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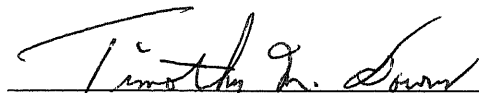
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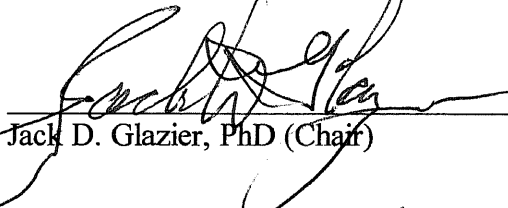
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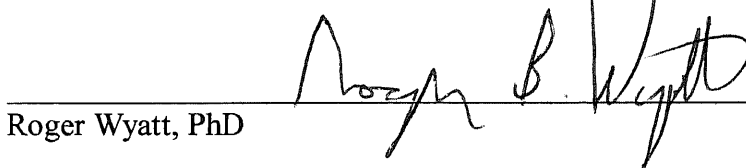
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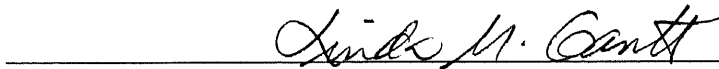
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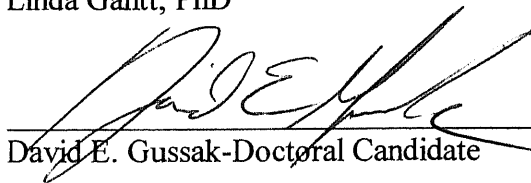
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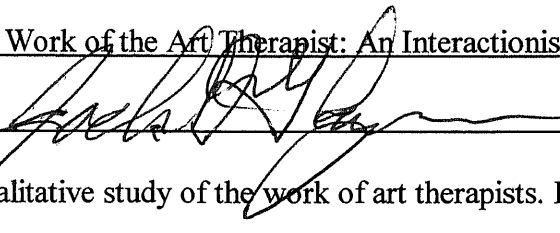


David E. Gussak-Doctoral Candidate

AN ABSTRACT OF THE DISSERTATION  
FOR THE DEGREE DOCTOR OF PHILOSOPHY IN THE  
SCHOOL OF LIBRARY AND INFORMATION MANAGEMENT

David E. Gussak presented on September 11, 2001

Title: The Work of the Art Therapist: An Interactionist Perspective

Abstract approved: 

This is a qualitative study of the work of art therapists. Eleven art therapists were interviewed and/or observed within their professional systems and the interactions between their theories and their actual practices were explored. The research questions focused on the art therapists' relationships within their systems, their perceptions of what constituted their work, the interactions between their theories and their practices, and reflections of what they said they did compared to what they actually did during their own work. Interactionism was used as the theoretical framework. Systematic observation and interviews were used to gather the data, using a grounded theory approach. Five art therapists were chosen for observation; each was followed and observed during his or her work day, for no more than one week each. Six additional art therapists participated in open-ended interviews.

One component of this study explored various ways in which the systems influenced the art therapists' work. It was found that the participants' systems were comprised of: where they worked; the institution from where they received their degrees; the teachers and peers with whom they interacted within their respective institutions; state and national regulatory bodies; national and state associations; those they considered heroes of the field; other art therapists; and facilities in which they worked before. This

study revealed how the art therapists communicated within and between systems, the systemic negotiations that occurred, and the importance of personal and professional heroes. Routinization and conventions also became key components to understanding the practices of the art therapists. Much of what the art therapists actually did during the course of their days was not always easily articulated, but rather was instinctual and routinized.

This study also revealed that despite the art therapists' beliefs that practice took precedence over theory, theory and practice actually coevolved. The cycles created between the art therapists' theories and practices, and the manner in which the systems informed the theories and practices provided concrete examples of how information is transferred within an open organization.

THE WORK OF THE ART THERAPIST:  
AN INTERACTIONIST PERSPECTIVE

by

David E. Gussak

Emporia, Kansas

September 11, 2001

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A Dissertation

Presented to

EMPORIA STATE UNIVERSITY

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In Partial Fulfillment

of the Requirements for the Degree

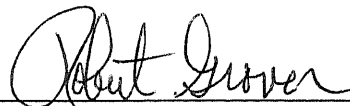
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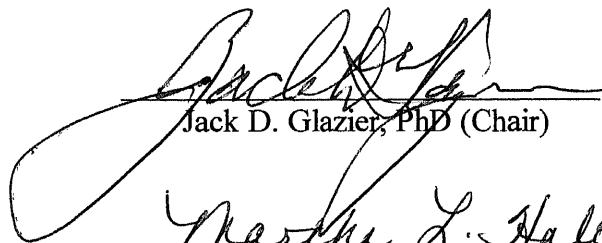
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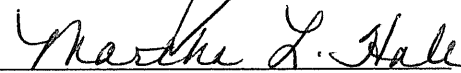
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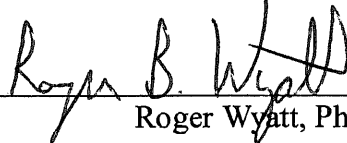
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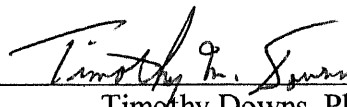
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Roger Wyatt, PhD



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Linda Gantt, PhD



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Timothy Downs, PhD  
Dean of Graduate Studies and Research

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I also wish to thank all my friends, colleagues and my family for providing support and guidance during this long process. All the faculty and students of the Psychology and Special Education Department at Emporia State University, especially in the Graduate Art Therapy Program deserve my gratitude as over the years they were extremely supportive and understanding. I particularly want to thank several of my colleagues, Dr. George Yancey, Ms. Emily Endreson, Dr. Ken Weaver, Ms. Rebecca Miller, and Mr. Jason Knight, who provided much valuable feedback, assistance and sanity. I wish to thank all the art therapists who participated in this study-although they must remain nameless, I will always remember their cooperation and patience.

I would especially like to thank my lovely daughter Samantha Rose. Although she does not comprehend now why things happened the way they did, I hope that someday she will understand and take pride in what her father accomplished.

I dedicate this doctoral dissertation to the loving memory of Dr. Nancy Knapp-teacher, colleague and friend. With Dr. Knapp's belief, support and tenacity, I found the courage to make many sacrifices to come to Kansas to pursue a career in higher education and my doctorate. She truly was the center of it all.

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## Chapter I

### Introduction

This is a study of the work of art therapists. Art therapists were interviewed and observed within their professional context and the interaction(s) between their theories and their actual practices were explored and analyzed. Tension between those who engage in theory development and those who engage in practice has long been present within professional groups (Marsden & Townley, 1996), and thus became an important characteristic of this study.

This study will contribute to two fields: art therapy, and the area of information transfer and the diffusion of information within the field of Information Management. The art therapy field will benefit from learning about the systems to which the members of the field belong and are influenced by, how its theories are used in practice, and the interaction between theory and practice. The area of information transfer will benefit from the understanding of how the theoretical information in a social system is disseminated, diffused and utilized for practice.

There are many definitions for art therapy (Kramer, 1966; Naumburg, 1971; Rubin, 1987; Ulman, 1975). In addition, members of the discipline hold an array of different titles and maintain different credentials (Berkowitz & Gussak, 1999). Much of the literature available describes how to conduct art therapy (Landgarten, 1981; Wadson, 1980), where to do art therapy (Rubin, 1998; Virshup, 1993), and the characteristics needed to be a successful art therapist (Robbins, 1982, 1987, 1998; Rubin, 1984). However, there has been very little published that is aimed directly at the art therapists and



their work, nor is there a substantial body of work intended to clarify the differences and links among the individuals and groups in the field.

This chapter will consist of the literature review that provides both the disciplinary and theoretical contexts that informed this study. Chapter 2 provides the methodological foundation for this study, followed by the research questions, the description of the sample, and the means by which the data were gathered and analyzed. Chapter 3 will present the results and discussions focusing on the systemic interactions of the participating art therapists. This will include: an outline of the systems to which each art therapist belonged; an exploration of how the art therapists' systems influenced their work, including how they communicated within and between systems and the negotiations that occurred; and an exploration of the importance of personal and professional heroes for the art therapist. Chapter 4 will focus on the interaction of the participating art therapists' theory and practice. Key components explored in Chapter 4 are routinization and conventions. It will conclude with a summary of how each art therapist defined "an art therapist." Chapter 5 will include an overview of how diffusion of information can be used to evaluate the interactions that occurred. It will also readdress the research questions and summarize their answers, and will delineate the conclusions that emerged about the work of the art therapist.

#### Literature Review

Several researchers have contributed to understanding the nature of work. Strauss (1978) examined the role of negotiation in the workplace. Strauss, with Fagerhaugh, Suszek, and Wiener, (1985/1997) also contributed to understanding work in terms of its

parts and categories. Hughes (1959/1994) concentrated on studying how individuals and groups constituted work and working environments. Hughes' methods of observing actual work situations have since served as methodological landmarks in this area.

Becker (1982) also contributed significantly to the study of work. He stressed the importance of conventions in his study of the art world. Conventions are shared symbolic meanings within a subculture that define the parameters of a large and diverse field; the artist subculture not only consists of the artists, but of the patrons themselves (Becker, 1982; Gilmore, 1990). These conventions are deliberately utilized within the subculture network. Artists anticipate how people will respond to a given convention and create their work accordingly. Conventions also emerged in this study of the art therapists.

Other studies of work have provided important information about discrepancies and imbalance within societal structures. In her study of janitorial workers, Chatman (1987) found that their environment was primarily defined and controlled through social barriers and the control of important information. Kanter (1977), while observing corporate work, found that there existed inequalities in structures of opportunity based predominantly on gender roles.

### Work

It is understood that there is one broad context, the system (Boulding, 1978), within which interactions occur that define the work. Interactions between the theories and practices of the systems' members also contribute to how their work is defined. Information transfer contributes to the developing coordination of theory and practice within a social context. Information transfer is the means by which members gain

information from their system, and how it is ultimately redistributed and cycled back into the system. Therefore, the work of art therapists was explored within a system's context in which the theories and practices were encompassed.

Part of the challenge is to gain an understanding of the interactions between these theories and practices within the system. The relationships between theory and practice are constructed by the actors and cannot always be predetermined because of rapidly changing situations (Boulding, 1978). This study employed a grounded theory approach to explore the practice and work of art therapists within their system (explained further in Chapter 2).

#### Systems, Theory and Practice

Systems theory is integral in understanding the systems context. Generally, this view maintains that the whole is more than the sum of its parts. Most systems theorists stress that everything is an open system and the interaction with other systems in the environment influences the organizational development (Capra, 1996); these theorists (Kelly, 1994; von Bertalanffy, 1988; Wiener, 1965) contend that the interaction of an individual component within a system allows us to better understand systems. This includes interactions between two objects, or between an object and its environment. To understand these objects, they must be studied and observed interacting with and within their environments and contexts. Capra called this "contextual thinking" (1996, p.37), "environmental thinking" (1996, p.37), and/or "process thinking" (1996, p.42). The environment is continuously influenced by other systems, which in turn influences and changes the responses of another's system. Each component is linked together through a network, and these networks are linked together through their interaction, creating a web.

Becker referred to the social organization of the art world as a web, indicating that the conventions linked the members of the system together (1982). Understanding this web provides a fuller comprehension of the full notion of work as it occurs relative to art therapy. The members of the group, the art therapists, need to be understood as part of an interacting system (Luhmann, 1995).

Through the interactions within and between systems there is an input, an output and a "throughput" (Wyatt, personal communication, October 28, 1999). In biological terms, something is consumed, it gets transformed and gets expelled. What is consumed, defined as "input," varies, modifying the output. For example, the input, theories of art therapy, might be influenced by the throughput, the contextual system to which the art therapist belongs, and are thus transformed into the output, the applied practice of the professional. It is the throughput (Heylighen, 1998), the actions of the networks within the system and how the system responds to the input, that transforms what is consumed. This stems from Wiener's (1965) concept of cybernetics.

Cybernetics is the study of organizational control in complex systems by focusing on its feedback mechanisms (Wiener, 1965). Wiener argued that the world is one large feedback system (McAdams, 1995; Wiener, 1965). Incoming messages influence the systems; information goes in and it is processed. As the system responds to the information, various actions occur. What is "inputted" (Wyatt, personal communication, October 28, 1999) how much is inputted, and how it is transformed into the output is based on the feedback received from the system.

The system makes and supports itself, and it is the linked components of the

system that form an influential network. Each system is able to maintain its own boundaries, defined by the processes that occur within it. However, each of these systems is linked and influenced by other systems, to create a whole new self-influencing network, which in turn interact with other, larger, networks (Maturana & Varela, 1980). This was called autopoiesis by Maturana and Varela (1980), which they defined as a network of processes, in which each component produces or transforms other components in the network. Art therapists are frequently linked to each other to form one type of network, while many art therapists are linked to other health care professionals to create larger networks.

Organisms or systems require each other to evolve, to develop. Achleitner, Wyatt and Vowell noted that from a system's view, "[s]tructure is emergent and coevolutionary, having some of the following characteristics: self-organizing, self-transcending, self-maintaining" (1997, paragraph #3 ). A systems perspective paves the way for a clearer understanding of the structures and transfer of knowledge. Schwartz and Ogilvy (1979) indicated that a new paradigm has emerged in order to understand the more complex systems that have been developing in fields, from economics to art. The major consequence has been the shift from a single absolute truth to the acceptance of multiple 'rights', explained through many methods (1979). No longer is there one true way to assess how knowledge is processed in disciplines, but rather complex dynamics are accepted, and no two processes are the same.

Schwartz and Ogilvy (1979) accepted the systems notion that "diversity, interaction, and open systems are the nature of things"(p.12) and that the use and gain of

knowledge is structured as a complex web, a network. It is the acceptance of this understanding that provides a basis for observing the 'web' of the art therapist. The web of the art therapists includes, but is not limited to, professional organizations, the educational and professional standards, the agencies and institutions where the clinician works, other art therapists and professional representatives, and the art therapists' clients.

Art therapists both belong to and influence the systems to which they belong. In order to understand their systems, and how these systems interact with and influence the art therapists' theories and practice, the art therapists' interactions need to be observed. However, to understand how these interactions influenced and changed their systems, the development of the theories of the field needs to be discerned. The theories of the art therapy field, and the adoption of these theories by professionals, constitute an invisible college of art therapists (Gussak, 2000).

The process in which an idea is created, presented, and if interesting enough, investigated by a cluster of people constitutes diffusion through what is referred to as an invisible college (de Solla Price, 1963). For purposes here, an invisible college is a group of like-minded individuals who are linked together by a range of theoretical beliefs. Its boundaries are socially defined around these beliefs, and are often used to guide the group's research or applications. Eventually, cohesive networks form out of which a discipline may emerge. For this study, a discipline is a conceptual area of inquiry in which the members, the invisible college, explore a set of theoretical propositions (Grover & Glazier, 1986), and who may or may not have divergent perspectives on similar concepts

and ideas. Hence, an invisible college that debates the underlying theories and ideas of art therapy has formed.

Mullins and Mullins (1973) argued that theoretical ideas are diffused through connections made through networks of students and colleagues. Connections are made between theorists by communication, coauthorship, apprenticeship and collegiality. Theorists continuously form, break, and re-form these connections, depending on the theorists' current theoretical perspectives. Thus, what may have been intended as one idea can progress into several innovative theories. Ideas and theories can branch off to formulate a variety of perspectives. Ideally, the practice of the discipline may then be guided by the developed and diffused theoretical ideas.

Still, there has been much debate over the difference between the role of theory and that of practice; whether or not they interact, are mutually exclusive, or fall somewhere in between. For some, they appear to interact (Marsden & Townley, 1996) within a system. In essence, the theoretical idea is the input, it is processed through the system, and the practice is the output, transformed. For example, it may be that although art therapy theories are initially learned, their practical application changes depending on the system to which the art therapist operates. In some settings, uncovering unconscious material from a client in a private clinic may benefit the healing process (Naumburg, 1966). However, such disclosure and awareness in a prison may leave the client vulnerable and the target for harm. Therefore, the art therapy process is modified to benefit the clients in that specific system (Gussak, 1997).

There are some who claimed that theory maintains no significance for practice.

Thomas (1997) argued that although theory is established as a means to guide inquiry, it has become accepted as the gospel of what is true until it is challenged. In other words, a theory is established, thereby creating rule sets or parameters of what is correct or accurate. Studies are then conducted to support this notion. Theory is created or developed, and the ensuing studies conducted in the name of this theory are completed to justify and validate the stated theory. It distorts the understanding of practice so that the practice as formulated and observed supports the theoretical premise, and all else is discarded as superfluous or anecdotal. It is theory-first (Thomas, 1997), and the practice is seen through a distorted lens.

Others have argued against a single overriding theory dictating or predicting a practical outcome. In this camp, theory is still linked with practice-it is, however, practice that dictates which theory is used. Many of the art therapists observed and interviewed in this study tended to believe this perspective; that their theoretical orientation differed depending on the situations and individual interactions.

Bolan (1980) conceived of a gap between theory and practice; however, he claimed that this stemmed from the professional's view that action is guided by knowledge. Bolan insisted that knowledge derives from action; that it is interests and activities, the *practice*, that guides what is known, which, in turn, becomes theories.

Bolan also wrote that practice begins to separate from theory when "environmental turbulence" (1980, p. 263) creates a need for adaptation and shifts in theoretical concepts to deal with specific situations. According to Bolan, the observance of an action of an individual in practice would provide a better understanding of a social or organizational



situation, rather than relying on theory. Although Bolan did give some credence to theory, he claimed individual practitioners constructed their own “individualized espoused theory from his [or her] own perspective. . .” out of which “. . . [an] individual’s theory-in-use is constructed” (1980, p. 264). Therefore, the theory that someone originally subscribes to transforms into a practical response, given certain circumstances and interactions within a system. The art therapists observed revealed a tendency for situational routines a proclivity to adapt to situations that disrupted their routine.

While academicians stress the importance of theory, and practitioners stress the importance of practice, others stress that the two maintain an imperative, interactive relationship. Argyris and Schon (1974) created the distinction between espoused theory, and theory-in-use or action. They claimed that there is a fundamental “difference between formal theory and the explicit informal knowledge of everyday life”(p. 8). Theory-in-use may not even be available for discussion or explanation-it becomes tacit. Theory-in-use takes into account everything about human behavior, and its context; it is the understanding that in everyday life systems, theory does not exist in a vacuum. It becomes implicit. Argyris and Schon (1974) argued that models could be created for theories in action, to be the bridge between theory and practice. However, the theory is required in order to move to the next level of action. The theory becomes altered and is accommodated in order to fit within a new contextual construct. For example, a new theory was developed about how art therapy can benefit prison inmates (Gussak, 1997). This theory was not developed until an art therapist was in a situation where originally held theories were not applicable. A new series of theories were developed, which in turn

helped guide the practice of future art therapists in prison settings. From this perspective, regardless of which is more significant, theory or practice, both are relied upon to explain the other.

The field of art therapy is eclectic (Rubin, 1998) and it may seem at times that there is a discrepancy between what is taught and what is practiced. Weick (1996), an organizational theorist, used teaching as a means to bridge theory and practice. He approached his students as a theoretician who talked about his own work, his own practice. He presented his theoretical concepts and provided a systemic context for them; he grounded them in experience. Weick “. . . was interested in connections and integration, in patterns that constitute meaning and in sensemaking” (p.257). By this, he meant finding the bridges, the interaction, between theorists and practitioners so that they may understand each other.

Weick (1996) argued that those who relied on theory, academicians, relied on generality and accuracy; whereas those who relied on practice best understood simplicity and accuracy. An understanding of these differences, as well as the overlap, would allow a theoretician to communicate with a practitioner. It was in this manner that Weick constructed the bridge-as a teacher, he was able to present his theories in practical and applicable ways for the practitioner. It was through the interaction between the teacher and the student, an understanding of the system that includes the teacher and student, and an interaction between the people and the words that were used to communicate the ideas, that such knowledge could be conveyed.

The area of information transfer in the field of Information Management will

benefit from this study through the understanding of how the theoretical information of art therapists in their social system is diffused and ultimately utilized.

### Diffusion of Information

In the field of Information Management, there are several information transfer models that have been identified. One information transfer model has been described as a value chain process-the creation, production, dissemination, organization, diffusion, utilization, preservation and destruction of information (Achleitner, Vowell & Wyatt, 1997). A similar model divides knowledge development into eleven distinct processes: identification; acquisition; generation; validation; capture; diffusion; embodiment; realization; utilization/application; architecture; and storage (Johnston & Blumentritt, 1998). Although both models can be seen as a chain or linear process, they are actually cyclical. Information can feed back or feed forward (Wyatt, personal communication, October 28, 1999) on itself at any juncture within the process. What is more, several of the processes can occur simultaneously, and some may not operate at all. The models parallel in their emphasis on diffusion, a complex yet crucial component of information transfer.

Beal and Bohlen (1955; 1957) theorized that five stages in the diffusion process existed: 1) awareness, 2) interest, 3) evaluation, 4) trial, and 5) adoption. Everett Rogers (1995) built upon and expanded the theory of diffusion.

According to Rogers, diffusion is defined as ". . . the process by which an innovation is communicated through certain channels over time among the members of a social system" (1995, p.10-italics removed). There are four elements within his model-

innovation, communication channels, time and social system. These elements emerged as crucial to the diffusion of art therapy by the participants of this study.

Innovations are seen as new ideas, practices, or objects presented for adoption (Rogers, 1995). They maintain the characteristics of: relative advantage (how an idea is perceived as better than what it replaces); compatibility (how the new innovation fits in with existing values and needs); complexity (the easier the innovation is to understand, the easier it is adopted); trialability (how much the new innovation can be tried and experimented with for a period of time); and observability (concerned with how visible the innovation is to others-the more visible, the more likely it will be adopted). The art therapists observed and interviewed in this study recognized the necessity for introducing the innovations of art therapy and keeping them visible and compatible within their individual systems. In order for them to spread the innovations, they maintained communication channels.

Communication channels are concerned with the homophilous or heterophilous composition of the social group in which the diffusion is attempted. A homophilous group is composed of two or more interacting individuals who are similar; a heterophilous group is composed of two or more individuals who maintain different attributes (Rogers, 1995). In the beginning of the diffusion process, homophily is more desirable to ease the diffusion process through common language and communication channels. As time progresses, heterophily tends to be more critical, to spread the innovations beyond the limited boundaries of a single group. An art therapist's theoretical perspectives are easier to accept within a community of other art therapists. However, when art therapists interact

with members of more diverse systems, the ideas of art therapy will spread and may well be altered.

Time is another major component. It is concerned with the innovation-decision process, in which the idea is passed on from beginning of an innovation through its adoption or rejection; innovativeness and adopter categories, assessing how early certain members within a group adopt an innovation as compared to other members; and rate of adoption, the relative speed with which an innovation is accepted and utilized. The design of the social systems is yet another important component for how an innovation survives a diffusion process. Each social system maintains its own set of norms that will help dictate what types of innovations are acceptable. An art therapist's style or format may be diffused in one system, but not another. The members of a social system also understand who the opinion leaders and change agents are of their group or system. The pioneers, or personal heroes, of art therapists seem to maintain a profound impact on their work. The effect of the innovation that was adopted or rejected must also be considered, and it may be profound. Thus, the diffusion of information also relies on the negotiations that occur within a social system.

### Negotiation

One more element that needs to be discussed briefly for the purpose of this study is negotiation. "Negotiation enters into how work is defined, as well as how to do it, how much of it to do, who is to do it, how to evaluate it, how and when to reassess it, and so on . . ." (Strauss, 1997, p.267). A social order is developed in an organization or work system in which participants work out shared agreements in response to daily events

(Strauss, 1975); it depends on hierarchical structure as well as manipulation. All of the participants of this study practiced negotiation, which depended on the social interactions inherent in the art therapists' systems (Hughes, 1971). All of the art therapists' work not understood by the other members of their systemic environment was subjected to negotiation. This study revealed different levels and types of negotiations occurring between the art therapists and the other members of their systems. These include: systemic negotiation; identity compromise; and micro level, macro level, and managed care negotiation. These will be explored in detail in Chapter 3.

