separate "scope of practice" sections in professional licensure bills. Other states simply describe a profession or specialty by the academic and experience requirements needed to qualify for licensure , without specific definitions for the profession/specialty or its scope of practice *(the New Mexico and Kentucky art therapy acts and Texas ' LPC art therapy subspecialty statute follow this approach).*

An important strategic goal of the Association is to ensure that licensed and credentialed art therapy professionals are recognized by legislators, regulators and insurers in all states. This will require a high level of uniformity in standards governing licensure and practice of art therapy in state licensing laws. AATA's Government Affairs Committee (GAC) has developed the following legislative provisions , modeled on the language of the 2012 Maryland law, to guide chapters in describing professional art therapy and the practice of professional art therapy in state licensure bills. Chapters are strongly encouraged to use one or more of the model legislative provisions that correspond to the structure of licensure legislation in their state.

DEFINITIONS OF PROFESSIONAL ART THERAPY AND THE PRACTICE OF PROFESSIONAL ART THERAPY:

"Sec. . Definitions.

(a) "Professional art therapy" means the integrated use of psychotherapeutic principles , art media, and the creative process to assist individuals, families, or groups in:

(1) Increasing awareness of self and others;

(2) Coping with symptoms, stress, and traumatic experiences;

(3) Enhancing cognitive abilities; and

(4) Identifying and assessing clients' needs in order to implement therapeutic intervention to meet developmental, behavioral, mental, and emotional needs.

(b)"Practice of professional art therapy" means to engage professionally and for compensation in art therapy and appraisal activities by providing services involving the application of art therapy principles and methods in the diagnosis , prevention, treatment, and amelioration of psychological problems and emotional or mental conditions that includes , but is not limited to:

(I) Clinical appraisal and treatment activities during individual , couples, family or group sessions which provide opportunities for expression through the creative process;

(2) Using the process and products of art creation to tap into client' s inner fears, conflicts and core issues with the goal of improving physical, mental and emotional functioning and well-being ;

(3) Using diagnostic art therapy assessments to determine treatment goals and implement therapeutic art interventions which meet developmental , mental , and emotional needs ; and

(4) Employing art media , the creative process and the resulting artwork to assist clients to:

(i) Reduce psychiatric symptoms of depression, anxiety , post traumatic stress, and attachment disorders ;

(ii) Enhance neurological, cognitive, and verbal abilities, develop social skills, aid sensory impairments , and move developmental capabilities forward in specific areas;

(iii) Cope with symptom s of stress, anxiety, traumatic experiences and grief;

(iv) Explore feelings, gain insight into behaviors , and reconcile emotional conflicts;

(v) Improve or restore functioning and a sense of personal well-being;

(vi) Increase coping skills, se lf-esteem, awareness of self and empathy for others;

(vii) Healthy channeling of anger and guilt; and

(viii) Improve school performance, family functioning and parent/child relationship.

Scope of Practice for Professional Art Therapy:

Sec. _ . Scope of Practice of a Licensed Professional Art Therapist.

The scope of practice of a licensed professional art therapist includes, but is not limited to:

(a) The use of psychotherapeutic principles, art media, and the creative process to assist individuals, families , or groups in:

(1) Increasing awareness of self and others;

(2) Coping with symptoms, stress, and traumatic experiences;

(3) Enhancing cognitive abilities; and

(4) Identifying and assessing clients' needs in order to implement therapeutic intervention to meet developmental, behavioral, mental, and emotional needs.

(b) The application of art therapy principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems and emotional or mental conditions that include , but are not limited to:

(1) Clinical appraisal and treatment activities during individual , couples, family or group sessions which provide opportunities for expression through the creative process;

(2) Using the process and products of art creation to tap into client' s inner fears, conflicts and core issues with the goal of improving physical, mental and emotional functioning and well-being; and

(3) Using diagnostic art therapy assessments to determine treatment goals and implement therapeutic art interventions which meet developmental, mental, and emotional needs; an

(c) The employment of art media , the creative process and the resulting artwork to assist clients to:

(1) Reduce psychiatric symptoms of depression , anxiety, post traumatic stress, and attachment disorders;

(2) Enhance neurological, cognitive , and verbal abilities, develop social skills, aid sensory impairments, and move developmental capabilities forward in specific areas;

(3) Cope with symptoms of stress, anxiety, traumatic experiences and grief;

(4) Explore feelings, gain insight into behaviors, and reconcile emotional conflicts;

(5) Improve or restore functioning and a sense of personal well-being;

(6) Increase coping skills, self-esteem, awareness of self and empathy for others;

(7) Healthy channeling of anger and guilt; and

(8) Improve school performance, family functioning and parent/child relationship.

PROFESSIONAL ART THERAPY: REQUIREMENTS FOR LICENSURE

Sec.___ . Licensure of Professional Art Therapists

To qualify for a license to practice professional art therapy, an applicant shall be an individual who meets the requirements of this section.

(a) The applicant shall be of good moral character.

(b) The applicant shall be at least 18 years old.

(c) The applicant shall hold a master's or doctoral degree in art therapy from an accredited educational institution that is approved by the *(Board)*, and shall have completed:

(1) A minimum of 60 graduate credit hours in an art therapy program accredited by the American Art Therapy Association and approved by the *(Board);* and

(2) Not less than two (2) years, with a minimum of 2,000 hours, of supervised experience in art therapy approved by the (Board), one half of which, or a minimum of 1,000 client contact hours under appropriate supervision , shall have been completed after the award of the graduate degree.

(d) The applicant shall provide documentation to the *(Board)* evidencing the completion of 60 hours of graduate course work from an accredited college or university in a program of art therapy approved by the American Art Therapy Association , or a substantially equivalent program approved by the *(Board)* that includes graduate-level training in:

(1) The art therapy profession;

(2) Theory and practice of art therapy;

(3) Human growth and developmental dynamics in art;

(4) Application of art therapy with people in different treatment settings;

(5) Art therapy appraisal, diagnosis and assessment;

(6) Ethical and legal issues of art therapy practice;

(7) Matters of cultural and social diversity bearing on the practice of art therapy;

(8) Standards of good art therapy practice;

(9) Group art therapy; and

(f) The applicant shall pass the Board Examination of the Art Therapy