Thus, to study the work of the art therapist, the interaction of theory and practice and how this interaction is influenced by the system(s) through negotiations need to be understood. To understand the essentials of what art therapists know or do, they needed to be observed practicing, as well as asked about what they know.

## CHAPTER II

### Methodology

To understand the work of the art therapist, the interaction between the art therapist and his or her system was observed. Interaction between art therapists, and between the art therapists and their work environments, may alter art therapy theory into an individual's practical application. Thus, this study will primarily subscribe to an interactionist's perspective.

The theories of interactionism are built upon the philosophies of James, Cooley, Dewey, Mead and Blumer. William James claimed that the social self is developed through the interaction of the individual and social groups (James, 1890/1918). Cooley (1964), Dewey (1930), Mead (1964) and Blumer (1969) carried these ideas of interactionism further, and created a methodology in which one needed to observe the interaction in order to understand social constructions.

Cooley (1964) used interactionism as a framework to interpret social reality, asserting that a mutual interdependence exists between the social environment and individuals. He stressed that watching the interaction of people and interpreting the meaning of these actions was important in making sense of society. Dewey (1930) maintained that humans, their environments, and their thoughts are interrelated to form a larger whole; therefore, the interaction among them needs to be observed.

Mead, recognized as one of the major contributors to the theories of interactionism, argued that the self developed through its interaction and activities within social experience; he also claimed that it was the self's interactions that defined situations

(Mead, 1964; Morris, 1962). However, the self not only interacted with others, but also with its own thoughts and ideas (Mead, 1964), through reflexivity. This notion that the self is created and defined through interactions with noncorporeal objects was similar to Blumer's (1969) theoretical perspective of interactionism.

Blumer (1969) claimed that in an interaction, the person will interpret others' gestures and will then act on what they perceive the meaning to be from this translation (Blumer, 1969). But he also stresses the interaction between humans and objects. Objects have meaning for people; meaning is ". . . not intrinsic to the object but arises from how the person is initially prepared to act toward it" (Blumer, 1969, pp. 68-69). Objects can include ideas and thoughts as well as something tangible. It is the sharing of these objects, and the interpretations thereof, that define the action and interaction. Those who subscribe to interactionism claim that meaning emerges from the interaction between people (and objects). Thus, meanings and interpretations are social products. Ideas, or how meaning is attributed, lead to action and the construction of a practice and/or product. Therefore, in order to understand the work of the art therapists, this study observed them interacting with the other members of their systemic environment as well as with the environment itself.

#### Research Questions

There are several questions that guided this research project. The answers addressed what work is to an art therapist, and the relationship between the theory and practice of art therapists. The key questions that set the parameters of this study were:

–What components make up each participant art therapist's system?



- How does each participant art therapist define what an art therapist is?
- Do the art therapists' theories inform their practices?
- If so, how?
- How do the participant art therapists describe their work?
- What is the relationship between what the art therapists say their work is and what they actually do?

### Definitions and Limitations

For the purpose of this study, an art therapist was defined as anyone who has met educational or credentialing requirements laid out by the American Art Therapy Association, Inc. (AATA) and the Art Therapy Credentials Board (ATCB) to practice as an art therapist at the time the interviews and observations were conducted. The art therapists who took part in this study will be referred to as participant art therapists. Their work was defined as anything the art therapists did during the course of their scheduled day. This included, but was not limited to: paperwork; meetings, individual therapy sessions, group therapy sessions, preparing for the sessions, and informal and formal interactions with those with whom and for whom they worked. The professional environment of the art therapist is defined here as any environment that the individual is in at the time he or she is considered working.

While the sample is not broad, the object of this study is not to generalize, but to begin establishing criteria and understandings about the work of the art therapist from which theories can be drawn. This is further explored under the Sample section. Another

characteristic that could be construed as a limitation was the relationship between the researcher and the art therapy field.<sup>1</sup>

### Research Design

Interactionism was used to ground the methodological design. An understanding of the interactions that make up the art therapists' social systems, including work, was gained using an interactionist process.

To understand the individuals that make up a social system, they must be studied within the context of their environment through exploration and inspection (Blumer, 1969). Exploration (through data gathering), and inspection (through data analysis), are the observation and analysis of action. Interaction revolves around everyday action. Thus, the combination of data gathering and data analysis are naturally related to the interactionist perspective. Such methods have been used by social scientists and sociologists to study social relationships within a variety of different contexts and for a variety of issues, including the studies of work.

Hughes asserted that "work as interaction is the central theme of sociological and social psychological studies" (1971, p. 304). Corbin and Strauss (1993) indicated that it is only through interaction that one can understand work. Becker, Strauss, Greer, and Hughes subscribed to an interactionist perspective to guide their study of medical school (1961/1997).

Interactionism was needed as the framework to analyze the work within the "art world" (Becker, 1982). Strauss, Fagerhaugh, Suczek and Wiener (1985/1997) based their

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<sup>1</sup>The researcher is an art therapist as well.

work on an interactionist perspective when they exposed clear relationships and structured typographical categories of work in the medical field. Bakewell, Beeman and Reese (1988) used an interactionist framework to understand the work of art historians by observing them at work.

There are no theories on what constitutes the work of the art therapist, nor how the art therapist arrives at the practice he or she is conducting. Thus, there were no prior studies of the work of the art therapist to guide this study. The methodological approach reflected the open-ended nature of this study; this study was qualitative, and used a grounded theory approach.

#### Data Collection

Grounded Theory. The main purpose of using grounded theory was to develop a theory (Strauss & Corbin, 1990) generated from the data obtained (Glaser & Strauss, 1967). The initial inquiries started off quite broad, becoming narrower as the study progressed. The collection and analysis of the data were interrelated and occurred almost simultaneously. The units of analysis are concepts which revolved around the interaction of, in this case, the theory and practice within the system of the art therapist. These concepts that emerged guided the coding of the material. Observation continued with the emerging theory as a catalyst, and the research questions were considered given the new observed circumstances; the research questions were readjusted as observation continued, creating a seemingly never ending cycle of observation, interpretation, theory development and observation. These methods can be seen in Kanter's (1977) study of corporate work, and Becker, Hughes, Greer and Strauss' (1961/1997) study of the work of medical

students. These methods can also be seen in the doctoral dissertations of Thompson, (1998) with her study of the work of firefighters, Sudarsky-Gleiser (1995) and her study on the experiences and metaphorical communications of therapists, and Elkins (1994) with her study of professional nurses.

A grounded theory approach is deemed most appropriate given the fluctuation of the social contexts to be analyzed. Accepting that art therapists belong to expansive systems, analysis could not be successfully done in a sterile laboratory, nor quantified. Therefore, the interaction and the activities of the art therapists were analyzed within their systems. The activities included the interactions between the participants and other art therapists, their clients, their facilities for which they work and professional organizations, whether or not they belonged. The occurrence of some of these activities could be scheduled and predicted beforehand by the participant art therapists, but many were not.

Systematic observation and interviews were used to gather the data. Systematic observation was conducted to try to understand the practice of the art therapists and components of the systems of which they belong. The interviews and discussions were conducted to try to understand the theories of the art therapists. These methods of analysis were combined to clarify the work and practice of art therapists.

Sample. Five art therapists were chosen for systematic observation (see following section under Systematic Observation). The choices were based on: diverse geographical locations; different types of professional environments; and varying lengths of time in the field. Suggestions for appropriate participants were solicited from members of the field. Those suggested to participate were contacted by telephone, and were asked if they were

interested in participating. If they were, they were sent a preliminary letter (Appendix A), explaining the intent of this study. A release form (Appendix B) was sent. This form was signed by the art therapists chosen to participate; it explained that confidentiality would be maintained, and that the intent is to observe and study the art therapist in context, not to record any detailed information of the clients with whom the art therapist works.

The five art therapists chosen and observed for this study were equally distributed throughout the United States, and worked for a variety of different facilities. The length of time in the field for these five participants ranged from 1 year to 22 years. All but one of the participants were women.

All those observed were also interviewed, with six additional art therapists interviewed (see the following section under Interviews and Discussions). The art therapists chosen to participate in the interviews and discussions, and who were not observed, were selected in a similar fashion as those observed. The responses were recorded on audio tape as well as written out during the interview. Confidentiality was strictly enforced, and each art therapist interviewed was asked to sign a release form to allow the discussions to be taped (Appendix C). These procedures were reviewed and approved by the Emporia State University Human Subjects Committee.

The six art therapists chosen and interviewed for this study were also equally distributed throughout the United States. The length of time in the field for these participants ranged from 8 years to over 30 years. All but one of the participants were women. (See Appendix D for complete demographic information on each of the participants.)

Systematic observation. Systematic observations were conducted to obtain information of the systems and practices of the art therapists. Observation refers to actually following the art therapists during the course of their day and maintaining copious notes on everything they did. The researcher tried to be as unobtrusive as possible, and note not only interactions and communications, but environmental factors as well. A grounded theory strategy allowed for a small, theoretical sample. For example, in Hale's study on city managers (1989), only five managers were observed. However, it was necessary to get as much data on this limited group as possible, until saturation was reached.

Five participants were followed and observed for no more than a week each. Each art therapist was accompanied in his or her car to and from work, and all were closely followed except when in therapeutic sessions. (On rare occasions, the observer was invited to sit in on a session.) All formal and informal interactions with other art therapists, peers in the facility where they worked, subordinates and supervisors were recorded through written notes. When the researcher was alone with the art therapists, all discussions and comments were recorded on audio tape as well as written down. Each participant was informed each time the tape recorder was recording. The art therapist was questioned about what he or she was doing at that particular time, and if completing paperwork, and would be asked what it entailed. The art therapist would also be questioned about what occurred during his or her therapy sessions and the responses were tape recorded. Any interaction with the patients in an informal capacity, such as in the hallway of the unit where the art therapist worked, was observed and recorded.

Great pains were taken to ensure that no quotable dialogue was recorded from the clients, and no specific therapeutic discussion was recorded; rather, these conversations were generalized, and only behavior was meticulously recorded. The art therapist was later questioned in greater detail. In this manner, confidentiality of the therapist/client relationship was maintained without exception.

Interviews and discussions. Interviews and recorded discussions were used to obtain information of the theoretical perspectives of art therapists. An interview for a qualitative design is established in such a manner that the interviewer has a general plan of inquiry, but specific questions are not asked in any particular order, nor in any particular manner (Babbie, 1998). The interviews and discussions focused on the topics of the art therapists' personal theoretical orientation, when it developed, what they were taught in school, and what they actually did during the course of a day.

Along with the first five participants observed, six more were interviewed, with all conversations recorded on audio tape. Each participant was made aware when the tape recorder was recording. After demographic information was obtained, each participant was asked general open-ended questions to guide the discussions, but there was no set, formal interview. The participants were interviewed for an average of one hour each, and the topics for discussion included, but was not limited to: where they went to school, their theoretical focus, their professional experiences, their current professional placement, why they became art therapists, and how they defined an art therapist. All precautions were made to assure that their names were not used on the tape; however, on the off chance that a name was used, it was later stricken from the transcription.

### Data Analysis

All written and audio recorded data was transcribed, including questions posed to the participants. A large, four- inch margin was left on the left side of each transcription page for notes and coding entries. All the data was reviewed several times; the statements made and the behaviors observed were paraphrased in the left margin for easier and more succinct review. If a paraphrase was insubstantial in capturing the meaning of what was transcribed, then the entire quote or transcribed observation was rewritten. Using these paraphrased statements, the data was reviewed again, to note similar language or concepts. After several reviews, similar categorical concepts began to emerge, using the “constant comparative method” (Glaser & Strauss, 1967). A relationship between thesis, antithesis and synthesis<sup>2</sup> was employed to guide memo writing and to reflect back on the questions that materialized through the grounded theory process. Memos were written as the process continued to maintain records of potentially emergent categories. As these categories emerged, a color-coding scheme was devised to make for a more accessible review of the data. Each color was used to highlight like-terms and similar categorical concepts. The categories that ultimately emerged were: systemic influence and interaction; the participants’ interaction between theory and practice; any type of “forced” negotiation that occurred; the participants’ self-definitions of art therapists, and what they do that works; and any reflection on heroes of the field.

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<sup>2</sup>For the sake of this study, thesis and antithesis are not opposite terms. Rather, *thesis* refers to the knowledge directly obtained from the data, *antithesis* refers to the new perspectives that emerge from the data as it is constantly reviewed and coded, and *synthesis* refers to the weaving together of the two. This constantly ongoing process is not necessarily linear (Glazier, 1992).



An outline was then created to separate all the colors from one another, and to combine all the concepts together under their related categorical heading. For example, the category for “reflections on heroes of the field” were coded with a purple highlighter. All the transcriptions were reviewed, and any concept or statement that was coded purple was placed under the outlined heading “Heroes,” separated by participants to whom that concept referred. This allowed for concise reference of all the categories. These categorical concepts have then been used as the basis for this study to answer the research questions, and have led to a better understanding of the interaction between the art therapists’ theory and practice and how they are influenced by the systems to which they belong.

## CHAPTER III

### The Systemic Interactions of the Art Therapists

Individuals and organizations are not isolated; rather, their interactions with other individuals and organizations influence their definitions and development. Individuals- in this case, art therapists-survive and interact within a context and/or environment. They connect through links to create a large, web-like system.

To understand their work, the participating art therapists were observed interacting with and within their respective systems. In addition, those interviewed were questioned about their systemic influences. This chapter will present and define the systems to which each art therapist belonged. It will then explore various ways in which the systems influenced their work, and how the day-to-day activities relied on this interaction. It will do so through exploring the means in which the art therapists communicated within and between the systems, the systemic negotiations that occurred, and finally, the importance of personal and professional heroes for the art therapists.

#### The Systems

The art therapists' work is influenced not only by where they worked at the time their data was collected, and with whom, but also by their prior work history; their current clients or patients; past clients or patients; associations to which they may belong; the schools they attended; legislative, corporate or regulatory bodies that affect their status; and the art therapy field. As one participant believed, the work of the art therapist is entirely dependent on the facility for which one works. How he provided treatment, along with the details of his work, changed depending on where he worked. Or, as another

participant indicated, "We're chameleons." Each art therapist who participated in this study belonged to numerous systems.

For the sake of this study, some explanations of terms need to be provided. Internship hours refer to pre-graduate hours. As a student progresses through a program, he or she must complete a certain number of client-contact hours. At the time of this study, the American Art Therapy Association, Inc. required seven hundred pre-graduate hours of client contact using art therapy (American Art Therapy Association, 1994). These hours are supervised by an internship supervisor.

The ATR and ATR-BC are the designations that one has met certain standards for the field and are conferred by the Art Therapy Credential Board (ATCB). To qualify as a registered Art Therapist (ATR), after graduating from an AATA approved program, an individual must complete a minimum of one thousand client contact hours; if he or she did not attend an AATA approved program, then he or she must complete a minimum of two thousand direct client contact. One hour of supervision is required for every ten hours of client contact (AATA, 1999). These hours are supervised by an ATR supervisor. The Board Certification (ATR-BC) is awarded after a registered art therapist passes a national standardized examination.

Five art therapists, Amy, Bonnie, Carl, Debbie and Erin, were interviewed and observed interacting with their systems. Six art therapists, Fern, Greta, Kara, Lori, Mary and Nate, were engaged in informal discussions and interviews, but not observed in their settings. All the names are pseudonyms.

Amy attended a university that offered a dual degree in art therapy and marriage

and family therapy. Thus, she was eligible to obtain a state license as a Marriage Family Therapist (MFT). However, although she had her art therapy registration (ATR), she did not have her board certification (BC). She graduated in 1995, and obtained a position where she completed her internship. She worked for a community-funded gay and lesbian center. She worked with adults who were gay, and had mental health or substance abuse problems. Some were court ordered to attend sessions. She also had her own private Marriage Family Therapy/Art Therapy practice, which she had begun nine months before. She saw private clients in her practice about one-and-a-half days per week. She had been working at the clinic four days per week, but that had since decreased to three. She rented her own office approximately 10 miles from where she lived; she shared this office with another MFT. At the clinic she belonged to a treatment team that consisted of social workers, MFTs and case managers.

Bonnie graduated from an art therapy program in 1993. Bonnie had been involved with state and national art therapy organizations, including a term as president of her state association. She had both her registration and board certification. Prior to graduate school for art therapy, she was an art educator in a public school system. She had also worked in various hospital settings, including a "spinal cord unit" in 1980. Upon graduating, Bonnie worked with adult psychiatric patients. After two years, she went to her current placement, a not-for-profit inpatient psychiatric facility for adolescents. As part of her responsibilities, she also worked "across the street," and provided art therapy sessions two to three days per week for the day-treatment facility for adolescents. She was considered the Coordinator of the Creative Arts Therapies. She also provided internship training for

students attending local graduate programs. She belonged to a treatment team that consisted of social workers, nurses, program coordinator, nursing coordinator, psychologists, case managers and mental health workers. When asked to describe her facility she indicated that it was a “hybrid of weirdness . . . it’s a venerable institution, a training institution . . . so it’s not going to have a business mentality . . . .”

Carl graduated in 1999, and began working for the facility where he completed his internship. He was still attending his alma mater so that he could complete coursework necessary for him to obtain a license as a substance abuse counselor. He had not yet completed the paperwork for his registration. He was a member of a national art therapy committee. Carl worked full time for a facility that was a branch of a larger hospital, alongside other substance abuse counselors, case managers and an art therapist. He worked with adolescents, adults and families.

Debbie graduated in 1978. She had her registration, and had just recently become board certified. Before going to graduate school as an art therapist, she was a special education teacher as well as a dancer. After she left school she worked with children in a hospital for four-and-a-half years, and then worked for a city hospital, where she also worked as an administrator. At the time she was observed she worked for a short-term psychiatric inpatient hospital, primarily with adults. She had worked there for 12 years. She also supervised interns, and was considered the department head. At the same time, she was an educator for an art therapy graduate program.

Erin graduated in 1982. She had her registration, but was not board certified. She was also a licensed mental health counselor. She had been involved with her state art

therapy association, and at the time she was observed, she was president. Prior to her current position as a counselor for a psychiatric community facility, according to her she had: worked with girls who were considered "mentally disturbed"; taught a "survivor class for schizophrenic men"; was an art teacher for "mentally challenged adults"; and started a private practice. She primarily worked with adults with, as she described, "full occurring disorders" or dual diagnoses- psychiatric disorders coupled with drug and alcohol problems. She also led art groups at a day-treatment facility for adults.

Fern graduated in 1992. She had her registration and board certification. She worked at a mental health clinic for a short period after she graduated. She provided art for a summer, at-risk adolescent program, and ran church-based, specialized groups for adolescents with drug and alcohol problems. She also taught for a graduate art therapy program off and on since 1995. She also provided both ATR and internship supervision.

Greta graduated in 1975. She had her ATR and BC. She was a licensed Marriage and Family Therapist, a Certified Trauma Specialist, and a Certified Group Psychotherapist. Greta had been active in her state and the national art therapy associations, including serving a term as president. When asked about her work history, she indicated "Over the years it was one thing after another." Prior to the positions she held at the time she was interviewed, Greta worked in an outpatient drug-treatment facility for children and adults; she became a group trainer, internship trainer and supervisor, an internship coordinator, child-abuse advocate and an intake director. She worked there for twelve years. At the time of this interview she had a private practice and provided services to trauma centers, such as the Red Cross, and was a corporate consultant.

Kara received a Master's degree in psychology and a Master's degree in art. She did not attend a graduate program for art therapy. However, because of her experiences, a number of art therapy courses, and her two Master's degrees, she was eligible to become registered as an art therapist. She had her registration and her board certification; she also had earned a doctorate in education. She was active with her state association, and was at one time president. She was also active with the national association. Prior to working as an art therapist, Kara taught studio art at a college for seven years. She also obtained a teaching credential. After she became an art therapist, she developed an art therapy program in a special education school where she worked with children and adolescents where she became the director. At the time of the interview, Kara taught for a graduate art therapy program; she was also the program coordinator and acting director.

Lori graduated in 1975. She had her registration, but had "refused" to get her board certification. Lori is currently working on her social work degree. After graduate school she worked in several inpatient, psychiatric facilities. At the time of this interview Lori worked in a short-term psychiatric facility, focusing primarily on adolescents. She has worked there for 15 years. Lori has had a private practice for the past seven years, where she sees "a few clients."

Mary did not attend a formal art therapy graduate program. However, she has been involved with art therapy since the mid-1960s when she took courses offered by pioneers of the field, Margaret Naumburg and Edith Kramer. She had her registration and her board certification. She had a doctorate in clinical psychology. Mary had been active in the national association, and had one time been president. She had "a lot of clinical

experience;" she worked in special schools, residential schools, hospitals, community mental health facilities and has maintained a private practice. At the time of the interview, Mary had been running a graduate art therapy program for the past twenty years.

Nate graduated in 1991. Nate had his registration. Before attending graduate school, Nate taught art in an inner-city school, worked for a private psychiatric hospital, and a state psychiatric hospital. At the time of the interview, he had been working at the same facility since graduation, a private psychiatric facility that treats children to older adults. He has had experience with all the populations in that facility except the older adults. He was known as the Rehabilitation Coordinator for Adolescent Services. He had been a case manager, after-care coordinator, rehabilitation "person," and an art therapist, all in the same facility. Although he had worked for the same facility for ten years, it had changed owners many times because of managed care and mergers.

Diagrams are provided of the office and work spaces of those observed (Appendix E) to provide the readers an understanding of the organization of the art therapists' work space. This is important as the participants assumed that the researcher understood the organization of their work spaces, and subsequently may have referred to them periodically in the discussions.

#### Variety Within the Shared Art Therapy System

As noted, all participants were recognized as art therapists according to the education and credentialing standards of the American Art Therapy Association, Inc. (AATA) and the Art Therapy Credentials Board (ATCB). However, they received their



education at different times, and thus the training and graduation requirements varied.

According to the AATA, the educational standards have changed often.

In a report to the AATA, Inc., Agell, then Chair of the Education Committee, indicated that:

[t]he history of art therapy education, parallel with that of art therapy itself, is characterized by a rather long gestation period followed by a period of spectacular growth . . . [i]n the early days, courses were offered by art therapists who, convinced of the special qualities inherent in art, persuaded others . . . that art expression provided an enduring, moving message of human experience. Much of the early coursework was a review of professional experience and case material derived from work. . . .

The earliest model for education guidelines for art therapy training was drafted in 1973 by the AATA Education and Training Board (Appendix F). This was several years after the first graduate art therapy programs were developed. These guidelines continued to evolve until the present standards adopted in 1993 (Appendix G). They are scheduled to change yet again in July 2002 (AATA, 1999: Appendix H). Moreover, not all art therapy graduate programs follow these standards; not all are approved by the American Art Therapy Association. Additionally, the Art Therapy Credentials Board does not require that a person attend an art therapy program to become registered and board certified, as long as they can demonstrate that they have met the established criteria (Appendix I).

Appendix J presents a comparison between when the art therapists graduated from their respective programs and when their programs were approved by the national approval board. Please note that of the art therapists that attended a formal graduate art therapy program, three of them graduated prior to their program's approval. Two art therapists, Kara and Mary, did not even attend a formal art therapy program. Thus, it

could be surmised that the education received by the participants of this study was not consistent.

The status of the participants' registrations and board certifications also varied, depending on when they received their credentials, if at all. Originally, guidelines for registration were established in 1973 (Appendix K) by the American Art Therapy Association, Inc. These guidelines have also undergone considerable changes in requirements (compared to the current ATR requirements, Appendix L). The ATCB now has jurisdiction over, and grants the ATR (Hall, 1994). Therefore, seven of the participants received their ATR from the AATA, whereas, the remaining participants were registered through the ATCB. No continuing education credits are required to maintain the ATR—just payment of annual dues. Although Kara and Mary did not even attend a formal art therapy graduate program, they were both registered and board certified (BC).

The Board Certification, received after a member with an ATR passes a national standardized examination, did not exist until 1994 (Hall, 1994). The ATCB does require 100 continuing education credits, obtained within five years. However, Mary, who was an Honorary Life Member prior to the establishment of the BC examination, did not have to take the exam, nor is she required to demonstrate that she has accumulated continuing education credits. When the BC was established, a grandmother clause was written that all Honorary Life Members would be automatically granted BC status. What is more, several of the participants chose not to pursue Board Certification. For a graphic representation of the relationship between the participant art therapists and significant events in the history of the art therapy field, please refer to Appendix M.

Despite their obvious differences, the participant art therapists all shared one thing—they all emphasized that they all wanted to be recognized as “art therapists”<sup>3</sup> first and foremost. Moreover, they worked on fortifying this identity by pursuing other avenues in which they could interact with fellow art therapists outside of the system in which they worked. As Bonnie indicated, “we need to hang with our homies.”

### Maintaining The Identity

Each participating art therapist expressed a need to interact with other art therapists, presumably to maintain his or her own identity as an art therapist. Amy, who did not work with other art therapists (with the exception of an intern she supervised the week she was observed) attended a retirement party for one of her mentors. She indicated that attending a party with many art therapists was a wonderful experience. “. . . [I]t was really enjoyable; it was such an honor for me to be part of an amazing community . . . it was such an incredible roomful of people.” The rest of the anecdote included a list of all the art therapists she was able to “see again,” including a former internship supervisor, and how important it was that they could all interact.

Some of the participants worked for a facility that hired other art therapists, or taught art therapy courses which could have precluded the need to go outside their systems for this interaction and reaffirmation. Nate was a supervisor of various creative art therapists within his department, and interacted with them daily. Debbie, Fern, Kara and Mary were all educators, and thus interacted with new art therapists as well as other

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<sup>3</sup> This point will be reinforced in Chapter 4, under the section about how the art therapists define art therapists.

faculty members. However, such interaction did not seem to be enough, and several of the other participants did not have such an opportunity; thus, they created new means of interaction.

This was achieved through annual state and national conferences, teaching art therapy courses either for continuing education requirements or for graduate programs, supervising art therapy interns and ATRs, becoming involved with the state and national art therapy organizations, or informally interacting with others in the field. Bonnie and Erin were both presidents of their respective state associations, putting them in a position where they had to interact with other art therapists. Greta and Lori were both actively involved with the national association, including holding important positions. Even after their respective terms were completed, Greta and Lori continued to develop and participate in art therapy related projects for the national association. Amy attended state conferences for art therapists and remained in constant contact with her former instructors. At the time of her observation, Amy had just completed a four-day statewide art therapy conference and would soon begin teaching for the program from which she graduated.

Many of the art therapists observed attended the American Art Therapy Association annual conference, and several of them attended statewide conferences. Kara said that she was responsible for creating a unifying a state wide art therapy conference when she was president of an affiliate chapter in the state she once lived. She believed that it was:

“the most important thing that we did in [the state she lived in previously]

. . . because that still is a shot in the arm for about everybody who attends those and that had never occurred before . . . I think it is really important that the legacy [continues] and I'm really proud of it . . . I think it would be great if we could do it here in [the state she currently lived in]."

Erin established an informal art therapy group in which many of her peers would gather, talk "and complain" about their respective art therapy duties, and what they could do to improve their work.

Many of them supervised art therapy interns from various graduate programs. Bonnie and Debbie had established such a program in their facility. Although Carl had just graduated from his program one year before, he volunteered to supervise interns. Even when Fern was not affiliated with a university, she would still supervise art therapists for their registration hours.

Although the art therapists currently belonged to systems where their interactions with fellow art therapists were limited, and their jobs may not have included many actual art therapy sessions, they still actively sought out interaction with other art therapy clinicians. They all voiced a need to stay connected with other art therapists, and accordingly reinforce their identity as an art therapist. However, they needed to interact with other members of the systems in which they now belonged.

#### Systemic Communication-Crossing the Boundaries

Communicating to others within their systems who were not art therapists became a daily focus. Art therapists were put in positions, or placed themselves in positions, that would gain them visibility and acceptance. The interaction that is established within a system is used to gauge the significance of the information as well as

the means to which communication is conducted (Deal & Kennedy, 1982). Lipsky (1980) argued that social service people in general work within the constraining rules of the system while at the same time doing what they can to still meet the needs of their clients. To deliver the widest range of services, the art therapists needed to adapt. It is therefore important that the art therapists understood their place within the system, and used the rules and standards where they worked to communicate the worth of their work<sup>4</sup>. This understanding allowed the art therapists to cross perceived boundaries. Some of them did so using the systemic policies on "charting" that were already established, policies the art therapists adopted upon entering their new contexts.

Charting. Charting was seen as a tool that could obtain a sense of systemic equality or validation for the art therapists despite the different clerical approaches that each participant art therapist employed in completing these duties. "Charting" was a catch-all phrase that either referred to the daily, weekly or monthly paperwork that focused on the progress of the client, or any paperwork that was required by the facility for which they worked. Depending on the type of setting or client focus, the requirements for charting differed. Charting was at times seen as a necessary evil; it was considered by most to be unchallenging, and they generally did it because they felt like they had to. Although most professed to the importance of this paperwork, they still had a tendency to "cut corners."

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<sup>4</sup> Besides the network's or system's rules and standards, the art therapists also had a tendency to use terms that belonged to the system to which they belonged. These included acronyms. These terms not only allowed easy communication between the members of the system they presently belonged, but it also signaled that they were now members of that group (Deal & Kennedy, 1982). This at times required an explanation before the interviews or observations continued. From now on, such terms will be defined either in the body of the text, or will be footnoted.

Carl charted to “keep people happy,” and “to keep two auditing groups satisfied”: Joint Commission of Accredited Hospital Organizations (JCAHO) and Substance Abuse Treatment and Recovery (SATR)<sup>5</sup>. He indicated that he needed to know which group was going to audit which chart, and that he would then chart accordingly. Conversely, he indicated that most of the charting was for internal use anyway so that a review of treatment progress could be made before each session. All of his charting had to be completed by the end of the month, so it was apparently not unusual for him to be charting about something that happened the week before; he indicated that “we are supposed to do notes right after the session,” but it did not often happen. He also did not chart on the art therapy that occurred; rather “only if it is profound.” It is important to note that the charts were reviewed at times by attorneys and the judges that presided over cases in which the clients were involved.

In her private practice Amy would spend some time immediately after her sessions (which were generally “one-to-ones<sup>6</sup> or couples”) “jotting down” what happened in the session. These would be kept in a folder, and left in a locked file cabinet by her door. The notes were available to keep her focused on her clients’ treatment, but she seldom referred to them as she was “able to remember what was going on” in treatment. If art work was completed in session, she would either describe the art work or redraw it in the notes

This differed from what was expected at her placement at the community center.

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<sup>5</sup>Carl first called these auditing groups by their acronyms; it was only after he was asked by the researcher, an art therapist, did Carl explain what the letters stood for; and this was only after he researched it himself.

<sup>6</sup> One-to-one referred to individual sessions; just the therapist and the client are present.

While in her office she often filled out reports about the patients; there was little reference to the art sessions as she simply completed the paperwork as required by the facility. If she did comment on the art work, it was strictly her own choice, and this was generally viewed as anecdotal and unnecessary by the facility.

Like Carl, both Bonnie and Debbie stressed the need to chart or "do notes" on a daily basis, but would rarely do so. Bonnie recognized the importance of the charting for the facility requirements and commented on how important it was that she charted on all her clients, referring to the art work whenever she could. She indicated that she received recognition and accolades from the city and county offices for her records, but the facility had never commented on her notes. The entire week she was observed she rarely wrote a note, indicating throughout that she should be doing them, but was either too tired or preferred putting them off. She also pointed out that Wednesdays were her day to catch up on paper work, but even then she spent the time interacting with the clients and staff.

Debbie indicated that she would chart daily if she could; these charts would include a weekly progress note and initial notes. The forms were generally standard; the progress notes would include what the patients did in groups, and how they met the goals that were established during the patients' meetings with their treatment team. She would often do them during rounds because "I'm sitting there anyway." Otherwise, she indicated that she had trouble keeping up with them because she was "so active." Throughout the week that Debbie was observed, she rarely charted but would spend most of her time in the hallway of the patient's unit, talking with staff and her clients. One time she brought charts to the small room that housed the coffee and microwave. The dietitian walked in and Debbie



immediately began speaking with her about issues on the unit. Very little charting was done that day. She also admitted that she was not as thorough in her charts as she once was.

Erin would chart in her office. However, according to institutional policy, to get the charts of her clients she would have to walk down the stairs and go to a large, library-like room. She filled out a piece of paper, and placed it in a book, to indicate that she was removing charts. Once she completed the patients' progress notes, she would bring the charts back to the library. However, if the charts were not completed, she still needed to bring the charts back before she left for the evening.

Erin would not only write progress notes, she would also update her clients' treatment plans. She intended to complete a progress note sheet immediately after a session and put them in the chart. However, she was observed keeping the notes on her desk for several days. She pointed out that when she had as many as six clients in one day, she would write the notes while they were in session. Often she would use these notes as a means to discuss current and future goals. She would write about any art that was done, and either describe the drawing, or put a copy of it in the chart. She would also fill out the Individual Plan of Care sheets (IPCs)<sup>7</sup> with the clients, before including them in the chart. She admitted to having difficulty with the new charting procedures since the merger of the facilities and the move to a new building. Initially she was given more control over where to "put things" in the chart, but that had since changed.

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<sup>7</sup>Like Carl, Erin used the acronyms of her agency; it was only after she was asked that she explained what the initials meant.

Charting seemed to be a way in which the art therapists communicated information about the effectiveness of treatment to others within the system. It was often seen as a bridge to those who did not understand the art therapists. One art therapist indicated that she did not have to chart, but she did so anyway. This validated her sense of belonging to the system, and she was seen as contributing. Conversely, Fern indicated that she would include very little information about the clients in their chart so that she could not be held accountable. This was similar to what Lipsky (1980) described as a deliberate action to keep the records incomplete or recorded sketchily to avoid close scrutiny and accountability.

The charting the art therapists did in their respective settings was something that they learned within the system, not something they learned how to do in school. Bonnie indicated that she learned one method while in school; ASATMJ<sup>8</sup> (appearance, speech, affect, thought, memory, and judgment—"a typical mental status exam") notes. This type of charting was adequate at the first facility she worked; but when she acquired the position in the facility she was in at the time of the observation, she was taught SOAP (subjective, objective, assessment, and plan) notes. However, her notes remained generally narrative. Erin learned one way, but had to learn an entirely new charting system when the facility changed hands. Amy charted for her private practice, but indicated that it was mostly for her own use. She would often just chart key words, just to keep in mind what the focus was of the sessions.

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<sup>8</sup>Like Erin and Carl, Bonnie only provided the acronym, and needed to be asked by the researcher what the initials meant.

However, although the art therapists saw such procedures as key to being accepted and validated, they would not chart as often as they had indicated they should. Despite the important role charting was seen as having, it was not necessarily a popular means of crossing the boundaries. Thus, other strategies were attempted to transfer information. For example, all of the art therapists had provided some form of training about art therapy to the staff at their respective facilities.

Training the systems. Many of the art therapists would provide formal training either through inservices or through art-based workshops. Bonnie indicated that she would do "backdoor P.R." (public relations) for art therapy, in which she would do formal presentations of the client's art in rounds, but would also talk to the staff individually, and discuss the dynamics that were evident. She also tried holding an open studio for her colleagues at the facility. Although it was fun and "nice," after a while only social workers and other creative art therapists attended. It eventually ended because of "schedule conflicts."

Debbie indicated that when she first began her job, she had to spend a great deal of time educating others about the field. She would provide formal presentations, complete with "slides and theories, to establish credibility." These presentations eventually stopped because of lack of time.

Erin pointed out a sign on the bulletin board about an art therapy workshop that would be provided by a colleague from outside the facility. She made it a point to inform those she worked with about this training. She also indicated that she herself had volunteered her time and did many presentations to show the value of her service. Greta

stressed the need to provide formal inservices and presentations, and often used them to ingratiate herself with the corporations with which she was currently working.

Sometimes formal inservices were not enough. Carl indicated that he provided inservices for the faculty for his facility, and believed that they did indeed learn about art therapy. However, he later complained that he is often asked to “interpret” the art, and the staff had difficulty understanding that he “cannot do that.”

Amy indicated that she was unable to provide inservice training to the staff at the facility because they were so busy. Instead, she used the weekly case meetings as a means to educate the rest of the staff at the clinic about her work; she would bring whatever art work a client had completed to the meetings, and discuss them. On the Wednesday that Amy was being observed, she brought plasticine<sup>9</sup> sculptures to the case meeting. Interestingly, she did not comment on them, nor bring them to everyone’s attention—despite the fact that the focus of the current discussion was on other clients however, the staff wanted to hear about the sculptures. Amy sat silently for several minutes listening to their speculations about the “meaning” of the pieces. Only when Amy was asked directly did she then begin to elaborate and explain the significance of the sculptures. Like many of the participants, Amy used the art as a form of information to cross over the systemic boundaries.

Using the art. While this may seem unique to those outside the field, using the art making as an information catalyst was common to the participant art therapists. If the art therapists could not present a formal inservice or training, they would exhibit their clients’

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<sup>9</sup>A modeling clay with plastic-like consistency

or their own art work. As with the plasticine sculptures used by Amy, the art provided “conversation pieces” to further deliver information by making the other staff curious about the work completed. Carl, as the “art guy,” painted a mural for the radiology department in the hospital across the street. Although he felt that this went against his identity of a counselor/therapist, he maintained it helped keep him visible and a viable part of the system. Erin spent some of her daily time creating art shows of her clients’ art work. Some of the treatment plans that she designed with her clients would focus on exhibiting their work.

Bonnie spent a great deal of time creating a tile mural with her clients to be put up on the wall. Yet, she still found this demeaning. The dichotomy between respect for the art therapist versus “Oh, could you decorate the day room?” was frustrating, and she indicated that she would like to be taken more seriously as a clinician and researcher.

Some of the art therapists would lend the other members of their system art materials. In this way they became an integral part of the system, and created and supported a demand that only they could fill. Debbie indicated that she became associated with the art and materials, and at times, this identity became somewhat skewed. She relayed an incident when the unit desperately needed drawing materials:

And all of a sudden I hear they’re paging me. I called them on the phone, they said “we need some crayons and stuff for this person to do.” And, uh, I said “Okay, okay, I’ll be right there.” I said, I got to go [to a person with whom I was talking on the phone]. They need crayons. It’s a dirty job, but somebody has to do it.”

One night, Bonnie’s job was to make sure the nursing staff had enough art materials

before she left for the night. This began as a courtesy, and eventually became routinized into a convention. This will be explored in greater detail in Chapter 4.

Informal interaction. As noted, many of the art therapists spent a great deal of time interacting and educating the other members of their system informally. Bonnie and Debbie were extremely gregarious, and both admitted to favoring informal interaction over everything else. Bonnie's office was two floors above the unit on which she was stationed. In order to get to the floor, she would use an access card, a "key," to open a door leading to the elevator, retrieve the elevator car, and use the key to "push" the floor button. Once on the floor, she still needed her access card to unlock the door to get onto the unit. Despite the amount of time and effort for Bonnie to reach the unit, she spent most of her time there with the staff and clients.

On the first day of observation, Bonnie spent 30 minutes in the hallway talking with the charge nurse (the nurse in charge of the unit on which she worked) and the program coordinator. Although Bonnie was planning on going into the nursing station after speaking with the two administrative staff to listen to a more formal report about the patients on the unit, she spent a great deal of time informally discussing the patients. This included what the patients did over the weekend<sup>10</sup>, and what she would do in groups that week. Bonnie was observed speaking to both patients and staff alike about her plans for that week's art therapy sessions. During lunch one day Bonnie discussed cases with a psychiatrist that she ran into outside the facility's front door for approximately 15 minutes.

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<sup>10</sup> This might include: behavioral problems, group attendance, visitors they may have received, as well as any new patients that came in during the weekend.

This contrasted greatly with her behavior in several formal meetings, where she generally remained silent. During one meeting with the day treatment staff, Bonnie was mostly quiet while they were discussing issues about clients' length of stay and insurance coverage. When asked later about why she was so quiet, she indicated that she did not have a real grasp of case managing.

Another gregarious personality, Debbie spent most of her time on the unit, speaking with the nursing staff and the patients. During the formal rounds which were held every day to discuss the patients on the unit, she generally remained quiet.

Well, before, we had treatment planning meetings on every patient and you got really in-depth about what you were doing, what you were going to do and those specific terms of the intervention of the art therapist. And then, you know, it got smaller so then we just had it in rounds. And we'd bring the artwork in rounds. And then we just didn't have the time to [discuss the art completed in art therapy sessions]. Unless something is really, you know, outstanding . . . usually we'd tell the doc or the staff out of rounds.

However, after rounds, she cornered the program director, who supervised the rounds and presented each case, and discussed what she wanted to do with her clients that day.

Carl spent a great deal of time informally interacting with those he worked. Although this may have been because he had few clients as "census was down<sup>11</sup>," he generally spent most of his free time talking with his peers. For example, the first day he was observed Carl picked up lunch, went into his facility, and went directly to a room where several other staff members were sitting, eating their lunch. While eating, Carl described a conference he had been to the week before, and talked to the others about the

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<sup>11</sup>Census refers to how many openings the facility has for clients, as compared to how many clients the facility is currently serving. A low census means fewer clients than usual, and can at times, result in downsizing.

art he was currently doing. One of his peers asked him a question about art therapy; he spent several minutes describing what he thought was the proper answer. He often exchanged articles or books with whom he worked. There was only one formal meeting held a week.

Greta indicated that she ingratiated herself with the influential figures in the facilities she worked. She made it a point to befriend psychiatrists and hospital administrators:

. . . we needed them because they were the big guys, and they were the ones who had to do with how money was dispensed, and how treatment was planned, and who was included in the treatment scheme. We needed to get their approval, so we set out to make friends with psychiatrists, and hospital administrators, and clinic directors.

Oftentimes this interaction would serve as a learning experience for the art therapists.

Learning from others in the system. Not yet specified but just as important were the environmental and systemic influences to which the participant art therapists were receptive. For example, many of them continued to receive supervision within their placements from people who were not art therapists. Most regarded it as a positive experience. Bonnie met with a postdoctoral psychology intern weekly:

She's really my therapist . . . the content of our conversation is so work-focused that a lot of times it really is like supervision . . . I mean she's really, you know, my therapist, my mentor, my supervisor . . . a great ally. Because she happens to be not just a psychotherapist, but a creative art therapist, there's ways in which we can have a dialogue about stuff that I wouldn't be able to with other people . . .

Bonnie indicated that she learned a great deal from many of the other members of her systems. During the week, she co-led a psychotherapy group with one of the psychologists. After the group, they held "an informal supervision session" and they talked



about everything that happened in the session. The psychologist questioned Bonnie's perceptions of what occurred which led to dialogue. She explained that this was one of her richer learning experiences.

Erin met with a supervisor every week for one hour; they discussed work issues. Yet, not all learning interactions occurred with others directly related to their positions. When Debbie was charting in the staff coffee room, the dietitian walked in, and they began talking. Debbie began asking her questions about her work that week, and they carried on a discussion for several minutes about respective clinical issues. Debbie indicated that she learned a great deal from the others in the facility, including the dietitian, nursing staff, psychologists and administrators. She pointed out that since she had such a good rapport with the nurses she could go to them at any time and ask them questions; in a sense, she would exchange information with others and receive informal supervision about daily systemic issues.

Carl would often venture into the facility director's office to ask her policy or systemic questions. Their interaction, which maintained a banter-like quality, served to include Carl in the system while ensuring that he was still taking in new information.

All those observed and interviewed stressed the importance of the treatment team, groups of different clinicians all assigned to one client; all would work together to meet the needs of the clients. Although sometimes these meetings became territorial, all the art therapists indicated that they learned a great deal about the systems they shared from these interactions.

Interactions occurred to educate others, so the art therapists could get what they

wanted. They also occurred to educate the art therapists so they could belong to the system; some occurred to meet the needs of the client. However, such means of communication and attempts to cross over systemic boundaries did not always work. Often the art therapists were placed in positions where they needed to negotiate and compromise to maintain their identity and do the job they felt they needed to do.

### Systemic Negotiation

All members of a given setting generally work toward a similar goal; in the observed cases, the treatment of their clients. Negotiation needs to occur to achieve these goals. All of the participants of the study practiced negotiation, which relied on the social interactions inherent in their system (Hughes, 1971). Strauss (1975; 1997) saw the development of a social order in an organization in which participants work out shared agreements in response to everyday events. "Negotiation enters into how work is defined, as well as how to do it, how much of it to do, who is to do it, how to evaluate it, how and when to reassess it, and so on . . ." (1997, p.267). Individuals are subjected to, and are a part of, negotiations either because of ambiguity or conflict (Hall, 1987). However, negotiation does not stop once a goal is reached; negotiation and renegotiation is an ongoing process (Lam, 1994). Negotiation can be coercive in nature or it can be compromise.

Art therapy is often times viewed as ambiguous or may be new to the other members of the system; even if these members had been previously exposed to an art therapist. Because of the differences between art therapists, the work of a new one is still unfamiliar. Therefore, all manner of work for the art therapist, within a systemic

environment that does not understand the work, is subjected to negotiation (Hall & Spencer-Hall, 1982; Schulman, 1993). Even still, such negotiation may have been employed not for purely altruistic reasons, but to maintain the working identity of the art therapists. If and when such negotiation occurred, it usually served to maintain employment or to assure a position within the system to facilitate an exchange of information. This was often accomplished through an identity compromise.

Identity compromise. Many of the art therapists struggled daily with what their identity should be and how it was currently considered. Art therapists have historically compromised their specific identity to gain or maintain additional validation through credentialing or legislative recognition (Kondziolka & Gabriels, 1998; Gussak, 1998). Fern believed that the field is delegated to a “stepsister” role in its relationship to the other professional groups because of the lack of licensure and regulatory options. Consequently, there has always been a need for “. . . constant jockeying for a position to be seen as a viable service .” In many states art therapists seek licensure or another form of state recognition to secure employment or professional status, and to be seen as a viable service<sup>12</sup>.

Greta was instrumental in gaining licensure for the art therapists in her state.

Immediately upon graduating in 1975 from her art therapy program, she began petitioning

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<sup>12</sup>It should be noted that many state licenses exist which art therapists are eligible for or petition to become. Many are listed in the body of this study. Those discussed with the participants but not listed include:

LMLP– Licensed Masters Level Psychologist

LPAT– Licensed Professional Art Therapist–Exclusively for art therapists in New Mexico

LPCC – Licensed Professional Clinical Counselor

MFCC– Marriage Family Child Counselor (the predecessor of MFT already described)

her state's licensing board to allow her to take the licensure exam. She indicated that at that time art therapists were seen as a "second cousin to a Martian." She used her role as AATA conference chair to arrange a legislative meeting in her state; the conference was to be held in one of the state's major cities. She did this to increase legislative and the licensing boards' knowledge of the field. Ultimately, she convinced the licensure board that she was eligible to take the exam, and ultimately received her license.

She was initially viewed as a "heretic" by some of her colleagues for violating the purity of the field. She initially had difficulty convincing others to "go for it." After some time and marketing however, others began to see its value. Ultimately, the state licensing board developed more stringent criteria for who could take the exam, leaving art therapy out of the equivalency language. It was then that the university where she attended compromised and developed a dual degree option for those wishing to pursue a state license. Amy was one of these students that benefitted from this change.

Amy graduated in 1995 and received her Marriage Family Therapist (MFT) license in 1999. She worked as both an art therapist and as a Marriage Family Therapist in her facility. She indicated that the facility was not specifically seeking an art therapist when she was hired, but that the facility has since accepted her as an art therapist. However, it is unlikely that she would have been able to begin a private practice in her state unless she had an MFT. What is more, she was able to obtain the office space (with which she shares with another MFT) by telling the landlord that she is an MFT; she believed that the landlord would not have rented her the space if she was an art therapist, for fear that she would have "made a mess of the place" with the art materials.

Carl, like Amy, obtained his job at the same place where he completed his internship. Although he was hired as an art therapist, he is pursuing his state license as a substance abuse counselor to keep his job. He is currently taking additional course work so that he can satisfy the state criteria for eligibility. The facility is helping him with the cost of this process.

He claimed he had been "given an identity" with which he does not necessarily concur. He also pointed out that his door labeled him with one profession (art therapist), yet his facility-issued employment badge labeled him as something else (counselor). He indicated that despite wanting to be seen as an art therapist, he vacillates between the two identities, as "circumstances dictate which one he is to be called." He believed that counselors are taken more seriously, and that "society validates them," which is why he is sometimes forced to call himself a counselor against his wishes.

Debbie recognized a need for additional credentials, but indicated that she did not want to pursue counseling or social work. Instead, she pursued biofeedback training, believing that this would make her more marketable. She lived in a state where art therapists and counselors, along with several other professional groups, have been working together to secure their own license under an omnibus delegation.

For Erin to "keep her job" she was forced to obtain a counseling license; in order to do so she needed additional course work which her facility paid for. She pointed out that she was specifically fired from a previous facility because she was an art therapist "and they had no idea who I was." So, in her current facility, when told she needed to get her license, she did so "for survival."

Despite this license she still struggles with those that did not recognize who and what she was; to make herself more visible Erin wanted to join a mental health and substance abuse coalition. The following interaction with a woman she spoke to about joining this coalition was relayed by Erin:

Erin: “. . . and I said “I’m a mental health counselor.”

Contact Person: “Ohhhh, AND you’re an art therapist?”

Erin : “Yes, a registered art therapist.”

Contact Person: “Well, I don’t know if you can join. I have to get back to you.”

Erin indicated that the woman rejected her intentions because she was an art therapist, regardless of the fact that she was also a licensed counselor. This frustrated her, because although she was willing to compromise her identity, she was not willing to accept such disrespect for art therapy. Eventually Erin spoke to a gentleman who held a higher position with the coalition, and was allowed to join. Mary’s graduate program, at the time of the interview, was changing it’s courses and credit hour requirements to reflect the counseling requisites for that state’s licensure criteria to allow the program’s students to obtain this license. Nonetheless, this program has since closed.

Some of the art therapists furthered their own education to make themselves more marketable. Both Kara and Mary pursued their doctoral degrees. Kara did so to gain more knowledge, yet Mary did so because it made her “more sophisticated.” Ultimately, it provided Mary with a more “valid platform” from which to work. Kara obtained a teaching credential, which allowed her to work for the special school prior to teaching at the university. She indicated that while in the educational system, she had to learn how to

write IEPs (Individual Education Plans)<sup>13</sup> and had to “focus more on behavior than the art.”

Lori indicated that in the past she fought for her identity as an art therapist, but believed she was getting too old to do so. She had therefore gone back to school for a degree in social work as it is licensable in the state and has more societal credibility. “Although society has a misconception [about art therapy], I can no longer fight it . . . .” In the past, she had also studied hypnosis.

In some cases, the art therapists compromise in the duties they perform. Although hired as art therapists, they may be expected to take on additional tasks. Debbie indicated that although her title is art therapist, “I do everything else.” This included running non-art therapy groups such as community meetings, career groups, and stress-management/relaxation. She was also observed gathering together the patients on the unit to attend different groups, lighting the patients’ cigarettes during a smoke break, and redirecting patients in the hall who were “not doing what they were supposed to, and doing things they weren’t.” Bonnie indicated that she wore many hats. Although she indicated that there was a certain level of acceptance that she needed to “surrender to within this system,” in some cases these experiences created an avenue for negotiation.

Negotiating at the macro level. Negotiation does not always occur on an individual basis. Negotiation can also occur when professionals from different organizations form a professional organization to further their identity and influence (Nathan & Mitroff, 1991).

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<sup>13</sup> Similar to the other participants’ systemic terms, this one was presented through its acronym, and only after questioning, was it clarified

In many states, affiliate chapters of the national organization form and art therapists from different facilities come together. As a group, they may strive to change state legislation for recognition and validation. Moreover, such pursuits are done with the support of the national organization. Although previously supported informally, in 1994 a formal resolution was introduced by the AATA Assembly of Chapters, passed by the membership and ratified by the AATA Board of Directors to support legislative efforts of Northern California (AATA, 1995). Subsequently, the AATA Board of Directors issued a formal statement and policy outlining their support of all state and affiliate chapters' legislative efforts. Erin, Mary and Kara were instrumental in working with their respective affiliate organizations to pursue state legislation and regulations for a permanent professional identity. Although thus far unsuccessful, they all saw it as necessary.

Negotiating at the micro level. When some of the art therapists could not negotiate at a national level, they did their best to influence local policy at the point of production by negotiating with those in positions of immediate authority (Burawoy, 1985). Unlike the compromise of credentials and identity, which occurred at higher levels, i.e., national and state regulatory boards, some of the art therapists negotiated with the policy makers in their own facilities to change their status or to benefit their clients.

The "negotiative process not only allows the daily work to get done; it also reacts upon more formal permanent rules and policies" of the immediate system (Strauss, 1975, p.199). When Bonnie first arrived at her current position, she was expected to do many things beyond her job description. This description was an existing formal and "permanent" policy. Eventually, after some time completing the tasks as expected, and



thus “showing her worth,” she managed to negotiate with her supervisor. She rewrote the job description to accommodate what she believed were her “new” duties. This description was negotiated until both parties agreed upon the finished product. This finished product became the new permanent policy. With such changes, she was paid more money for her work and had a clearer delineation of her job. Thus, in some cases, negotiation can change local policies.

Bonnie complained that her work environment was somewhat passive; this made it difficult to instigate change when she wanted it. “So how I would use my creativity is with a great deal of initiative.” She believed that she required creativity to provoke change and to allow her to do what she believed the clients needed. As an example, she pointed out that before she arrived at the facility, the clients would get “do-nothing time-outs” in their rooms. This was, in essence, a secluded period of time in their rooms as punishment for poor behavior. This could last for several hours or a few days. Bonnie believed that this was anti-therapeutic. Therefore, she worked toward getting those in seclusion art supplies. She would then give them a directive so they could address their issues and change the focus of the time from purely punitive to a time of reflection. She indicated that there was some institutional resistance at first, but eventually she was able to “shmooze this into happening . . . it really requires a lot of grassroots organizing.” Local policy was changed to get the clients’ needs met.

Bonnie would also negotiate to determine how and where she would hold groups. She would confer with the staff, and then decide that since the staff were feeling “uneasy” that day, she would hold groups on the unit rather than the art room next to her office.

Constant negotiation resulted directly from incidences that occurred in Bonnie's groups. (The following incident will be used to illustrate a number of different points throughout this study). In a group that the researcher was allowed to observe, a patient included the statement "F— you" on her art piece. According to Bonnie, such profanity is allowed if strictly contained within the art piece, and not for gratuitous attention. When this happened there was a relatively new nurse on the unit who had not interacted with Bonnie on more than a superficial level. Such profanity went against this nurse's values, so she confronted the patient which resulted in the patient getting angry. Thereupon the patient took a paintbrush that was hidden behind her back, and when no one else was looking, painted the nurse's face with orange paint. This evolved into a fairly stubborn yet isolated confrontation between Bonnie and the nurse about the incident. Only the victimized nurse, another nurse and Bonnie (and the researcher) were in the small room off of the nursing station during this confrontation.

Bonnie explained to the nurse the parameters which she established for such expression. However, she also told the nurse that she would accept some responsibility for not providing a safer "container" for the patient, i.e. structure. She also told the nurse that this was not the fault of the art therapy, but indeed was her own error of judgment. She felt that the meeting ended on a note of conciliation. Bonnie then made it a point of discussing this with the patients who were there, and talked about what went wrong.

She felt that this resolved the issue. However this was not the case and the next day the nurse wanted to bring this up at the staff meeting:

. . . my boss [called] to say "I hope you're going to be at staff meeting today since we need to discuss what happened in art therapy yesterday". . . and

then the nurse coordinator, who I worked with for five years, said “[the nurse] approached me and I’d really like to hear what went on yesterday” and, of course, I said you know, “The way that you’re approaching me right now is clearly a defensive position. You’re asking me to say my point of view and you’re acting like you’re a mediator, like there’s something to mediate here. And if you really mean to do that then you need to bring this into a formal setting. I don’t like this.” She said “I don’t mean to do that!” And you know, she and I have worked together long enough...I mean basically I just wanted to state what my position was. [The nurse] wanted to take this and make this a personal issue, and anyhow we had a nice long conversation for about 45 minutes. It was one of these informal meetings. And...I was able to say that if we really were going to discuss content here and form, then it needs to be brought into a larger forum of policies and not a personal thing between [the nurse] and me debating the epicure of art therapy . . . I mean, to bring it into a staff meeting and talk about policy. She said that she agreed and she also said that she agreed that [the nurse] had heat on for other reasons. And that it was being displaced anger on her teammate. That ...this was the third time she had been assaulted in a week and...you know, yada yada yada.

Bonnie indicated that such an address gave too much power to the art therapy as the great disruptor, and part of her responsibility was to make sure that it was not considered as such; “It doesn’t . . . take into effect the whole system when it’s happening . . . Oh yeah! Art therapy has that much effect!” Yet, at other times she indicated that indeed the art does have a great deal of “power.” When such a belief became detrimental to her stance, the “power of the art” was downplayed.

Bonnie later indicated that she knew how to defend this situation because she has experienced such actions before. She believed that anytime a new person came on board, she would have to negotiate a defensive stance for the art therapy. She also stressed that these incidents have become much more rare, and that for the most part she learned a great deal from the nursing staff. She made it clear that she was “taking on the system, not the individuals.”

When Lori was first hired by her facility, she had to fight over a proper departmental title. She believed that since she was the first art therapist hired, the facility did not have a clear understanding of who she was and what she did. Eventually she and the facility compromised on the title Creative Therapeutic Activities; neither side was happy. The facility did not like the term “creative.” Lori stated in the interview that she did not appreciate the term ‘activities’ feeling that it lessened her clinical standards, like she was playing harmless games with the patients. Regardless, a new policy was created at the lowest hierarchical level.

Erin had to negotiate for the art therapy services she offered to the day-treatment facility. Because the term “therapy” carried a stigma, Erin had to agree to call her groups “art group”; otherwise, it would not have been allowed.

Debbie indicated that when she wanted to start a new group, no new policy was created nor a proposal submitted to the director. Instead, she would bring it up for discussion in report<sup>14</sup>, or discuss it with the supervisor. When talking about how she started the Reflections group, she indicated that

. . . I told her (a previous program director) about it and she liked the idea. I didn't have to write up anything else about it. She said great. Great idea. We brought it up in staff meeting and we talked about it and that's how it was implemented.

Even if she was told that she could not do a certain group, she “might have done it anyway.”

Negotiating with managed care. Several of the art therapists needed to negotiate

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<sup>14</sup>“Report” is a term that means a formal meeting to discuss client progress and needs.

for their positions and duties upon the advent of the managed care system<sup>15</sup>. Debbie indicated that the focus of her facility changed. The facility once had a unit that focused on eating and dissociative disorders; it now just focused on short-term treatment for drug and alcohol and acute psychiatric care. This allowed for a shorter, and easily “fixable” patient stay. She indicated that it is the role of the case managers to focus on reimbursement and insurance issues, so she did not concern herself with those nuances. However, she was observed negotiating with the program director on how a particular patient might stay longer. One patient stayed for three weeks, considered a long time in the managed care system, and was only removed after all of his insurance ran out. Whether or not Debbie was instrumental in this lengthening of services is unclear; what is apparent is that Debbie would negotiate at the local level for the benefit of “her” clients.

Nate is the director of a rehabilitation department which was once comprised of fifteen people but has since been “cut down” to five. When the department was reduced, their titles were changed to primary masters-level clinicians. Their main focus was the “psychotherapeutic, psycho-education groups,” and the activities became the responsibility of the mental health workers. According to Nate, in the new system’s hierarchy these workers were considered to have a lower status than primary masters-level clinicians.

Nate claimed the department was reduced because of managed care, with which he had to negotiate for an identity and tasks; although he tried not to get involved. There was a systemic influence that allowed for negotiating:

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<sup>15</sup>For the sake of this study, the generic term of managed care will refer to any Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and any corporation run, insurance funded institution.

. . .well I don't mind . . . the budgeting . . .but when it comes down to . . . facts of managed care and . . . patient concessions, that why we're being assessed, that they go inpatient that they get a certain . . . denomination defined; if at any time the insurance company determines that their status changes again our fees get reduced although they could still be in the same program and still receive the same services at any time. You and I [the researcher] had talked about the insurance companies [and how they] can remit and what they promise to pay, they can choose not to afterwards; so I'm conscious of it. I get [sic] a general understanding but I just don't get too involved because it takes away all the critical issues that are my primary focus.

Nate demonstrated an ability to negotiate for his tasks, and although he indicated a “distaste for budgeting” and managed care nuances, he seemed to understand the language. In essence, he could talk the talk. He indicated that after twenty years of psychiatric experience, he has “learned to play the game.” This provided a more even playing ground.

Nate also had to prove that he was not expendable by being able to lead therapy groups while directing the rehabilitation services. This was where being an art therapist as well as an administrator worked to his benefit. By proving he could take on more tasks, by “doubling” his responsibility, he proved himself cost-effective and a valuable commodity to the new system.

### Heroes

Each art therapist had a tendency to refer to his or her predecessors, people whom he or she considered pioneers, mentors, someone whom they could emulate or refer to, to validate their own work. In some cases, they may not even be using the therapeutic perspective of these people, yet in a sense, the heroes represent the embodiment of the art therapists' values. The members of the system that influences the work of the art therapist

do not have to be those with whom they have direct or constant contact. Even an interaction that happened in the past is still influential; temporality does not appear to lessen the impact of the interaction. Although the individuals referred to by the art therapists in this study may not have been regarded by all members of the field with admiration or emulation, they will be known in this study as "heroes."

In the case of this study, the term "heroes" is gender neutral. The term is borrowed from Deal and Kennedy (1982), who saw the corporate hero as someone who personified cultural values and who is held up as a means to demonstrate that the ideal of success lies within "our capacities," regardless of their sex. They are the role-models who make a lasting impression. This becomes even more pronounced in such a young field as art therapy, where most of the heroes are still alive, and perhaps even practicing. Every year, students from various graduate programs look forward to attending their first national conference so they may meet the figures about whom they have read.

Two of the art therapists who were interviewed may be viewed by some as heroes and influential figures in their own right. It is also likely that future art therapists may also recognize some of the other art therapists who were interviewed and considered them heroes as well.

Each art therapist mentioned the name or names of the art therapists they admired and emulated, even if they were no longer directly doing art therapy. It should be noted that such name dropping is common; however, in this case, aside from the sense of self-inflation, name dropping also provided systemic links.

### Hero References as Shorthand

Some of the heroes mentioned have been described as pioneers of the field, such as Kramer and Naumburg; others were mentioned simply as role models or leaders with a particular focus.<sup>16</sup> While many of the participant art therapists attributed a level of importance on these people, the reasons for why the art therapists mentioned the names seemed to vary. In some cases, the names served as shorthand to explain a theoretical perspective or approach.

When Bonnie tried to explain what she recognized as a dichotomy in the field, using a research versus artistic model, she described it as “getting away from Linda and moving more toward Shaun.” Bonnie used Linda Gantt as the representative of scientific and experimental research, and Shaun McNiff as the representative of an art-based focus. Such a statement was clear and did not require further clarification from Bonnie’s perspective; it defined her ideas concretely. When describing another theoretical perspective, she explained that it “. . . was sort of like David Reed Johnson’s (a drama therapist) concept about shame dynamics”—it was tacitly understood that this was the explanation; nothing else needed to be said. When Kara wanted to establish that her theoretical orientation was art as therapy, she used the name Kramer as shorthand to explain her view. Amy mentioned Francis Kaplan’s work on research as an illustration to explain her own perspective about research. Greta reflected on Janet Bush and Mickie McGraw, indicating that both are remarkable representatives in the field, but used them an example of what she was not. Similarly, Nate referred to Elinor Ulman, indicating that

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<sup>16</sup>All of the following names refer to well-known art therapists unless noted otherwise.

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Ulman would not approve of his approach. If one was familiar with the work of Ulman, then Nate communicated in one statement what he may do in his sessions.

It was not necessary to the art therapists that such shorthand was accurate; rather, just that the heroes represented what seemed to them a common meaning. For example, when Erin was talking about her perspective as pro-Rogerian (from the humanistic perspective of Carl Rogers) she also indicated that she “. . . like[d] to do Linda Gantt stuff . . .” When she was told that this comparison was unclear, she indicated that she was relating to Dr. Gantt on a more personal level, when Dr. Gantt was one of her teachers in graduate school. It was how she chose to remember Dr. Gantt that resulted in the way she became her hero, and ultimately a shortcut to explain what she thought she herself was like: “I remember Linda Gantt as being touchy-feely (warm and open)—well, it was during a pizza party, outside of class.”

To explain that the opposite of art making was “verbal psychotherapy,” Bonnie needed a clear way to make the distinction as to who might fall within this relationship; she stated “OK, I’ll make Doris be the bad guy.” It was clear that she was talking about Dr. Doris Arrington, identifying her as one who focused on verbal therapy rather than art making. However, this view has also been refuted, and Dr. Arrington has been linked with the reliance on art making, not verbal therapy. Bonnie also used Laurie Wilson’s name to clarify a point about the importance of symbolism. Again, Bonnie had to explain what she meant, assuming that the name was enough to express and validate her view. Despite attempts to use these representatives as shortcuts, the references just served to make their intentions more confusing.

### Hero Reference as Secret Handshake

Such references served another purpose. Referring to art therapists in the field who were well known created a shared concept; these figures almost embodied professional ideals. Whether or not they agreed with what these pioneers said, and whether or not all supported or referred to the same archetypal characters, they were still understood as belonging to “us.” Thus, such a reference could only be made successfully to another art therapist. Not only could the reference serve as “shorthand” as noted above, but almost as a secret handshake—a way to identify who belonged to their subculture. This was evident throughout the observations and interviews. Since the researcher who was interviewing and observing them was another art therapist (see Chapter 2), the names could be used without need for explanation; the language was the same.

Bonnie would constantly refer to a number of her heroes, and at times even imitated the way they talked. She had a tendency to mimic Edith Kramer’s voice when mentioning a favorite and well-known quote, or would mimic Bobbi Stoll when discussing self-marketing or bringing art therapy into corporate industries. However, it was not clear if Bonnie mimicked these heroes because of the rapport she developed with the researcher or if she would have acted that way with someone else. Regardless, this still emphasized that Bonnie knew these pioneers, and perhaps was even showing off. Such actions seemed designed to elevate the art therapist’s own importance.

### Hero Reference as Power Leverage

While maintaining a hierarchical structure by assigning these mentors an inflated identity, the art therapists would also elevate their own place in the professional system by

linking themselves with the mentors. Amy indicated how often she interacted with Maxine Junge and Debra Linesch. It was important for her to reveal the personal interaction she had with both of these figures, and create categorical definitions for them; she created archetypes. Amy considered Dr. Junge more than a mentor or her professor. She was someone who made her feel like “I had someone that was very aware of who I was as a person.” She described her as both loving and confrontational when necessary. According to Amy, Dr. Linesch was challenging, especially with research—she was rigorous and inspirational. She also relayed a story about attending Dr. Junge’s retirement party, making a point to indicate that Helen Landgarten was there, and that she had spoken to her. This was similar to how Erin referred to Dr. Gantt, and how she later made a point that she had met Elinor Ulman, Bernard Levy and Edith Kramer. It elevated her own self-perceived stance in the field.

#### Hero Reference to Validate Personal Work

More commonly, the art therapists would often refer to these well-established figures of the field to validate and elevate their own work. Many of the art therapists in one manner or another referred to these figures’ writings as established information, and influential on their careers. Bonnie referred to the writings of Judy Rubin to support her own view on what art therapy is or is not. She also identified “Hanna, Edith and Elinor’s<sup>17</sup> little book. . . Art in The United States” (1978) as an influential book, one that helped her make sense of the field she was entering. Lori remembered reading a journal article by

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<sup>17</sup> Note the use of just the first names—these figures were considered so well known that the last names (Kwiatkowska, Kramer, and Ulman, respectively) were not needed.

Kwiatkowska, which excited her about pursuing art therapy. Before Fern even talked with Naumburg, she read some of Naumburg's writings, which was how she originally became interested in the field.

#### Hero Reference to Create Personal Historical Context

Referring to their interaction with these professional ideals also allowed the art therapists to place themselves in, and be understood within, a historical context. It was understood that an art therapist knows when certain figures practiced, and a reference to the people who have since become systemic historical figures creates a temporal context. Greta referred to her interaction with Judy Rubin and Helen Landgarten to illustrate when she worked on obtaining a state credential for art therapists. Specifically, Greta referred to when Judy Rubin was president of the American Art Therapy Association. It was then made clear that Greta had been active since at least 1979. Mary indicated that she had been trained by both Margaret Naumburg and Edith Kramer, which not only signified an inherent value of her education (Naumburg and Kramer are considered pioneers of the field), it also made clear that Mary had been practicing since the 1960s. Since she also provided a humorous anecdote of her relationships with both of these pioneers, it also reestablished Mary as a valid and important figure in her own right.

Fern often referred to Margaret Naumburg, explaining that she had been communicating with her about attending Naumburg's not yet developed training program; not only did Fern use the reference to Naumburg as a means to validate her own entry into the field, it also provided a historical reference of how long Fern had been interested in art therapy. She also referred to Bob Ault as an early instructor in the program she eventually

did attend, a figure who has been elevated because of his status as one of the founding members of the national association.

### Non-Art Therapist Heroes

There was also a tendency to mention figures who were not art therapists, but were well known throughout professional systems. It seemed as if mentioning other well-established professionals strengthened the art therapists' own place within the system. These names created a shortcut to other systems, and allowed an overlap. Debbie referred to Joseph Campbell, a mythologist and writer, as a major influence, while also citing Emanuel Hammer and Irvin Yalom, psychologists who specialized in projective drawings and group therapy respectively, to explain what she taught in her own courses. Carl, while not mentioning many art therapists except to reference those whose works he had read, would often mention Carl Rogers, Carl Jung and Erik Erickson, names that would more commonly be used by the non-art therapists with whom he worked. Fern stressed the influence that the well-known Midwestern artist, Elizabeth Layton, had on her.

The reference to their heroes also provided insight into understanding what the art therapists' original theoretical orientation may have been. Aside from the link that the heroes may have provided for the art therapists within and between the systemic spheres, this reference also provides a link to the next chapter-the interaction between the participating art therapists' theory and their practice.

## CHAPTER IV

### The Interaction of The Theory and Practice of The Art Therapists

This chapter will reflect the relationship of the art therapists' practices to their theories. Key components to understanding this relationship which will be explored in this chapter are routinization and conventions. The participant art therapists' relationships to their theoretical orientations and how these were influenced by their settings and practice will be investigated. This chapter will conclude with a summary of how each art therapist defined what an art therapist is, followed by their responses to the question on whether it even "had to be art therapy." Because of the number of interacting variables to consider, this chapter is complex; however, ultimately a synthesis will be provided at the end of this chapter and in the concluding chapter.

#### Practice

Practice is treated here in a general way, to include routinized and unscripted interactions with the participants' systems; routinization creates structure and guidelines. As noted, some of the participating art therapists' practice is defined by the facility in which they work. Their practice did not simply consist of therapeutic sessions. Their days also consisted of: attending meetings, both informal and formal; doing paperwork and "charting"; ordering art supplies; planning for their sessions; and being available for any situations. (What constitutes a situation will be defined later in this chapter.) For the most part, each art therapist, when asked, could describe his or her daily schedule. Bonnie indicated on the first day she was observed, she had:

. . . first “Report,” then a planning session, check the art therapy room and decide whether I can or want to take the kids and run group on the unit, or go off the unit. Uh, 9:00 goals meeting; 10:00 group with the inpatient unit; uh, break, then charting; 2:00 group over at adolescent day treatment unit and then charting for the rest of the day. . . .

Noticeably, the sessions with the clients and meetings with fellow staff had designated times, whereas the paperwork was given the more ambiguous concept of “the rest of the day.” Accordingly, each art therapist was able to explain in one way or another what their day would consist of, and each attempted to establish a routine.

### Established Routine

Morgan (1997) noted that routines may “act as primary points of reference for the way people think about and make sense of the contexts of their work” ( p.144). As Lipsky (1980) indicated, people “create routines to make tasks manageable. . . to make tasks and perceptions more familiar, less unique” (p.83). James (1890) indicated that routines become established habits that can then allow people to work without thinking. This can free up their ‘minds’ for more important tasks. In many cases, routine was established to combat the ambiguity of the art therapists’ work. Bolman and Deal (1984) reflected on how uncertainty within an organization can result in increasing bureaucracy. In agreement with Weber (1947; 1978), they found that bureaucracy inevitably lead to routinization of practice to simplify and concretize the tasks within the organizations.

What the art therapist does is relatively new in many environments, and is viewed, even by the participating art therapists, as ambiguous:

Carl: It’s like any time people try to define art and then you attach the word therapist, you’ve got two hugely ambiguous words. . . . I mean everything’s so ambiguous.

To combat the ambiguity, the art therapists created concrete schedules, routines that would both validate and simplify their work. Creating structure allowed the art therapists to establish a tentative definition of their tasks. Never mind that Bonnie's schedule as listed above was not closely followed; she, in fact did not chart the rest of the day as indicated. Little time was spent completing paper work. Nevertheless, such a schedule allowed her to define the tasks for the others' in the system. Debbie even created routines for her breaks. She would go back to her office, drink water, take vitamins and use the bathroom.

Carl's schedule was not as clearly delineated, but he still established a routine within loose parameters. During the week he was observed, the facility's census was down. He had six clients scheduled for individual sessions, when normally he would see between thirteen and fourteen clients. In addition, he had one therapy group once a week.

Carl spent some time calling his clients for appointment verification; he said he did so because he was bored because census was down, not because it was his responsibility. He immediately documented all the calls he made in the clients' respective charts, even if the person he called was not available. He charted and completed the clients' progress notes, or talked with his peers. He indicated that when there is nothing to do, he spent his time reading art therapy and counseling literature. On one day he only had one session scheduled later in the afternoon. He spent the entire day reading until the session. Despite the lack of scheduled tasks and sessions, a routine was still intact.

Erin's schedule was more specific, and she maintained a consistent routine. The



following description was of one day, which was a fair representation of the rest of the days of the week<sup>18</sup>:

Erin got to her office at around 8:30 a.m., turned on her computer, and watered all the plants. She checked messages on her answering machine while waiting for her computer to warm up. She then began reading a three-page letter slipped under her door. While reading it, she was saying out loud “I can’t believe he was referred back to me; I said please don’t let him be referred back to me.” She then chose a file out of her cabinet and began leafing through it. She picked out a few sheets, indicated “I have to copy this” and went to a copying machine down the hall. While in the hall, she spoke with several other staff members about scheduling sessions. She then called a “consumer”<sup>19</sup> and seemed to have an informal session over the telephone, stating, “uh-huh;. . . that’s good. . . you have some work to do. . . [rolled her eyes] you’re talking to your parents like that? Right, right, so it’s the same issues then.” She scheduled the consumer for a 9:00 a.m. appointment on Thursday of that week. After she got off the phone, she put her head on the desk, and stated “The saga continues. . . I know too much about him. . . .”

Erin then went downstairs to a room where the Medical Records were kept to retrieve the charts of her clients and filled out a form that was called “Records Request.” She walked back to her office with several charts. Erin next met with her supervisor who specialized in drug and alcohol counseling to schedule a meeting later that day. She next made telephone calls until she met with clients in her office from 10:00a.m.-12 noon.

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<sup>18</sup>While most times were recorded in the data, most are generally excluded in the following descriptions as some of the times were arbitrary and serve to confuse the reader.

<sup>19</sup>Consumer was what Erin’s facility called their clients.

At 12 noon a peer brought lunch back for her, as she was busy making telephone calls. Erin ate lunch in a group room with three other staff members; they were filling out forms that were labeled "Quality Assurance for Individual Served." These served as case reviews of the clients of the facility. She indicated that normally during lunch she walked to the lake, but could not because of the case reviews. She worked in this room with the three other members until 1:30 p.m., when she went to a meeting with her supervisor for one hour. The researcher was not present for this supervision session as confidential information was discussed. She next worked on progress notes for two of her clients. She then spoke with a probation officer about a client over the telephone. She spoke with him until 3:00 p.m., and then continued writing in one of the charts. Afterwards, she read some e-mail messages, and wrote a letter on the computer.

She had a client scheduled for 4:00 p.m. who arrived early, so Erin decided to meet with him before the scheduled time. The session ended an hour later.

Most of her days were similar, except for when she went to the day treatment facility on Wednesday, located several miles away. She pulled her vehicle in the parking lot at the rear of the building, and loaded it with art supplies. She arrived at the day treatment facility and had a group session for one hour. She then went back to the main facility, and attended a facility-wide meeting held in a large conference room downstairs from her office. Otherwise, her daily schedule rarely varied.

Unlike Carl's schedule and routine, Erin's was full of designated tasks; she had little time that was not accounted for or planned. It seemed Erin created the routine to better adjust to such a full schedule. What is more, by reflecting the routine established by

the facility, Erin did not have to stop and consider what had priority; it was understood what was expected, which made it easier for her to work. Her time was not wasted considering priorities and minutia, which freed her up to focus more on her clients' care. Her response to the routine, her ability to adjust to the bureaucratization of the facility also communicated that she was part of the team. This was undoubtedly valuable for a person who had been let go from a previous position and whose current facility had undergone several changes.

Amy established two different routines, one for each setting; the private practice and the community center. Before actually going into either setting, Amy would consider who she had appointments with that day, and dress accordingly. She indicated that if her clients had little money, she may dress more "down" than usual to make her clients more comfortable. On her drive to work she would think ahead to what she had to accomplish, who she had scheduled, and what she may do in her sessions. She would also mentally review some of the progress of her clients to determine a likely direction for the therapy sessions. It was at this point that the routine split off into two different directions.

For her private practice, Amy arrived 20 to 30 minutes earlier than her first scheduled appointment. She said she may review her progress notes on her clients to verify what she had done the previous session, but generally did not as she indicated she has so few private practice clients it would be difficult to forget. She set up a table between a chair and a couch, placing art supplies on the table. This included paper, oil and chalk pastels, markers and pencils. Amy set up a fan near the table, not because it was warm, but to make it difficult for anyone in the next room to hear them talking through the

thin walls. She then began to “center herself” which was essentially sitting quietly and relaxing herself. The sessions were scheduled to run exactly 50 minutes; if the clients were late, the session still ended exactly 50 minutes after the originally scheduled time. Amy indicated that the clients knew this. If they were late, they would call, such as the first day Amy was observed. She did not answer the telephone when it rang, but rather listened to the message after. On the day she was observed, she saw a couple and then a woman.

The couple did not draw; Amy stated that she talked 20% of the time during the session. She said she let the clients do most of the talking, with her role being “giving suggestions, not advice.” This was later proven otherwise during the one session that was observed.

Amy’s second client drew a picture. Amy indicated that the client was worried about the final product of the art, not the goals, and spent the remainder of the session discussing the art piece.

If a client does an art piece, Amy would place it in the file where she kept the notes after the session; the art would be returned to the client after the therapy session, so she tried to write about each art piece in detail. She would also take slides of the art work if the piece was “meaningful.” However, she was unable to clarify what meaningful meant. She also indicated that the notes may not be complete if she is in a hurry, such as having to race over to the clinic, so she may only write down a few key words.

She admitted after the sessions on the first day that she was tired. She explained that it took a lot of energy; she then withdrew her statement, and pointed out that she was not really exhausted, but just had a lot of things “inside” from just having to listen.

She had a more specific structure established in the community center, one that revolved around systemic expectations. For example, one day she was observed, she left her home at 8:15 a.m. Upon entering the facility, she immediately went to her office, reviewed her schedule for the day in her appointment book, and began to do paperwork. She then went to a room to check to see if it was ready for the next session. When Amy returned, she spent a few minutes arranging art supplies on a small folding table. She carried this table to the group room, and laid out the supplies on a larger table. She left this room and proceeded to the lobby, where she spotted her client. She escorted the client back to the room with her. After each session, she escorted the client back to the lobby, spoke with the receptionist in the partitioned room off the lobby to schedule the next appointment for that particular client. If she had another client scheduled, she would then ask him or her to accompany her to her office.

A second session was held in her office. The office was substantially smaller and crowded (please see illustration in Appendix E). She set up the folding table with the art supplies between two chairs. Amy sat on a chair by her desk, and the client sat across from her, by the door. Before beginning the session, she hung a sign on her door that indicated "Session in progress."

She also held a third session in her office, which the researcher was allowed to observe. The client spoke little English; however, Amy was fairly fluent<sup>20</sup> in Spanish, and was able to communicate with him. This client completed an art piece. Although she

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<sup>20</sup>The verbal interactions were fairly simple, as both seemed to "dummy down" what they were saying so they could understand each other.

indicated (noted earlier) that she spoke 20% of the time, in this session she spoke at least 60% of the time. After each session, she would complete what was known as the “super bill” which included what the session was about, using already established “codes”<sup>21</sup> that would then be used to bill for the sessions. She had 5 minutes between each session to complete these. She would also try to record notes in each client’s chart on their progress; however, she often times did not get these completed because of how much work she had. She did not leave for lunch until around 2:00 p.m. After returning back to her office at 3:30 p.m., she spent time on the computer responding to e-mails, completing paperwork that was due at the end of the month, and writing in the “Mental Health Services/Addiction Recovery Daily Activity Log” to record all the billable hours for her clients.

Additionally, she worked with another staff member on a letter to the court on behalf of a client who she claimed was “wrongly accused of battery,” and who was court-mandated to attend groups in the facility. However, this letter was not completed that day because of complications obtaining some necessary information. She then spent some time on the telephone speaking to a potential client. She completed what she thought was her last session of the day at 4:00 p.m., and then continued working on some paperwork. However, she discovered that she had a client scheduled at 5:00 p.m. and was waiting for her in the lobby. She went to the lobby to greet her at around 5:30 p.m. She explained that she had forgotten to write the schedule down in her calendar. The session ended a little

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<sup>21</sup>Certain treatment foci are given designated numbers that are written in a specific place on the billing sheet. This allows the billing clerk to know immediately what the treatment was for, and what it should consist of.

after 6:00 p.m. She went back to her office to complete some more paperwork. At 6:15 p.m. she indicated, “even if I had time to do more charting, I would be so brain-dead, I don’t think I could do it.” She completed her work at 6:30 p.m., indicating that she had to leave her desk neat, because someone used it at night.

Most of the schedule remained consistent the rest of the week she was observed; however, she did have a treatment team meeting later in the week. These meetings were scheduled on a regular, pre-arranged basis. One day Amy met with clients in her private practice in the morning, then went to the community facility immediately after, and stayed until the evening. However, the tasks themselves rarely varied.

It was clear that the routine that was established was influenced by the system. It was also apparent that the routines and structure were indeed established to accomplish the tasks of the facility, combat ambiguity and control the chaos. As Amy organized her private practice, she “borrowed” routines from her community placement to make sense of the day: charting, paperwork and time scheduling. This allowed her to make sense of the environment. The community setting had structure and parameters built into her work; the paperwork, billing documents and when she could schedule clients became part of her routine. She knew what was expected of her, and the facility had clearly delineated expectations for the paperwork. However, in some cases, schedules did not always guard against unforeseen circumstances, and chaos did occur. Situational routines were born out of such developments.

#### Situational Routine

Even when situations arose that could cause deviations from the current schedule,

a new routine was implemented. Debbie was down on the unit ready to start a group when a client became angry. This behavior disrupted the established routine. Yet everyone present had designated, although not necessarily assigned, tasks. After trying to intervene with a psychiatric client who was becoming increasingly agitated, Debbie then worked with the nursing staff to keep the patients in their rooms and clear the hallways:

We tried to intervene. You know “Come on, come on, let’s talk.” We tried to do it on the verbal level. We tried not to get a show of force. You know, we went into the room and we tried to de-escalate him. . . he gets like a big baby, you know. Once he goes off sometimes there’s no pulling back, but we went in and we tried to talk to him but he wasn’t going for it. He walked out and left us (laughing). Then, you know, she [the nurse] got him meds and I think he was refusing the meds.<sup>22</sup> That’s when I cleared the hallway ‘cause they had to do a show of force.<sup>23</sup>

There seemed to be a series of steps that everyone took. When asked, she indicated that although she had been trained in the Management of Assaultive Behavior years ago, she still knew the proper procedures because she had been in that environment for a long time.

She knew the process:

Debbie: I mean, but everybody responds to code. When we call Code White everybody needs to show up, whoever’s free.

Researcher: Call Code White?

Debbie: Code White. It’s a management issue. . . . And there is procedurally a person to clear the hallway and then the team leader– the team leader organizes the code team.

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<sup>22</sup> Medication

<sup>23</sup> A show of force refers to many staff arriving to get the client to comply; if he does not, and remains agitated, and is deemed dangerous to himself or others, he would be restrained using Management of Assaultive Behavior techniques, put in a seclusion room, and/or placed in restraints.



Researcher: Who is the team leader?

Debbie: Depends. Usually a nurse. This time it was [nurse's name]. And they get the people together, but first we do verbal intervention. And then we go for meds. And if they're that out of control we might [ask them] to go the quiet room or just go sit in their room with them. And if they can't do that then they'll [the staff] go to the quiet room with them. And if they're acting up in there, then they'll do a show of force hands-on. Bring them back into the room and if they have to, restrain. But I do the hall. Or I'll hold the door that they have to talk through. Or I'll sit with a person who's scared. But usually I just do the hallway.

Bonnie also experienced such situations; she had what was called PART<sup>24</sup> training which established a routine to deal with aggressive and "acting out" clients. Whenever someone became "dangerous to themselves or others" the current program would be interrupted, and the staff would address this problem. Each person took on assumed roles, although they were not always consistent from situation to situation. For example for one incident Bonnie may be responsible for keeping the hallway clear or calming the other clients; one incident, Bonnie may actually find herself in the situation of having to subdue the client with a team; some incidences, she may become the "team leader" to "call the shots" on who was to do what in the given situation. The team would then restrain the client, which sometimes meant "carrying" the client to the floor, placing him or her in leather restraints, lifting him or her onto the gurney, and transporting the gurney [a stretcher on wheels] to the seclusion room. The client may or may not be placed in five-point restraints<sup>25</sup>

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<sup>24</sup>Physically Assaultive Response Training

<sup>25</sup>Five- point restraints refers to the restraints used to secure a client to a bed in the prone position. They are usually padded leather belts attached to a leather collar along five body points; one restraint is used for each wrist, each ankle, and one for the client's midriff.

depending on whether the client has substantially calmed down or not. While this was happening the nurse would be contacting the doctor for “Denial of Rights”<sup>26</sup> order. Thus, although Bonnie’s planned session or program might be interrupted depending on whether or not she was involved, a situational routine was established. Bonnie, as a team member, recognized her various roles, and knew how to act accordingly. Once again, although a situation might appear chaotic, there was still a structured routine.

Such interventions were not taught in the participants’ respective graduate programs but were learned in the system. For some of the participants, these interventions became part of their everyday practice. However, Erin indicated that her facility did not have to deal with such situations as often, and thus, she did not seem as familiar with a set process. She was asked about what she would do if a client became agitated in her small office during a session:

Erin: You know, try to get help as soon as possible. But usually there’s people around. So if I start screaming, somebody will come and usually if there’s somebody that I know is really unstable, I, you know, I will say to somebody “Would you just keep your ear on the door?” People will run to do that. I won’t close the door all the way. Then that person is a little more intimidated than when the door is closed. If I knew that someone was going to be upset, I would plan for it.

Researcher: So, basically you call the shots on deciding how you want to handle it each time?

Erin: Yeah. I mean, there is obviously a policy. You know, we have a policy book. . . . It’s a big policy book. Um, and usually we do an incident report. . . . [long pause] You know, if there is any physical contact. Or if there’s anything that you feel that, you know, could come back to you and slap you in the face.

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<sup>26</sup>This specifically refers to an order denying the client the right to make his or her own decisions.

Erin was asked if any such incidences have happened that have warranted such a response:

Well, actually we had a person on Thursday who had become disoriented in the waiting room and [the front receptionist] called 911 and she didn't realize that she still had to dial 9 and then 911. And, you know, being in somewhat of a panic, she said it made her feel scared because at first she couldn't get through. And then it dawned on her. She needed to dial 9-911. . . she didn't know that until she did it, and then she was telling everybody. It started the day a little more intense than we usually do. But it's usually calm here.

### Client-Directed Routines

Lipsky (1980) made a distinction for bureaucracies that focused on helping others; these organizations, such as the facilities in which the art therapists worked, create a routine that is defined by the interaction of the members of the system. The routinization and simplification are developed with the clients in mind. The routinization in these structures, although set up to simplify the ambiguity, were not predetermined. Treatment goals, for example, varied from client to client, but were established to create a measurable and concretized means of gauging the clients' progress.

Most of the time, these goals were created so there was some level of consistency in the focus of treatment for all members of the clients' treatment teams. For example, Debbie would specifically chart on the clients' progress, focusing on their treatment goals:

Researcher: Who designs the goals?

Debbie: The treatment team. . . . It's standard. They have like a standard form. They [the team] check off whatever they feel that they [the clients] need. The specific objectives to meeting their goals.

Researcher: And then you chart those goals?

Debbie: Uh-huh.

This was also the norm even if the art therapist was not working with a team of clinicians. For example, in her private practice Amy created goals for her clients; the couple she had seen the first day of her observation had goals that focused on improving their communication, improving anger management skills, and improving one of the women's ability to tolerate the other taking time-outs, and to learn to remove herself when she was feeling angry. The art work was used because their communication was volatile. According to Amy, the art provided another means of communicating that was not quite as impulsive.

Erin worked with her clients on their treatment goals so that both she and her clients could work within a clear structure. She would also create daily plans for the clients so that they could feel safe within a structure. "We would structure a daily routine, to continue engaging daily in decisions regarding exhibiting his work in the community...which is what we do, we talk about that."

#### Client-Defined Routines

Grover (1993) stressed that it is the professional's responsibility to diagnose the needs of their respective clients on a daily basis, and implement services as deemed necessary. Bonnie stressed that although there was a tendency to attempt a routine, she would often make a decision to go off the schedule based on the needs of the clients. Although she had scheduled meetings, she would consciously decide not to attend them so she could "get ready for group." Although she may have had a specific directive or task in mind, she could change her mind in the middle of a session, depending on how she would "read the group."

Debbie indicated that she generally had a routine established for how each group would begin: how she set up the tables, how she put out the art supplies, how she retrieved her participants from the unit. However, the session would always develop into different directions; "it becomes more organic." In this way, Debbie created a structure that would be safe for the clients, something the clients felt comfortable in, but then would allow the dynamics of the group to take over.

Nate created a routine to provide structure which in turn provided a healthy environment for the adolescents he worked with; such routine also provided the clients an idea of what to expect that day:

The set up in group is the same consistently. The patients will come into a room and they will know immediately what group it is simply by the way the table is set up: the art materials that I choose and use, the color pencils, color marker, Mr. Sketch smelly thick markers, pastels, oil pastels, they are set up the same way each time; a piece of paper 18 x 12 in front of each chair; they walk in it is set up exactly every time. They know. It provides them a safe environment. They know this is the group where we can talk about our stuff, where its confidential; although I mention that and cover that in each introduction they know the routine- they know that the drawings are going up on the wall they know that they are going to have to talk about them afterwards. If they run out of markers I go right over to the locked cabinet and get them a new one. There's that safety involved, there's that nurturing mother concept. [I tell the new clients] this is the psychotherapy group and it meets at such and such time and this is the time, this is the process group- process means that you are going to working seriously for the next 45 min. Teenagers need to know the rules.

### Conventions

Despite the variations of routine, there was an unstated custom among all the art therapists that they would be responsible for certain actions; these actions crossed all temporal and location boundaries. These actions were incorporated in their practice.

These were the conventions (Becker, 1982; Hall, 1987) that created the bond that linked

all the members of the societal group together. Although each art therapist may have practiced differently, there were established parameters of what they could or could not do; or would or would not do. It was not the action that was shared, but the implicit meaning behind the action that created the social organization. Some of the conventions linked them to other professional groups, such as actually using art supplies. Conventions also separated the art therapists from other groups that may use similar materials and techniques, and created a separate social world. It was not enough to indicate they all used art materials within their sessions; so did art teachers, occupational therapists, and recreational therapists. All those observed seemed to share the standard conventions, albeit they remained flexible within the respected standards.

The materials as convention. The art therapists shared conventions that were specific to the art making process. It was not enough for the art therapist to use art materials; they needed to understand the structural characteristics of the materials (Rubin, 1984). For example, if a client has a problem with control, or becomes easily frustrated, an art therapist would not use a material that would be hard to control, such as watercolor paints on a large piece of paper or wet clay that would have difficulty holding its shape. The art therapist may begin with "structured" materials such as pencils, colored pencils, markers, or crayons, on a relatively small piece of paper. Such materials are easier to manipulate. Contrarily, if the art therapist wishes to "regress" a patient, or induce frustration for the sake of treatment, then less structured materials may be used.

The art therapist is responsible for providing external control if internal control breaks down. This understanding is universal (Charlton, 1984; Stott & Males, 1984). In

some cases, the environment may place some restrictions over what materials can or cannot be used, depending on the population. Ultimately, however, the clinical considerations are taken into account, and the art therapist decides on the materials (Gussak, 1997b). Such considerations have even been implemented as part of the ethics document of the American Art Therapy Association (1999b), with an emphasis on toxic and hazardous materials.

Nate indicated that he used markers, pencils, oil pastels, and moderately sized paper. It is understood that such materials are more structured and more manageable. The materials were chosen specifically for the need for structure and control.

Amy varied in her materials and in her environment. In one session, held in a larger room, she provided chalk pastels and paper. This had been with someone she had worked with for several sessions. In a session in her office she supplied pencils, markers and smaller paper. This session was with someone whom she had only seen once or twice before. She loosened the artistic structure based on what she knew, or how much she knew, about the client. She did not speak about why she chose the materials; she just decided.

Lori indicated that she had her adolescent clients make magazine picture collages because they needed structure. She seemed to implicitly know<sup>27</sup> that such a technique was needed for structure.

Bonnie provided a session in which an adolescent acted out, and ultimately painted a nurse's face with orange paint (see Chapter 3 for details about this incident). When

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<sup>27</sup>Collage making is also used for an assessment technique established by Landgarten (1981) that Lori was not aware of.

discussing this with the nurse, she reiterated that it was her own fault, not the art therapy process. Indeed, the session was provided in a large room, using a loosely "structural" material (paint). By indicating it was her fault, she was in a sense, indicating that she was not aware of the client's current state, and did not provide adequate structure for the client through her choice of materials. Although understandable to another art therapist, this was not clearly understood by the nurse with whom she was speaking. Bonnie indicated that this nurse was not someone with whom she had worked closely. Thus, there was no development of shared understanding of the convention. Similar to Becker's audience members (1982), many of the other staff members understood only as much as what they needed to know to "play their part in the cooperative activity" (p.50). The full meaning of the conventions was not shared between the art therapist and the nurse.

Storing and ordering supplies as convention. Because of the importance of the materials, it was part of the art therapists' everyday work to order and store the materials themselves. They ordered certain materials depending on the clients' needs and abilities. They were also responsible for the careful storage of the finished products. No matter the size of their office or work space, each art therapist who was observed had cabinets filled with various materials. Unfinished projects were spread along tables, shelves or taped to the walls, and finished products were carefully stored on shelves or in file cabinets. Erin had little room for the materials, so she stored them under one of the chairs. Debbie had a floor-to-ceiling cabinet along an entire wall in the office she shared with three other staff members. Amy kept sculptured pieces in her office. For her private practice she brought in her own supplies for her clients to use, depending on what they were working on. Bonnie



had the entire art room next to her office that held all the art supplies and finished or unfinished products. Yet she still had a great deal of art supplies stored in her office. She even had an oversized puppet stage that she created with her clients for a puppet show. It took up a great deal of space, and was at times difficult to maneuver around; yet she still kept it in her office. It was more than the fact that the ethics document of the professional association outlined some considerations when storing and displaying art materials and finished products (AATA, 1999b).<sup>28</sup> Each art therapist spoke about the importance and respect they held for the finished products, and the importance of maintaining the materials in a carefully organized fashion.

All the art therapists indicated the importance of the structure of the art therapy directives within a session, to create a "safe environment." Nate indicated that the routine of his sessions created a safe place for his adolescent clients, a place they can feel

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<sup>28</sup>More specifically, particular sections of the AATA Ethics Document state:

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2.6 Art therapists shall maintain patient treatment records (researcher's note: many art therapists believe that this includes patient art work, although this is not clearly delineated here) for a reasonable amount of time consistent with state regulations and sound clinical practice, but not less than seven years from completion of treatment or termination of the therapeutic relationship. Records are stored or disposed of in ways that maintain confidentiality.

...

3.4 Art therapists may display patient art expression in an appropriate and dignified manner only when authorized by the patient in writing.

...

11.0 Independent practitioners of art therapy must provide a safe, functional environment in which to offer art therapy services. This includes:

...

d. knowledge of hazards or toxicity of art materials and the effort needed to safeguard the health of clients.

e. storage space for art projects and secured areas for any hazardous materials.

comfortable to express themselves without fear or discomfort. Many of the art therapists also had rules specific to their sessions.

Client safety as convention. In a sense, rules for client safety were a form of routinization, but enacting the rules were also a convention they all shared. The need to make rules to protect their clients emerged as a convention of their professional culture (Becker, 1982). As Becker indicated, only those who participated in these shared experiences understood the art culture. Thus, the members of their societal culture understood the real impact of the art on the clients. Nate pointed out that his clients understood the need for rules to provide a safe environment. Many of the art therapists complained that some people downplayed the impact of what they did, that they were merely supplying crayons for the clients for coloring. The art therapists understood the import of what they did. They debunked the myth that art making is innocuous and safe in its non-verbal qualities; accordingly part of their responsibility was to assure that their clients were safe. That was why the rules created were not strictly precipitated by the system; they came directly from the art therapist. At times, the rules differed from group to group, and individual to individual.

Nate indicated that along with the expectations in the sessions, he had created three rules that clarified his expectations of the finished product, helped make the adolescents comfortable, and helped address the new constraints imposed by a system that was changed by managed care:

Rule #1: the clients can pass on a question in the group if it makes them uncomfortable.

Rule #2: no stick figures; because of time constraints, according to Nate “did not have time to limit the alliance development through avoidance”; by drawing a stick figure the client is being defensive, and not providing any useable information.

Rule #3: the clients can label drawings with words, but they cannot do pieces with just words on it. In other words, they were expected to draw.

Debbie explained the rules that she established for her clients were a direct result of the type of setting she was in. To keep all the client feeling safe, she outlined three rules:

. . . the three major rules are no violence, no acting out and no contraband and then I go from least restrictive consequences to most dire; one being full room restriction . . . and the other one is having people arrested if they break the law. (laughing) You know. I mean you get the real sociopaths, you know, I like to say that one because it really sets the stage. . . .

Although not specific to her sessions, all the clients understood that if they in any way “acted out,” regardless of the standards set in other therapist’s sessions, Debbie would not let them participate in her groups.

Some of Bonnie’s rules corresponded to the setting, such as “no acting out behavior,” the number of warnings given before a client would be asked to leave, and the length of time they would be in “time out”<sup>29</sup> based on their offense. During one session that the researcher was allowed to observe, Bonnie demonstrated the steps she went through before asking a client to leave, to go to “time out.”

One of the clients began to “act out”; he stood up, walked around the room without permission and verbally challenged the other clients. Bonnie asked him to sit

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<sup>29</sup> Room restriction

down and focus on the directive.<sup>30</sup> The client sat down at the group table, but continued to disrupt the group by mocking a few of the other clients and making fun of their art work. Bonnie indicated that his behavior was not appropriate, and reminded him of the rules of the session. She said that if he continued he would have to go to “time out.” The client remained quiet for a few minutes, but then began again. Bonnie indicated later that she felt that the client was seeking attention since there was someone new in the room (the researcher). Bonnie stood up, asked the client to come with her; they walked several paces away from the group and spoke quietly. They both returned to their seats; the client remained quiet a few more minutes. When the client stood up again, walked around the room, and insulted the other clients and their work, Bonnie asked the client to take a “time out.” After several minutes of “discussion” the client left on his own accord. Several minutes later, after the other clients were working quietly on their art pieces, Bonnie left the room for one minute. She later indicated that she checked with a nurse to follow up and make sure the client was in his room. Bonnie made it a point later to speak to the client in his room after the session to discuss what happened.

Bonnie also had certain rules that were specific to the art therapy sessions. The clients could draw whatever they wished; however, if it included curse words or derogatory remarks, the clients could not show it to anyone else, and it would not be hung up in the day room.<sup>31</sup> All the clients had to clean up their own area and help put away supplies after session. Moreover, the clients had to understand respect for each other’s

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<sup>30</sup>A request by the art therapist for a specific drawing or other art product.

<sup>31</sup>The community room they all shared.

work-they could not draw on someone else's, nor could they make a negative comment about someone else's art work. The rules involved respect for the materials and the finished products.

Each art therapist would explain the rules before each session, whether the art therapist had been seeing the client for a while or it was the first session. Some of the participants also posted a set of rules where everyone can see them.

Confidentiality as convention. All the art therapists had one rule that they all recognized above all others- the rule of confidentiality. Confidentiality is the agreement that an "art therapist shall respect and protect confidential information obtained from patients" (AATA, 1999b, p. 4) and that they will not disclose such information without written consent unless there is reason to believe that the client may be in danger or may be dangerous to another. Confidentiality is considered a "cornerstone of the therapeutic alliance between the client and the art therapist" (Moon, 2000, p. 31) and provides a unique challenge. In many other therapeutic interactions, the only records that may exist of the clients' personal and private issues are those written by the therapist. At the end of an art therapy session, a reflection of the process exists in the art work-a tangible piece of evidence that a therapeutic process occurred.

Great pains were taken to protect the clients' confidentiality. All the participating art therapists had their clients sign release forms. Such forms had stipulations that allowed the art therapist to photograph the image, either for future publications and/or for professional and educational presentations. If the art were to be displayed, names would be covered. Confidentiality was also explained to their clients as their responsibility as

well. Basically, "anything said inside a session stayed in the session." The clients could not talk about other group members' issues to anyone else on their units. However, it was understood that the art therapist may share the finished products with the rest of the clients' treatment teams to illustrate the clients' needs or progress. As noted in the previous chapter, Amy brought clay sculptures to a treatment team session to illustrate her client's progress.

Many of the art therapists would try to hold sessions in enclosed rooms separate from the rest of the unit. Barring that, they would go to great lengths to ensure privacy. For example, Bonnie held one session in the open day room on the unit, which the open-counter nursing station looked over. Although many staff members walked about the room while the clients were doing art, Bonnie provided the illusion that confidentiality would be maintained. She had purchased a portable partition unit on wheels. She wheeled it out, and built a temporary wall around the tables on which her adolescent clients were drawing. If they had other staff members in the room for security reasons, the art therapists would reiterate the group rules with them, including confidentiality.

Despite the apparent differences in therapeutic approaches for these participating art therapists, the conventions remained consistent. Conventions crossed over theoretical boundaries, and are in fact, an inherent part of the theoretical constructs that guide the field. For example, there are two basic theories that are believed to have grounded the field, the making of art as a therapeutic process (Kramer, 1971) or the use of the final art product (Naumburg, 1966) as a means to assess or reflect upon. Despite the differences between the two, both theorists understood the value in the art making, understood the

importance of knowing the qualities of the materials, and understood the need for actively protecting confidentiality. Thus, despite the marked differences in their theories, both Kramer and Naumburg maintained the conventions that bound all the art therapists together. What became clear as this study progressed was that the participating art therapists believed that their conventions and routines continued to guide their practice, whereas their theoretical beliefs became less significant. They believed that they relied more on routines and interactions than theories to shape their practice.

### Theories

#### Their Theories of Theories

All the art therapists indicated that their clinical approaches shifted from 'theory focused' to client focused. That is, it did not matter what art therapy theories they were familiar with, everything was focused on what the client needed. However, what soon became apparent was that when the participating art therapists referred to theory, what they were really referring to was the specific terminology that they learned in school; the terms that became what they considered the meaning of art therapy and proper therapeutic treatment. In many cases, the participating art therapists used their practice to try to explain their theories.

Kara indicated that although she used "Kramer's approach" she had recently come to understand how it is not just the doing of the art that was significant but the verbal expression about it afterwards. In her classroom, when teaching art therapy, she has difficulty translating this to her students. When, as an assignment, her students were asked to go out and interview an established art therapist, they became frustrated when the art

therapists were unable to tell them what they did. The art therapists generally told the students "I don't know, I do whatever comes to mind." Therefore, she felt she needed to teach her students how to be with the client:

. . .and that's really hard and especially for students because they don't want to think that they are just flying by the seat of their pants and [it's a] very different distinction when a professional comes in and assesses the situation and does something and says 'this idea is not going to work I'm going to do something else' instead of saying wait a second; you know it just not a crystal clear recipe, let's figure out let's really listen and trust that we can be intuitive and really pay attention to what the clients are telling what they need and want. . . .

But she still believed the students needed a theory to build upon. She indicated later that her own theory had altered; it is now important to "look at the art and talk about it, picking up the unique quality of it that makes it important. . . and to work from a strength perspective" rather than staying focused on one theoretical perspective. When asked about what her theory had become, she indicated:<sup>32</sup>

My theory is for the students [with whom I worked as a therapist in a special needs school] to do the art and then to also then be able to look at the art; whether it is there art or somebody else's and then to listen to what their peers said about it. And of course I would also say something about it too. . . and in the beginning they would say "oh you like everybody's work" and they do that a lot to, you know, the adult who work with children because they apparently do like everybody's work [laughing] but the point would be that is why you like because that is a lot of things that we do in school too and the kids say "oh this is boring. . . ." And you can really get down to it if you know that they don't understand what is being taught. So in terms of my theoretical faith, I think in terms of looking at the art and talking about it; that picking up what is really the unique quality of it that makes it important; of this child's expression, because we all know that these expressions are important, and to really work from a strength perspective.

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<sup>32</sup>This section becomes confusing in that she is referring to two different types of students; one group consists of the students in her graduate program, and another were the special needs students she worked with as a clinician.



You realize it is just the way that the child used a color, you know that “wow that’s really a wonderful way to use that red, because it gives me a feeling that there’s a lot of energy there; and I bet that you have a lot of energy about what you were doing.” And the child may or may not say “yes,” yet that is not really the point; the point is that they have somebody else experiencing their work; to give them a way of listening that may have something to do with them personally. . . so for me I guess the theoretical base has gotten away from Kramer. . . it is just not doing it but it is experiencing it at a lot of different levels; and having the client experience it that way.

Each art therapist started with a theoretical concept that they felt was, according to Bonnie, the “bee’s knees,” but later changed based on where they worked, and with whom. Some of their reliance on theory varied. Amy explained that she originally followed a psychodynamic approach, which was a direct influence of the graduate program she attended. Her program mostly focused on systems and psychodynamic theory.

Bonnie, however, was more hard pressed to explain one specific theoretical orientation. As noted in the previous chapter, Bonnie relied on her heroes to explain and validate her work. Yet, she explained that:

I can use two totally different theoretical approaches, it doesn’t matter; as long as you know your language well enough to follow it thoroughly so that you can get there.

She stressed that her ideas about art therapy were inherited, yet she needed to remain flexible.

However, Bonnie also had a tendency to speak in the language of ‘object relations,’ specifically as the theories were developed by Mahler (1968), Klein (1932/1975) and Winnicott (1971), a theoretical perspective she learned in school. She indicated that her clients could be described through dynamically oriented perspectives, and that she could also address the issues through a cognitive-behavioral approach. She

also indicated however that this just made it easier to speak with the psychologists and nurses on the unit. Bonnie emphasized that since 1978 [it was unclear why she chose this date-the debate has actually been going on longer than this] there has been a debate about who we are; she has also struggled with this question.

Bonnie indicated that sometimes in a session she needed to be in

. . . the act of creating, and be free and spontaneous; then afterwards, you can say that this works, and this works, but this doesn't-you need to go through it in your head after. In the moment, in the therapy, it is important to just let go and just try to be present.

However, she indicated that she will try and plan ahead of time, and that she will have different strategies, but she does not do so often, and really just thinks of them before the session. Most of her decisions happened spontaneously just before the session.

It was not unusual for Bonnie to have to jump up and do "stuff constantly"; that was part of her job, something she had never been taught in school. However, she did feel she has arrived at the point that she did what she wanted to do, not what she believed she was supposed to do.

She still had difficulty articulating how she felt about some of her work and clients:

. . . It's difficult. I think I'm probably pretty more successful at it the more I do it. Um, but I was incredibly frustrated the first year or two out of graduate school, you know, trying to follow what I had learned and knowing it was right, but not knowing how to communicate it with other colleagues. I'd just get so frustrated. . . however, I'm not quite so busy looking down at those footsteps on the Arthur Murray dance floor.

She indicated that a major part of her day constituted constant self-monitoring and self-reflection.

Bonnie also indicated a need to change her language when working with interns.

For example, one intern used a Rogerian approach (the humanistic approach as designed by Carl Rogers, 1961) which seemed to work well for her; yet, it was still the clients that directed her approach.

Carl indicated that he learned a lot of theory in school. Originally, before going to graduate school, Carl believed that "looking at archetypes would be cool" (from the Jungian perspective), but it proved not to be "acceptable" where he received his degree. He believed that archetypal studies would be more acceptable "on the West Coast," thus his theoretical orientation changed "to the Rogerian approach." However, he has been struggling with the notion of theory since he graduated from his program the year before. He indicated that since he was working, he had to learn to be the "chameleon" which was different from what he was "forced" to learn in school. When in graduate school, in his practicum training, he always "needed a plan," a direction for an art therapy session. When he first started working, this approach was not successful; "the plan never went through"; he explained this away by indicating that he believed the "plan limited the client in a way." As he progressed at work, he began to rely on the notion that he wanted to react to what the client wanted; the more he prepared, the more rigid he became and the "less their [the clients'] needs could be met." Once again, the participants tended to use their practices to explain their theories.

Carl tended to affirm his patients, to make them "feel like a special person, a good person." He tended to think about a session before it happened, as the whole situation, but had difficulty articulating what he would do, or why. For example, he was trying to explain what he was going to do with a client he was seeing, a nine-year-old whom the

family makes a scapegoat, and who ultimately developed a "poor self-image." He described the synopsis of the plan for his client:

Carl: I think at first I'm gonna talk about, his parents were here last week or whatever and I'm gonna talk about their weird relationship. . . he's an only child and it's almost like they're siblings. You know what I'm saying? They bicker between each other and also I noticed that this kid originally came in here for anger control. . . but it sounds like Mom and Dad have anger control problems. . . . Last session was so intense, they were just, they were horrible. His Mom and Dad were like "Tell Carl what you did today" like it was a bad thing. . . pointing out all these little things, like he was getting food for the dog or something and he spilled dog food on his clothes, his new cargo pants before he went to school or whatever. They just got really upset. . . like they were pointing out all these situations that he'd done and the kid's just about ready to lose it. And, I tried to like, you know, tell him that sometimes you can let things go. You need to understand what's really important and what's not important. And I'm like "Hey, man, you don't always have to crack a joke every time. You know what I'm saying?..I think it just went in one ear and out the other. So, I'm a little frustrated with the situation.

Researcher: Do you do art with him?

Carl: Yeah. In fact, I think I'm gonna do like, I think I'm gonna do a big watercolor painting because sometimes you can't control that. . . or whatever just to see how he reacts to like the...the flow of it. . . . And see how that turns out and, uh, I think that, uh, I think that, um, I'm gonna kinda be my own directive and kinda laid back this session 'cause last session was just so intense. You know, it was really hard on him.

Carl had an idea what the problem was, what they would focus on, but then seemed to stumble over the words on what the plan would be. Incidentally, Carl never did do art this session-he later explained that after the session began he felt that the client just needed to talk.

Debbie indicated that she learned the object relations perspective while in school, as well as a Jungian approach. She also believed in a strong spiritual approach, specifically when working with those with drug and alcohol addictions:

Debbie: I feel that when somebody has a strong addiction they lose sight of who they are spiritually. They become a little dis-spirited. It doesn't mean we [inaudible] away or anything, but they lose sight of who they are in a very meaningful way and that they're caught up in the addiction. That's why I think, um, the Twelve Step program works very well for a lot of people because they bring spirituality back into the foreground. Um, so when I meet with somebody I feel a spiritual connection with them so I kinda work from that, help the spiritual part and try to nurture that part and then work with the problems from there, if that makes sense. . . I don't get religious or anything. That's not what I do at all, but I try to work with that person in a core and try to get past a lot of the other stuff. . . . And that doesn't mean they have to know what I'm doing, you know, but I try to meet them at that point...And I do it naturally I think.

Researcher: Okay, what's that mean, "they don't know what you're doing?"

Debbie: In other words, you know, I'm not gonna say to them let, you know, let me try to meet you on a spiritual level. . . . But I just do it. I just live it that way. I feel that's why I'm successful with the people that I work with, than what they hear from me because I think they feel my connection on a spiritual level.

However, she later claimed that she "came from a more eclectic" point of view.

She understood the importance of a theory to help guide a clinician, but not necessarily one theory. She believed a theory "pigeon-holes" a client into a single, narrow belief. During one conversation, Debbie explained an intern's behavior through the psychoanalytic construct of counter-transference. When it was pointed out to her that she originally indicated she subscribed to the Jungian perspective, and yet she used a Freudian construct, she exclaimed, "Exactly; that's what I mean when I say it's never just one thing. It's multi-level, multi-dimensional." She indicated that she also constantly used a cognitive-behavioral approach, the perspective generally adopted by the facility, to address coping skills. She indicated that she "wore different theoretical hats" depending on her

clients. When describing a group that occurred, she indicated that there were some distractions and that she decided to address them:

Debbie: I just told them . . . you have to deal with distractions. This way you learn to do it when there are distractions. And, um, at first I do stretches to get everybody going . . . . And, uh, then I go into biofeedback. Then I teach them breathing and then I go into progressive relaxation. Do you know what that is? Then I go into passive. And then I go into guided imagery. . .and sometimes what I do is I'll make the guided imagery the relaxation technique shorter and I'll leave time at the end for drawing. . . . I didn't do that today. 'Cause I didn't know I was going to do the guided imagery. I did it spontaneously.

Researcher: How come?

Debbie: Because I just felt it. You know, I felt like they were a good group, you know, they were in it. I didn't feel like anybody would like drift into space. And I decided to do it because I felt like they could handle it. I had some time left over and, uh, I was in the mood.

Debbie's decision to do guided imagery was spontaneous, after ascertaining the mood of the group. Later, she had an art therapy group, when she let them do "what they needed to do." She indicated that while they drew, she was able to "pick up on" what a specific client was needing based on what he or she was saying or drawing; "sometimes you can't put it into words, but you feel it on that intuitive level." She pointed out that she usually decided in rounds<sup>33</sup> for herself whether a group will be "open-ended" or will have a directive focusing on a specific issue.

However, this was contradicted later when she indicated just before a series of groups that she did not have a plan, and may not decide until "during the walk back" to the unit or even when sitting in group. In one group the decision was left up to the clients,

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<sup>33</sup>Morning staff discussions about the patients.

when she asked them "What do you want to do?" According to Debbie, no strong, singular theoretical model guided Debbie's work-the clients did.

When asked what she did and how she did it, Erin indicated that "this is one of those professions you just do, not as much have to explain [sic]." Erin later indicated that she was "pro-Rogerian" (Rogers, 1961), and that she also reflected on what she learned from her teachers. When she first started with her clients, specifically those with drug and alcohol addictions, she did a lot of "motivational enhancement, cognitive-behavioral skills, and relapse prevention skills." She indicated the art therapy is very important because "it gets them to look at something they have not yet looked at." However, she was unable to clarify what that meant. She also believed that she was more developmentally focused- she couched treatment goals and directives in the terms of developmental psychology, including creative development (Lowenfeld & Brittain, 1987).

However, she denoted that her current theoretical orientation was "eclectic" and client centered. She was once told by a former teacher not to use the term eclectic, that it was important for one to be "defined." She felt that this did not apply to her, more to the students just starting in the field. Similar to what Kara indicated, Erin believed that students need a theoretical base to begin, and then they can develop the intuitive process of "just knowing" when they have been in the field for a while. Eventually, "every art therapist does art therapy different [sic]."

When discussing her theoretical orientation Erin became increasingly frustrated. She indicated that what she does has become so automatic. "Well, I guess to me it's...I just do it. I don't really think about what's the next thing I'm going to do....it's a groove

by now.” She indicated that she has difficulty in discussing what it was she did, because much of what she did was so “automatic.”

As an example, Erin relayed what had occurred with a client she was seeing. The client could become delusional, so to keep him focused she would begin with a critique of his previous art work; she would then progress to talking about the decisions he would make. She indicated that he would then do an art task, which helped him focus. One of his drawings was of a rendition of “The Last Supper” where all the characters looked alike:

So the artwork really helps him . . . focus. I know the last drawing he did . . . he did this drawing, The Last Supper. . . . Because when he was growing up there was a picture of The Last Supper in his home . . . he does very little erasing. This is all freehand. This is all very. . . he doesn’t sketch. He’s very definite in his lines.

His drawings were described as “fairly intense, and fully detailed,” which he would complete in one hour. The drawings would eventually lead the session into new discussions, and they would develop in various, sometimes unpredictable directions. Despite the initial attempt to keep the client focused, the session would delve into unpredictable directions, depending on the “groove” [routine] of the moment.

Those who were interviewed all clearly indicated that their theoretical perspectives had become blurred over the years, and has become less significant than the practice. Fern indicated that despite her initial exposure to the psychodynamic perspective, and although she still had a “heavy dose” of it, she mostly looked at the strengths of the client, and encouraged these strengths.

Greta was more apt to maintain her theoretical perspective, indicating that her theoretical orientation bridged from psychoanalytic theory to family systems theory. She



noted this was a direct result of where she obtained her degree. However, this changed because she did not often work with families and had little need for systems theory. She also warned that people in the field of art therapy have a tendency to lose sight of their goals, and thus get caught up in the method, without emphasizing what “we can do using that method.” She also believed that no one should “graduate from a program without having to learn the spectrum of experiences and responsibilities of the setting for which they will work. . . .” yet that is not currently happening according to Greta.

Lori indicated that she had come to appreciate the Gestalt approach as well as herbal therapies, theories she was not taught in school but learned through her practices. She believed that she had learned more on the job. However, Lori indicated that she was disappointed about having to use the art as therapy approach. She indicated that this was not as much fun as art psychotherapy approach, especially “interpreting” the art, but that art as therapy worked better for her adolescent clients. Despite personal preference, she used what worked in her practice.

Mary said that she had originally maintained a psychoanalytic perspective, which stemmed from her training, but that has changed over the years. She indicated that she, as well as the program that she directed, had become more eclectic. However, she believed that eclectic may be a difficult term to use, in that someone may or may not be eclectic, and one never really knows until they are observed. She indicated that her perspectives came from her training, the people with whom she has worked, and from reading different theoretical texts; however, she felt the approach should be based on interaction with the client. Unlike some of the other participants, Mary believed that a theory is still helpful in

understanding the client in a particular way, initially to “pigeon-hole” them, and then “you can listen” to them; some need a theory to be more self-confident. Moreover, she indicated, having a theory to believe in helps explain “who you are.”

### Theory After. . . and Before

Connecting oneself to a theory seemed to support the identity of the art therapists. It also seemed to support what they had already *done*. Frequently, art therapists would use a variety of practices in sessions; yet when pressed, they would define their actions through theoretical explanations. It seemed the work of the art therapist was mostly instinctual rather than driven by manifested theoretical understanding. The art therapists still relied on theoretical terms to validate their practice to others in the system. In this section, it will appear that practice drives theory. However, what will become evident before the end of the chapter is that theory and practice rely on each other.

Kara stressed the need to teach theory to create a base. Mary stressed the need to have a theory if for no reason than to help explain “who you are.” This seemed apparent throughout the study. Although all the art therapists spoke of the need to not let theory drive the sessions and focus on the client, many of the art therapists relied on theory to explain what happened during a session *after* it occurred.

Bonnie continuously stressed the need to be client focused, to alter the approaches depending on the direction of the session. Yet the object relations perspective provided a language to explain her clients’ dynamics. The theory was the terminology used. She used it to explain why something did or did not work after the session. It provided for her a framework for understanding. It also provided her a language that she could use to

communicate with others in her system. Bonnie used terms from a cognitive-behavioral perspective to explain what the nursing staff did to defuse the clients' behavior, and how she also at times had to adopt that language to explain what she herself did. It made it easier for her work to be accepted.

The art therapists used theory to provide initial understanding and strategies, but as the art therapists' sessions evolved, they moved away from theories to whatever worked. After a session, however, the therapist might use theory to explain what did or did not work. At this point, many of them downplayed any reliance on theory, insisting they were unhindered by the constraints put upon them by a single theoretical perspective. What soon became clear, however, is that theory did indeed provide a guide which the art therapists would follow in subsequent sessions, albeit loosely. The theoretical constructs helped guide the goals of the sessions, and they knew what directives may help, but the theoretical constructs did not necessarily dictate what would be done in following sessions. They intuitively knew. What emerged was a routinization of theory[ies] into their practice.

Before a particular group began, Bonnie began placing plastic bowls for water, paintbrushes, paints, pastels, and paper on a portable cart. She also traced a few circles on a sheet of paper, indicating that it was for "mandala drawings" in case anyone needed "a little containment." However, when asked what she was going to do she indicated that she was not really sure what the focus of the group would be as she had not yet seen the group. After the group, when asked this question again, she indicated

Mostly I tried to borrow from David Read Johnson's developmental ideas, [to create] possibility for self-expression, and freedom of it, but still a

structure to the group where they can come in and feel safe-that's the ideal. . . .

In essence, she was indicating that she allowed free reign for creative expression through non specific directives, but with structure. She borrowed from David Read Johnson's theories to validate her reason. What is more, the mandala circles, although not prescribed by her for any specific client, were borrowed from the Jungian concept of the circle symbolizing holistic containment (Jung, 1964). She did not indicate the theoretical reference before the session; she just "knew" that some of the clients may need to rely on such a structure for control.

Returning to the incident where Bonnie's client painted a nurse's face with orange paint, Bonnie reflected on the theoretical significance of the color orange, and the object relations development of the client. This was common for all the participants-they talked in the language of theory to explain what happened. Yet Bonnie continued to work with this client later, providing different forms of structure and safety. The client ended up in "time out." Bonnie made it a point to visit this client in her room with art supplies, and asked her to complete specific art pieces that focused on the client's relationships with her family, and subsequently with authority figures. Some of the directives also focused on the client's loss of control. These directives emerged out of discussions Bonnie had with the client in her room; if asked before she met with the client what she would focus on, Bonnie may not have been able to answer it. Asking her afterwards, she indicated that the sessions were focused on the client's attention-seeking behavior, and a need for affirmation from a mother figure. This explanation used classic object relations language.

Bonnie indicated that she no longer had to rely on the "Arthur Murray footsteps"

to guide her approach; what she accepted as no longer relying on theory, however, may just have been an absorption of the theory to where it became tacit understanding. What she knew and did became so embedded in practice, that it was only partially available for clarification and discourse (Giddens, 1979). A theory was available, and it guided a potential directive, provided it was necessary. Only when reflected upon, could Bonnie explain what she did, and why she did it.

Several of the therapists indicated that it was not until after an art therapy session that they could see what was happening-it required reflection in order to categorize and define it. Once it was defined, however, they could plan subsequent sessions with the particular clients. In some cases, these plans became part of their treatment goals; in others, it appeared as "flying by the seat of their pants." Nevertheless, the art therapists seemed to maintain a direction for subsequent treatment based on their theoretical and therapeutic understanding. What emerged was the need to internalize many theories, and the acceptance that they could refer to the ones they needed in any given moment. Out of these theories emerged the sense of who they were, and ultimately, what they felt constituted an effective art therapist.

#### An Art Therapist Is. . .

Part of the interviews and discussions for most of the participants involved asking them what they thought an art therapist was-the characteristics and practices that help shape an effective art therapist. This question emerged as a result of some of the general descriptions initially provided by the participants. Some used the interchangeable term of art therapy and art therapist to define the same thing. In some cases, the art therapy did

not play as important a characteristic in defining the art therapist as did personality traits.

Many of the participating art therapists tended to answer this question by evaluating and analyzing their own personal characteristics. They seemed to look to themselves as a model for what constitutes a good art therapist.

Amy: Someone who can see the potential for change in the client and be creative about how they encourage their clients to see that, and their clients can sort of hang onto that, and put it into place. So, finding the creative spark within the client to help them get to some point of change. . . .

She indicated that invariably, an art therapist has to be flexible, but strong enough to give structure. However, most importantly, she believed that to have love and faith in the art is the most important thing.

Bonnie also stressed that an art therapist has to be flexible. They "have to be fluid, and respond to the moment." The art therapist has to be sufficiently trained in the "mental discipline of psychology" as well as have an understanding of the symbols that may emerge in the art.

I, my client, the individual that I saw and presented [at a state conference] who I worked with for a couple of years. . . he and I made a certain kind of progress because we used a certain kind of language, the symbol of art.

Because of this an art therapist is someone who is visually oriented; "when they look for answers they look." They understand visual symbols. She indicated that she would like to see more art therapists knowing and using the art and symbols "and stay within the art process," to be committed to the art process, and help the client be committed as well.

Carl expressed what he expected an art therapist would be like when he started graduate school; he thought they would be weed-smokers and hippie-types. However, he discovered that:

Carl: They were intelligent, professional, serious about what they wanted to do and be, but I was surprised that, I was a little disappointed by the level of knowledge in art and commitments to art. It disappointed me. I felt like they were more clinical than artistic . . . .Except for a couple of them. They seemed like they were more clinical than artistic and it surprised me too when a lot of them said they'd rather be art therapists than an artist in a studio. I just, I can't fathom that.

Researcher: Did you want them to be more like the weed smokers?

Carl: I don't know. I mean, they were a lot like me. I related to all of them as people. I went into the field thinking that they would be like something else. But they were like me and stuff. They were like me.

Researcher: And that surprised you?

Carl: It did.

When pressed, Carl had trouble explaining the meaning of the term art therapist, for it was made up of "two ambiguous terms, art and therapy." He indicated that his definition of what an art therapist is changed everyday he went to work. He pointed out that if he did indeed define the term art therapist, he would be creating limitations. After five to ten minutes of thinking about it, he said "I can explain art therapy, just not an art therapist."

Debbie indicated that all the "people have their own personal identity as an art therapist." Debbie had a tendency to define what an art therapist was by explaining what she herself did. When asked about a friend who no longer practiced art therapy, but instead became a bio-feedback technician, she pointed out that:

Well, I think. . . if you're an artist and you're an art therapist, I think no matter what field you go in you'll always use your art therapy if you're in the healing arts. And she's, you know, she uses it. Sometimes she'll ask her clients to draw or, you know, keep an art journal, or make something out of clay. . . .

According to Debbie, her friend's identity remains intact, even if she no longer practices. So, although Debbie had difficulty generalizing what an art therapist was, she still understood that there was an essence, an identity that remained intact.

Erin's response to this question was similar to her response when asked about her theoretical orientation. She became irritated, pointing out that for as long as she has been an art therapist she has had to explain herself. Eventually she indicated that she believed that an art therapist is someone who is comfortable with the art materials, and someone trained as an art therapist. A good art therapist is also trained in psychotherapy and counseling. She then stated, "and I guess for me. . ." it is important to be able to integrate art in verbal therapy. She referred to herself as an example, by indicating that she has patience, empathy, perseverance, faith in the clients, rapport with her clients, and is open-minded-qualities important for success. She then admitted that she sometimes questioned whether or not she was doing enough as an art therapist, and was unclear about her own identity; later she indicated that the profession is defined by who you are.

Fern compared an art therapist to an artist, indicating that they both have different goals; art therapists are intimately involved with the art, stimulating their own visual side, but "we are not as focused on the product", then reiterated "I don't tend to be. . . ." Fern relied on herself as the model.

Greta indicated that art therapists happen to use art as a tool, but that they still have to be able to accomplish the tasks given. "Art therapy becomes our means of working, not an identity." An art therapist has to be able to integrate the art with strong clinical skills.



Kara believed that an art therapist is someone who is not “totally in love with the material that they forget what the client has to offer.” They must be human services oriented, and can seek out ways to work with people that are different and atypical. As an aside, she insisted that the individual better “not be in it for the money.”

Lori believed that an art therapist is comfortable with art and is aware of how to use it. She must also be able to deal with its impact on others.

Mary indicated that “any therapist” needs to be sufficiently self-aware, sufficiently curious, and know how to best hold up a reflector. When she was questioned about why she used the term “any therapist” when the question was about “art therapists” she indicated the only thing that separates an art therapist from any therapist is the modality, and their experience with the art material. “Art therapy is not more holy, but it has something to offer besides talk.”

When Nate was asked what an art therapist is, he indicated that he could not define it, that it is based on self-interpretation because of different schools of thought:

Nate: What everyone is doing is technically art therapy; it's based on individual philosophies. . . . I mean all the people in these categories consider themselves or call themselves art therapist, so that's why I think it's a difficult question. I think it would be a way for a person to look at . . . . I think as a professional we use. . . the qualities and inherent abilities in art, what art and materials can provide along with a clinical psychotherapeutic education and/or basis so we can integrate both.

Researcher: What characteristics should an art therapist have to be successful?

Nate: Again, I think that is really focused on their center . . . what I do in my settings is very successful; of course for each of the populations . . . . I wouldn't give the same ideas you understand; in children's art therapy you don't have the same rules. . . . I don't have the materials out because if little kids see something in front of them they are going to pick it up. It was more

a choice a person can come over here . . . make sure the pencils are on the table make sure everybody has their own set of materials like I have these neat little containers that hold 24 color pencils and etc. . . they would all come out and make sure they get paper they were given the materials so they would sort of nurture themselves in that process that would be for the child population

Researcher: So you have two different approaches just for children and adolescents and they were both successful. What I'm asking is what characteristics of an art therapist works?

Nate: In a way, it is both of those two ways that I explained. . . and then well, being able to apply it to certain populations. I had worked with the adults more as chronic patients and in some ways, they are somewhat like children; you can't overwhelm them with a lot of materials and etcetera, and the tasks are certainly directed more toward what they're capable of doing, their orientation at the time-they could be in any psychotic state-and that's where the psychological background in the education needs to come in. . . . I hold expectations of them; the people that I have worked with have always met the expectations as much as they're possible [sic].

Although Nate indicated that he could not clearly explain what an art therapist is, he talked about how he himself worked as an example of what a good art therapist would do. In some cases, it did not have to even be art therapy in order for sessions to be effective.

#### Does it have to be art therapy?

An overwhelming majority of the art therapists indicated that it was not necessarily the art therapy that worked, but rather who *they* were. The effectiveness came from the therapist. A paradox thus seemed to exist. In Chapter 3, it was shown that the art therapists stressed their identity; they needed to be known as an art therapist despite maintaining different titles in their settings. In the previous section, "What an art therapist is. . . ," many of the art therapists identified the characteristics of a good therapist by reflecting on their own professional performance and standards. Nevertheless it seemed

that the art therapists indicated that it did not have to be art therapy that worked; it was just a tool.

Greta: I was a clinician, and accepted as any other clinician. . . .

Researcher: Did you think that was unusual?

Greta: It was very unusual; but not in my experience, but I think it probably is a little unique. . . well, I just did a program [a presentation for an art therapy conference] this morning where the identity of an art therapist, you know, is like "I'm something special, I'm something unique." "Well, what can you do". . . "I'm unique, art therapy is unique"; "yeah, well, what do you do, what can you deliver for my population." "Well, I can give them art therapy, I can bring in these wonderful art supplies." But you know that is not really how it sells[ pause] OK, in the drug prevention program, they want to know that some action is taking place, with a sufficient number of students, to offset their drug use, that is the goal. . . . Art therapy is a terrific medium for that, but if I had been a hocus pocus therapist, I would have been using hocus pocus, and if it worked, it would have been an OK medium for that. . . but there is a goal to be obtained. . . and I think we lose sight of that goal and get too caught in our method, and we promote the method without really emphasizing what we can do using that method . . . . Nobody hires me blind without knowing I'm an art therapist, but I don't remember that I ever been. . . well that's not true, I was asked to be a consultant by several psychiatrists as an art therapist on art work that they were getting from their patients. . . that was specifically, being an art therapist. . . I wouldn't have been there if it hadn't been for art therapy, but other than the situation like that I think it's been 'do this job.'

Researcher: If you didn't have the art therapy, could you still have gotten those jobs?

Greta: Well, I would have had to have something...certainly equivalent, maybe I would have been a psychologist, or a social worker, or an MFT with the expertise that I have in terms of whether it's drug abuse or child abuse, or trauma treatment. . . .

Greta stressed that the art was just a tool that she used; it was the therapist that made therapy work.

However, the contradiction ends when it is realized that although the participants

indicated that it did not have to be art therapy, it had to be what they used. For example, although Bonnie insisted that any other therapy will work:

Researcher: So then do you need the art?

Bonnie: Yes you do. If you're going to. . . if this is the language in which you speak.

Researcher: Uh-huh.

Bonnie: [Art therapy] provided a particular container for us [she and a client] to navigate particular waters in. But I know he's also doing fabulous work with his psychotherapist. And she made incredible inroads and revelations with him. She just happens to speak Farsi or whatever. I mean, she happens to speak this particular language, uh, analysis. She can work with her client that way. Um . . . which is better? I'm not going to say. I don't know. I'm not going to. . . there's no reason to advocate that. All I know is what I can do. You know, and that's where my interest is because that's how I have to work. That's what suits me. It's simplistic to think that there's anything that can cure all. . . . [The art therapy is] a vehicle and a tool. You have to apply it.

Researcher: Who wouldn't it work with?

Bonnie: Oh. . . of course it's going to have some benefit to anybody. . . To some degree. There's going to be other modalities that will probably reach a client more because of their perplexities but. . . if you're any. . . if you're worth any of your mettle as a therapist, you're going to be able to effect some kind of positive change. [laughs] I mean, maybe the reason art therapy isn't working is because. . . not because of the art therapy, but because you're a crap therapist.

Bonnie stressed that art therapy is a tool; "I mean, you can't say 'Hey, a hammer is really an effective tool.' It depends on who's holding the hammer."

Kara: I don't think that it has to be art therapy and that's one of the things I teach my students. That it's not for everyone but I think it's a language that everybody has access to, that if they want to use it that they can. I think what happens. . . clients might be opposed to it in certain group situations. . . and yet it might be something that they come back on their own whether doodling, or scribbling, or just doing some art some day and

all the sudden they realize, 'oh ok' but I mean even if we feel like we failed . . . I think we have given them something that again they can access and feel comfortable with at some point if that is what they want to use.

Mary indicated that art therapy was not necessarily the right type of treatment for everyone:

Mary: There were some people who use art well, use materials well, and who are pleased to get a little messed up using the materials; and there are other people who are quite comfortable talking about what their experience was like. . .and I am happy to work with either one and sometimes rather than look at bad paintings I would rather have somebody talk to me [laughing] . . . they have languages more powerful than bad art work.

Researcher: How would you assess a person whether or not they were right for art therapy?

Mary: One of the first things I tend to do is to ask them.

In many cases, the art therapists did not use art, but simply talked with their clients.

#### Summary- The Interaction Between Theory and Practice

In summary, there seems to have emerged an interactive, coevolutionary relationship between the participating art therapists' theories and practice—they relied on each other. The theory and practice of the art therapists depended on one another to develop.

#### Coevolution

Coevolution is defined by Bateson (1979) as:

[a] stochastic system of evolutionary change in which two or more species interact in such a way that changes in species A set the stage for the natural selection of changes in species B. Later changes in species B, in turn, set the stage for the selecting of more similar changes in species A ( p.227).

Kelly (1994) pointed out that there is a “tango” between two systems, as they evolve toward and with each other, until they are inseparable. Theory and practice can be seen in a similar manner. In essence, a web is created with a constant cooperative interaction between the theory and practice of each participant.

Although many of the art therapists implied that once working in the field theory became secondary to practice, it seemed that theory and practice evolved simultaneously. The art therapists first learned their theories while in school. More specifically, they learned the terms that defined what it was they would do, and the language to help them explain why what they did worked. This, in turn, provided a base for their practice as they went into their respective systems. It was at this point, many of the therapists indicated, where a shift occurred. They believed that the theories originally relied upon became secondary to their practice. As Bolan (1997) argued it appeared that their practice guided their theories. It appeared that their work became client-focused not theory-focused and their original conventions and their respective systems started informing their practice. Theory became more a way to explain their practice after it occurred, and to allow for common language between systemic members.

However, what became evident was despite their claim for practice overriding theories, and theories used only to explain what it was they did, theory did in fact appear to inform their subsequent treatment procedures. Once the art therapists reflected on what worked for their clients in a given session using theories to explain how they did it, they created a structure on which to loosely base the following treatment sessions. Yet it was not clear why the art therapists downplayed the importance of theory.

Why?

The tendency for the participating art therapists to downplay theory may have emerged from several dynamics. As already indicated, they may simply not have been aware of their reliance on such theoretical constructs. It seemed their knowledge and understanding of what worked became so embedded in their practice, they may not have even been fully cognizant of their reliance of theories as their base for treatment. It became the routinization of theory into practice. It became intuitive. As noted above, this was summed up by Erin, who indicated "I don't really think about what's the next thing I'm going to do. . . . It's a groove by now." As well, many of the therapists soon developed a surplus of theoretical constructs, and picking and choosing what may work in a given situation downplayed the emphasis on one overriding "theory." The implication of relying on one theory means that one interaction would be consistent with another. However, as recognized by the interactionist perspective, meaning changes through such interactions. Accordingly, one theory may not apply to more than one situation.

Another reason may have been that the participating art therapists recognized theory as something that established constraints and rigid parameters (Thomas, 1997). As indicated by their descriptions of what constitutes an art therapist, the participants prided themselves on their own creativity and flexibility. Such reliance on theory may have seemed contradictory. What is more, for those in the helping profession, stressing that they believe in "people first" and are client focused is generally a more attractive and altruistic belief. Relying on theories that stressed the importance of the art and the value of art therapy; yet learning that in some cases verbal therapy may be necessary, may not have

been something that they could have easily resolved. Many of the art therapists stressed that it did not have to even be the art therapy. Consequently, the importance of theory was downplayed.

Regardless of the reason, it was clear that the theory and the practice of the art therapists coevolved. Both were necessary components of the art therapist, regardless of what they themselves emphasized. One section of the final chapter will address how the concept of the diffusion of information was used to evaluate how the participants' systems, theory, and practice inform each other to provide an idea of what constitutes the work of the art therapist.



## CHAPTER V

### Conclusion

This chapter will begin with an overview of how the interactions could be viewed through the lens of the diffusion of information. Next will be an evaluation of the research questions, followed by several summarized conclusions about the work of the art therapist that emerged from this study.

The interactionist perspective, used as a framework for this study, provided not only a means to gather data but a means to understand the dynamics that occurred within the system.

The interaction that occurred was not just between the participants and their environmental systemic components; it happened within each participant as well. As the participants' ideas guided their practices, their practices were reflected upon and informed new ideas and theoretical perspectives. What became evident through these observations was how the participant art therapists' ideas, and those acquired from their systems, were diffused and eventually adopted as their practice.

#### Diffusion of Information and the Art Therapist

In the introduction, two information transfer models were presented: Achleitner, Vowell and Wyatt's value chain process (1997) and Johnston and Blumentritt's model of knowledge development (1998). Both models illustrate that the transfer of knowledge and information do not simply follow a chain or a linear process, but rather maintain a cyclical process. This was evident among the participant art therapists. As knowledge and ideas were obtained or created, they were made sense of, shared and ultimately used or

discarded. Nonetheless, while the first bit of knowledge was being processed, the art therapists continued to gain knowledge by interacting with other systemic components, possibly altering the direction of the current information. This at times forced the information to be reevaluated, altered, accepted or destroyed.

Diffusion is a necessary component in both the value chain process and the model of knowledge development. Diffusion is ". . . the process by which an innovation is communicated through certain channels over time among the members of a social system" (Rogers, 1995, p.10, italics removed). Innovations, such as different theories and altered practices, are presented for adoption. Before they can be diffused, such innovations require that they be seen as advantageous, compatible to the system, are not extremely complex, can withstand a trial period and can be observed (Lievrouw & Pope, 1994) . If the ideas or new practices are indeed not compatible after a suitable trial period or the benefits are not observable, they will either be abandoned or altered once again for a cleaner fit. Thus, the diffusion of information is a crucial element for the interactions between the participant art therapists' theories and practices.

As the art therapists' ideas and theories informed their practices, their practices reinforce the changes made to the practitioners' ideas and theoretical approaches. Erin indicated that she went through an adjustment period when she moved from one setting to another. She altered routines depending on who she was working with or because of unforeseen situations that may have arisen. For example, a new member of the system, a nurse, questioned Bonnie's group art therapy approaches. Consequently, this resulted in her altering her approach. Many of the art therapists indicated that they went through a

period of time when they had to train the system. Moreover, many of them had to learn systemic expectations , such as charting and paperwork, in order to prove their own compatibility.

In addition, each setting provided the opportunity for art therapy to demonstrate if it was right for the system. Greta stressed that art therapists need to be able to convince the systems to “give art therapy a try” to prove that it is advantageous and compatible. To prove this, the art therapists had to demonstrate a certain level of flexibility and creativity (two characteristics that most of the art therapists used to define an art therapist). Because of the fluidity and ambiguity of the system, the art therapists felt they often had to compromise their own identity through additional credentials and changes to their job titles in order to adapt to their systems. Ultimately, it seemed obvious that all of the art therapists observed were successful in diffusing their ideas throughout their systems. Accordingly, theoretical ideas and unique practices need to be tried in a specific system to ascertain whether or not they are applicable. As this study indicated, systems constantly changed. Each art therapist, because of the volatility of a given situation, experienced many modifications to the system. Moreover, each art therapist experienced many systemic components, some of which he or she may not have expected nor prepared for when leaving training. For example, none of them were previously trained in their educational settings to manage assaultive behavior. Eventually the art therapists’ situational routines emerged from the actions that evolved from the situations.

The participants’ practices were shaped by the interaction between the systemic components and their ideas. As Rogers (1995) stressed, a heterogenous environment is

more conducive to a broader diffusion of information. Ultimately, each situation with clients, peers, setting administrators and other art therapists required the art therapist to be flexible and creative to adapt to that interaction. Thus, one theory or idea may work in one situation, but perhaps not in another.

Theoretical connections are made between theorists and clinicians within and between their systems by communicating and collegial interaction. Theorists continuously form, break, and re-form these connections. Each new idea can be pursued to its own adoptable conclusion. What may have been intended as one idea can progress into several innovative theories. Each art therapist started with a similar idea; he or she would use art as a therapeutic modality. Many of the participants had similar credentials, and they all believed in the "power of the art." However, they presented differences in their therapeutic approaches and to some extent, their theoretical ideas. Upon entering the system in which they would work, they were directed to practice in certain ways to meet the needs of their facilities. Slowly or quickly, they learned how art therapy would work in the respective settings, and they redefined themselves as they progressed. The meanings of what they did depended on the interactions within the system.

However, the art therapists did not totally discard the original theoretical constructs, nor did they "kill their teachers" as Bonnie indicated they needed to do in order to mature as therapists. Instead, they seemed to internalize the teachings and beliefs of their heroes, invoked these ideas to validate their own work or used these terms to communicate with others within one systemic component. They also learned new languages and series of approaches to work with and communicate with other components

of their systems. Many of them held onto routines and conventions to make sense of the ambiguity of their work. Ideas broke off and new information was transferred to formulate new perspectives, but they all still belonged to the same invisible college of art therapists (de Solla Price, 1963; Gussak, 2000).

### The Research Questions

The research questions provided a platform on which to stand, and allowed a direction for the data gathering. These questions were fully explored within the body of the previous chapters:

- What components make up each participant art therapist's system?
- Do the art therapists' theories inform their practices?
- If so, how?
- How does each participant art therapist define what an art therapist is?
- How do the participant art therapists describe their work?
- What is the relationship between what the art therapists say their work is versus what they actually do?

In answering these questions, a clearer understanding of the work of the art therapist emerged. Because of the nature of the questions, originally established to begin gathering the data, several relied on the answers provided to other questions before they could be clarified. For example, one of the research questions focused on the components that made up each participant's system. This proved to be a pivotal component of the research, in that understanding the participants' systemic influences was necessary in order for the work of the art therapist to make sense. However, the exploration and

understanding of the system in turn informed the interaction between the participants' theories and practices. In fact, what emerged was that both theory and practice interacted with the system. Theoretical ideas emerged as an interaction with the heroes, and systemic components such as educational settings and professional settings, whereas their practices were dictated by policies, systemic routines and systemic expectations. This section will provide summarized answers to the research questions previously answered in greater detail in prior chapters. In some cases, two or more questions have been collapsed into one heading, as the explanations inform multiple questions simultaneously.

*What components make up each participant art therapist's system?*

Each participant's system was comprised of historical contexts and current theoretical interactions. These include: where they worked; the institution from where they received their degrees; the teachers and peers with whom they interacted within their respective institutions; state and national regulatory bodies; national and state associations; those they considered heroes of the field; other art therapists; and facilities they worked for prior to their current setting. Each component was linked together.

There were many components from other systems they intersected with that contributed to the participants' systems as well such as those of other art therapists, the administrators of their placements and their teachers. The art therapists theoretical perspectives, their conventions and their routinized structures also tended to be components of their system. Each component of the art therapists' systems influences the interaction between their respective theories and practices.

*Do the art therapists' theories inform their practices? If so, how?*

This question was only partially complete; the question would have been more useful if it also asked to what degree the practice informed the participants' respected theories. Indeed, the theory influenced the practice of the art therapist. In turn, the participants' practice reinforced and altered the participants' theoretical beliefs. In the opening chapter, it was argued that:

“through the interactions there is an input, an output and a throughput (Wyatt, personal communication, October 28, 1999). . . for example, the input, theories of art therapy, might be influenced by the throughput, the contextual system to which the art therapist belongs, and are thus transformed into the output, the applied practice of the professional.”

As the study progressed, this concept did not seem entirely correct. The throughput was the interactions that occurred within the contextual systems, which in turn altered the input from which emerged an output. The input was the art therapists' theories, transformed into the output of practice. However, the input was also the practice which informed a new theory or ideological perspective, a new output. This output once again, took on the characteristics of an input, transforming the practice, a different output. Thus, a cycle was created. Neither theory nor practice was solely the input or the output—they both took on either role, sometimes simultaneously, creating an endless interactive, oscillating cycle. In this respect, theory and practice coevolved.

*How does each participant art therapist define what an “art therapist” is?*

This question emerged as a result of some of the general descriptions provided by the art therapists about art therapy, which specifically focused on the participants' beliefs of what characteristics and practices shape an effective art therapist. In most cases,

whenever the participants discussed what they considered effective art therapy practices, they described characteristics an art therapist has in order to meet the practice needs. To answer this question, eight of the participating art therapists referred to characteristics they themselves possessed as the qualities an art therapist needed; regardless, many agreed on several characteristics.

According to the participants, an art therapist needs to be flexible and creative. Using herself as an example, one art therapist indicated that to be successful she required patience, empathy, perseverance, faith in the clients, and open-mindedness. To some degree or another, many of the other participants reiterated these characteristics as requirements for success.

Nine participants indicated that they have to be sufficiently trained in psychology and counseling techniques. Art therapists need to be human services oriented, and somewhat altruistic. What is more, an effective art therapist accepts the ambiguity of combining art and therapy.

A few art therapists mentioned that understanding the art process was a key component to being an art therapist; however, this did not seem as prevalent a belief as presupposed. Although they all in some degree touched on the necessity of being creative, understanding "visual symbols" and having a "faith in the art," interpersonal skills were deemed more necessary. When asked what were the necessary characteristics for an art therapist, Mary described "any therapist" indicating that the only thing that separates an art therapist from any other kind of the therapist was the modality. Fern indicated that the art therapist is intimately involved with the art, but that the end art product is not as much



of a focus as it would be for an artist. Greta pointed out that the art is just a tool, and that the clinical skills are what is most important. Such responses led to the question about whether or not it was the art therapy that was valuable or the art therapists themselves; in other words, does it even have to be art therapy. An overwhelming majority of the art therapists indicated that it was not necessarily the art therapy that worked, but rather the interpersonal skills of the therapist; in other words, it was not the art of art therapy, but the therapy. Seven of the participating art therapists specifically indicated that they believed that the art was just a tool they used, much like a psychotherapist would use talk; or as Greta indicated "if I had been a hocus pocus therapist, I would have been using hocus pocus, and if it worked, it would have been okay. . . ."

*How do the participant art therapists describe their work? What is the relationship between what the art therapists say their work is versus what they actually do?*

The first question was established as a general vantage point from which to inquire about the art therapists' systems; the answers they provided for this question have been scattered throughout this study. The participants' responses contributed to a clear understanding of the relationships between the art therapists' systems, and how the systems interacted with the participants' theories and practices. All of the art therapists had a little difficulty discussing their schedules, and what they were supposed to do within the systems in which they worked. They were able to discuss the work in terms of minutia, the actions they needed to perform on any given day. However, much of their work became intuitive; the knowledge and understanding of what worked became so embedded in their practice, they were not always cognizant of what it was they were doing, or even

why. In many cases, the routines and conventions were so well established, descriptions of what it was they did was simply not always available for discourse; or as Erin aptly put it, "I don't really think about the next thing I'm going to do. . . it's a groove by now."

Ten of the art therapists indicated that they believed that after they had been out of graduate school for a short period of time, theories took a back seat to practice- that it was the practice that dictated future practices. All of them believed that theory was important to begin with, as it certainly allowed a groundwork on which to build; however, few were aware of the coevolution that seemed to occur between their theories and practices.

#### Summarized Conclusions

From the answers to the questions about the work of the art therapist certain conclusions transpired:

- The work of the art therapist emerged from the interaction between the art therapists' theory and practice within and between their systems.
- The art therapists' system is comprised of many components, and is not temporally nor spatially limited. They include, but are not limited to: their place of work; the administrators of these settings; policy and regulations of these settings; their peers within these settings; their educational settings; their teachers and mentors from these educational settings; the supervisors from their internship placements; national and state organizations; national and state regulatory bodies; their heroes; other art therapists; and their clients.
- Theory does not simply inform practice, nor does practice simply influence theory, but rather theory and practice are coevolutionary and interact in a cyclical fashion.

- The art therapists’ systems influence and inform the interaction between their theory and practice. The systems are the throughput through which the input is transformed into the output.
- The work of the art therapist, that is, the interaction between the art therapist’s theory and practice within his or her system, is individually determined. It depends on the art therapist, not on the art therapy.
- Conventions exist within the art therapy subculture and routines exist within the art therapists’ settings to create structure and help the actors make sense of an ambiguous professional field.

#### Future Research

Future studies on larger, more diverse samples will be necessary to support these conclusions. Furthermore, some of the individual characteristics that emerged as key components require further evaluation. For example, the significance of “charting” as a means for the art therapists to ingratiate themselves into a system and validate their own work may have proved a substantial systemic component in this study, but it may not be important for art therapists in other settings, such as those in schools. The concept of heroes emerged as a key component of the participating art therapists’ systems. Additional interviews, with a larger sample of art therapists, may be necessary to clarify and confirm the significance and roles of heroes to the field of art therapy. Questionnaires can be created, and further interviews conducted to determine the significance of the conventions and routines established in the work of the art therapist.

This study started with the claim that this research would contribute to two areas

of study; art therapy, and the diffusion of information in Information Management. The information revealed in this study may help the field of art therapy, specifically the art therapy educators, and art therapy education and association policy makers. It can help them understand the systems in which the art therapists will find themselves in, how the art therapists' theories and practice will coevolve allowing a more specific course of preparation for those entering the field, and how ultimately those who are in the field survive based on their ability to prove themselves compatible and adaptable to their new systems. Without an understanding that the art therapist needs to interact within a system comprised of more than art therapists, the practicing clinician, and the field itself, will flounder. The field of Information Management will benefit by comprehending how ultimately both theory and practice can be diffused and ultimately utilized to influence a system. The cycles in which theory and practice inform themselves, and the manner in which the system informs and is informed by theory and practice provides concrete examples of how information is transferred within an open organization.

## References

- Achleitner, H.K., Vowell, F. & Wyatt, R.B. (1998). Global conversations: New horizons for information professionals and students [29 paragraphs] First Monday.-[On-line journal].
- American Art Therapy Association, Inc. (1995). 1994 business meeting minutes. American Art Therapy Association Newsletter, 28 (4) 27-29.
- American Art Therapy Association, Inc. (1994). Education standards: For programs providing art therapy education. American Art Therapy Association Newsletter, 27 (3) 11-13.
- American Art Therapy Association, Inc. (1999a). Education standards: For programs providing art therapy education (effective date: July 1, 2002). Mundelein, IL: Author.
- American Art Therapy Association, Inc. (1999b). Ethics document. Mundelein, IL: Author.
- Argyris, C., & Schon, C. (1974). Theory in practice: Increasing professional effectiveness. San Francisco: Jossey-Bass Publishers.
- Babbie, E. (1998) The practice of social research (8th ed.). Belmont, CA: Wadsworth Publishing Company.
- Bakewell, E., Beeman, W.O., & Reese, C.M. (1988). Object-image-inquiry: The art historian at work. Santa Monica, CA: The Getty Art History Information Program.
- Bateson, G. (1979). Mind and nature: A necessary unity. New York: E.P. Dutton.
- Becker, H.S. (1982). Art worlds. Berkeley, CA: University of California Press.

Becker, H.S., Geer, B., Hughes, E.C., & Strauss, A.L. (1961/1997). Boys in white: Student culture in medical school. New Brunswick, NJ: Transaction Publishers.

Berkowitz, N., & Gussak, D. (2000). AATA qualitative report of professional art therapists. American Art Therapy Association Newsletter, 33 (2), 9-10.

Berkowitz, N., & Gussak, D. (1999). AATA qualitative report of professional art therapists. Board Report for the American Art Therapy Association Board of Directors Meeting/ Fall 1999, pp. 19-23.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Berkeley, CA: University of California Press.

Bolan, R.S. (1980). The practitioner as theorist: The phenomenology of the professional episode. The American Psychological Association Journal, July, 261-274.

Bolman, L.G. & Deal, T.E. (1984). Modern approaches to understanding and managing organizations. San Francisco: Jossey- Bass Publishers.

Boulding, K.E. (1978). General systems theory— The skeleton of science. In J.M. Shafritz & P.H. Whitbeck (Eds.), Classics of Organization Theory. Oak Park, IL: Moore Publishing.

Burawoy, M.(1985). The politics of production: Factory regimes under capitalism and socialism. London: verso.

Campbell, J. & Moyer, B. (1988). The power of myth. New York: Doubleday Publishing Co.

Capra, F. (1996). The web of life. New York: Anchor Books/Doubleday.

- Charlton, S. (1984). Art therapy with long-stay residents of psychiatric hospitals. In T. Dalley (Ed.). Art as therapy: An introduction to the use of art as a therapeutic technique (p. 173-190). London: Tavistock/Routledge.
- Chatman, E.A. (1987). The information world of low-skilled workers. Library and Information Science Research, 9, 265-281.
- Cooley, C.H. (1964). Human nature and the social order. New York: Schocken Books.
- Corbin, J.M., & Strauss, A.L. (1993). The articulation of work through interaction. The Sociological Quarterly, 34 (1), 71-83.
- de Solla Price, D. (1963). Little science, big science. New York: Columbia University Press.
- Deal, T.E., & Kennedy, A.A. (1982). Corporate cultures: The rites and rituals of corporate life. Reading, MA: Addison-Wesley Publishing Company.
- Dewey, J. (1930). Human nature and conduct: An introduction to social psychology. New York: The Modern Library.
- Elkins, S.G. (1994). The development of learned ethical behavior among professional nurses. Unpublished doctoral dissertation, Northern Illinois University, Dekalb, Illinois.
- Giddens, A. (1979). Central problems in social theory: Action, structure and contradiction in social analysis. Berkeley: University of California Press.
- Gilmore, S. (1990). Art worlds: Developing the interactionist approach to social

organization. In H. S. Becker & M. M. McCall (Eds.), Symbolic interaction and cultural studies (pp.148-178). Chicago, IL.: The University of Chicago Press.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine de Gruyter.

Glazier, J.D. (1992). Qualitative and nonqualitative research methodologies: Thesis, antithesis or synthesis? In J.D. Glazier & R.R. Powell (Eds.), Qualitative research in information management (pp. 201-214). Englewood, CO: Libraries Unlimited, Inc.

Grover, R. (1993). A proposed model for diagnosing information needs. School Library Media Quarterly(Winter), 95-100.

Grover, R., & Glazier, J. (1986). Implications for application of qualitative methods to library and information science research. Library and Information Science Research, 7, 247-260.

Gussak, D. (1997a). Breaking through barriers: Art therapy in prisons. In D. Gussak and E. Virshup (Eds.), Drawing time: Art therapy in prisons and other correctional settings (pp.1-11). Chicago, IL: Magnolia Street Publishers.

Gussak, D. (1997b). The ultimate hidden weapon: Art therapy and the compromise option. In D. Gussak and E. Virshup (Eds.), Drawing time: Art therapy in prisons and other correctional settings (pp.59-74). Chicago, IL: Magnolia Street Publishers.

Gussak, D. (1998). "How it happened in Colorado in 1998. . . A response". American Art Therapy Association Newsletter, 31 (3), 30.

Gussak, D. (2000). The invisible college of art therapists. Art Therapy: The Journal of the American Art Therapy Association, 17 (1), 4-6.



Hale, M. (1989). Nature of city managers' work. In H.G. Frerickson (Ed.) Ideal and Practice in Community Manager Government. pp.168-176. Washington, DC: ICMA.

Hale, M. (1983). A structured observation study of the nature of city managers' work. Unpublished dissertation, University of Southern California, Los Angeles, CA.

Hall, N. (1994). Art therapy credentials review: President's report. American Art Therapy Association Newsletter, 27(1). 24-25.

Hall, P. M. (1995). The consequences of qualitative analysis for sociological theory: Beyond the microlevel. The Sociological Quarterly, 36 (2), 397-423.

Hall, P.M. (1987). Presidential address: Interactionism and the study of social organization. The Sociological Quarterly, 28(1), 1-22.

Hall, P.M., & Spencer-Hall, D.A. (1982). The social conditions of the negotiated order. Urban Life, 11 (3), 328-349.

Heylighen, F. (1998). Basic concepts of the systems approach [9 paragraphs]. Principia Cybernetica Web [On-line journal] Available at:<http://pespmc1.vub.ac.be/SYSAPPR.html>.

Hughes, E.C. (1959/1994). On work, race, and the sociological imagination. Chicago: The University of Chicago Press.

James, W. (1890/1918). The principles of psychology. Vol.1 and Vol.2. New York: Henry Holt and Company.

Johnston, R. & Blumentritt, R. (1998). Knowledge moves to center stage. Science Communication, 20 (1), 99-105.

- Kanter, R. M. (1977). Men and women of the corporation. New York: Basic Books, Inc.
- Kelly, K. (1994). Out of control. Reading, MA: Addison-Wesley Publishing Co.
- Klein, M. (1932/1975). The psychoanalysis of children. Trans. Alix Strachey. New York: Delacorte Press.
- Kramer, E. (1971). Art as therapy with children. New York: Schocken Books.
- Landgarten, H. (1981). Clinical art therapy. New York: Brunner/Mazel.
- Lievrouw, L.A., and Pope, J.T. (1994). Contemporary art as aesthetic innovation: Applying the diffusion model in the art world. Knowledge: Creation, Diffusion, Utilization, 15 (4), 373-395.
- Lipsky, M. (1980). Street-level bureaucracy: Dilemmas of the individual in public services. New York: Russell Sage Foundation.
- Lowenfeld, V., & Brittain, W.L. (1987). Creative and mental growth (8<sup>th</sup> Edition). New York: MacMillan Publishing Company.
- Luhmann, N. (1995). Social systems. Stanford, CA: Stanford University Press.
- Mahler, M.S. (1968). On human symbiosis and the vicissitudes of individuation. New York: International Universities Press.
- Marsden, R., & Townley, B. (1996). The owl of Minerva: Reflections on theory in practice. In S.R. Clegg, C. Hardy, and W.R. Nord (Eds.), Handbook of Organization Studies. Thousand Oaks, CA: Sage Publications.
- Maturana, H.R., & Varela, F.J. (1980). Autopoiesis and cognition: The realization of the living. Dordrecht, Holland: D. Reidel Publishing Company.

- McAdams, M. (1995). Wiener: Ideas [5 paragraphs]. Cybermedia [On-line serial]. Available at: [www.well.com/user/mmcadams/wiener.html](http://www.well.com/user/mmcadams/wiener.html).
- Mead, G.H. (1964). On social psychology. Chicago:University of Chicago Press.
- Moon, B. (2000). Ethical issues in art therapy. Springfield, IL: Charles C Thomas Publisher.
- Morgan, G. (1997). Images of organization. Thousand Oaks, CA: Sage Publications
- Morris, C.W. (1962). Works of George Herbert Mead, Vol.1-Mind, self, and society: From the standpoint of a social behaviorist. Chicago: University of Chicago Press.
- Mullins, N.C., & Mullins, C.J. (1973). Theories and theory groups in contemporary American sociology. New York: Harper & Row.
- Nathan, M.L., & Mitroff, I.I. (1991). The use of negotiated order theory as a tool for the analysis and development of an interorganizational field. The Journal of Applied Behavioral Science, 27 (2), 163-180.
- Naumburg, M. (1966). Dynamically oriented art therapy. New York: Grune & Stratton.
- Robbins, A. (1982). Integrating the personal and the theoretical splits in the struggle towards an identity as art therapist. The Arts in Psychotherapy, 9, 1-9.
- Robbins, A. (1987). The artist as therapist. New York: Human Sciences Press.
- Robbins, A. (Ed.) (1998). Therapeutic presence. London: Jessica Kingsley Publishers.
- Rogers, C.R. (1961). On becoming a person. Boston: Houghton Mifflin Company.

Rogers, E.M. (1995). Diffusion of innovations., 3rd ed. New York: Free Press

Rubin, J.A.(1984). The art of art therapy. New York: Brunner/Mazel.

Rubin, J.A. (Ed.) (1987). Approaches to art therapy. New York: Brunner/Mazel.

Rubin, J.A. (1998). Art therapy: An introduction. Philadelphia, PA:

Brunner/Mazel.

Schwartz, P., & Ogilvy, J. (1979). The emergent paradigm: Changing patterns of thought and belief. Menlo Park, CA: SRI International.

Schulman, P.R. (1993). The negotiated order of organizational reliability.

Administration & Society, 25 (3), 353-372.

Stott, J., & Males, B. (1984). Art therapy for people who are mentally handicapped. In T. Dalley (Ed.). Art as therapy: An introduction to the use of art as a therapeutic technique (p.111-126). London: Tavistock/Routledge.

Strauss, A. (1975). Professions, work and careers. New Brunswick, NJ:

Transaction Books.

Strauss, A. (1978). Negotiations. San Francisco: Jossey-Bass.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage Publications.

Strauss, A.L., Fagerhaugh, S., Suczek, B., & Wiener, C. (1985/1997) Social organization of medical work. New Brunswick, NJ: Transaction Publishers.

Sudarsky-Gleiser, C. (1995) Therapists' experience of metaphoric communication in therapy. Unpublished doctoral dissertation, Ohio State University, Columbus, OH.

- Thomas, G. (1997). What's the use of theory? Harvard Educational Review, 67 (1), 75-104.
- Thompson, M.C. (1998). Volunteer firefighters: Our silent heroes. Unpublished doctoral dissertation, University of Calgary, Calgary, Alberta, Canada.
- Ulman, E. (1975). Problems of definition. In E. Ulman and P. Dachinger (Eds.), Art therapy: In theory and practice (pp.3-13). New York: Schocken Books.
- Ulman, E., Kramer, E., & Kwiatkowska, H.Y. (1978). Art therapy in the United States. Craftsbury Common, VT: Art Therapy Publications
- Virshup, E. (Ed.) (1993). California art therapy trends. Chicago: Magnolia Street Publishers.
- von Bertalanffy, L. (1988). General system theory (revised ed.). New York: George Braziller.
- Wadeson, H. (1980). Art psychotherapy. New York: John Wiley & Sons.
- Weber, M. (1947). The theory of social and economic organization. London: Oxford University Press.
- Weber, M. (1978). Bureaucracy. In J.M. Shafritz & P.H. Whitbeck (Eds.), Classics of organization theory. Oak Park, IL: Moore Publishing.
- Weick, K. E. (1996). Speaking to practice: The scholarship of integration. Journal of Management Inquiry, 5 (3), 251-258.
- Wiener, N. (1965). Cybernetics: Or control and communication in the animal and the machine. Cambridge, MA: Massachusetts Institute of Technology Press.
- Winnicott, D.W. (1971). Playing and reality. New York: Routledge.

## APPENDIX A

Dear Colleague:

I am currently working on my dissertation for a PhD in Information Transfer, at the School of Library and Information Management, Emporia State University. I will be studying the work of art therapists, exploring how the theoretical perspectives of our field translate into practice. My study will be qualitative in scope, and will utilize a grounded theory approach. My data will be obtained through systematic observation, discussions and interviews, and content analysis. Consequently, I am looking for volunteers to participate in this study.

Part of this study, the systematic observation, entails that I follow around five art therapists in their professional environment. This entails 'shadowing' each participant and recording the activities during the professional work day. These include, but are not limited to:

- Interactions with peers, superiors and subordinates
- All meetings, formal and informal
- Preparation for sessions

Client sessions will not be observed, but you will be asked to take part in a brief interview about each session after they are completed, without asking for privileged information.

The observations of the art therapist at work will not take more than one (1) week.

As well, informal and formal discussions and interviews will also be recorded, and may sometimes be electronically recorded. Permission from you will be obtained prior to the use of a tape recorder, and you will be informed each time the tape recorder is used.

For the sake of this study, an art therapist is anyone who has met the American Art Therapy Association Inc. (AATA, Inc.) educational requirements to practice as an art therapist. However, their title does not have to be "art therapist." These participants will be chosen from art therapists across the country, and I would like to ask you to consider participating. If you are not chosen to be shadowed for the observation, with your permission, you may still be contacted for a brief interview.

The consent forms are attached, and it explains that my intention is to follow you around, and record your work. No data will be recorded about your clients except possibly general diagnostic category.

Thank you for your consideration. If any additional information is needed, or your facility needs to facilitate a clearance or background check for me, please do not hesitate to contact me. My work number is 316-341-5814, my home number is 316-343-3950, and my e-mail is gussakda@emporia.edu.

Sincerely,

David Gussak

## APPENDIX B

## INFORMED CONSENT DOCUMENT

The School of Library and Information Management at Emporia State University supports the practice of protection of human participants for research and related activities. The study for which this consent form applies will be an exploration of the work of art therapists. Participants will be chosen from art therapists across the country. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

Each participant will be 'shadowed' by me, David Gussak, at their place(s) of work, and all observations will be duly recorded, including, but not limited to:

- Interactions with peers, superiors and subordinates
- All meetings, formal and informal (except with your clients)
- Preparation for sessions

Client sessions will not be observed, but you will be asked to take part in a brief interview about each session after they are completed, without asking for privileged information.

The observations of the art therapist at work will not take more than one (1) week.

As well, informal and formal discussions and interviews will also be recorded, and may sometimes be electronically recorded. Permission from you will be obtained prior to the use of a tape recorder, and you will be informed each time the tape recorder is used.

The job descriptions and policy and procedures of your job descriptions and responsibilities will be analyzed.

I will maintain anonymity and confidentiality for you, your peers and your clients. Your name will never be recorded, nor any other data that will clearly distinguish you: i.e. specific demographics, geographical location except by region, name of your facility. No information on anyone with whom you interact will be recorded and no photographs will be taken.

I would be happy to answer any inquiries concerning the procedures.

The field of art therapy and Information Transfer will benefit greatly from your participation in this study on the work of art therapy, as we strive to gain an understanding how our theoretical perspectives translate into the practice performed in professional settings.

*I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach.*

---

 Participant

---

 Date

## APPENDIX C

## INFORMED CONSENT TO AUDIO TAPE DISCUSSIONS

The School of Library and Information Management at Emporia State University supports the practice of protection of human participants for research and related activities. The study for which this consent form applies will be an exploration of the work of art therapists by me, David Gussak. Participants will be chosen from art therapists across the country.

This consent is to demonstrate that you understand that formal and informal interviews and discussions may be recorded with a tape recorder. You also understand that no privileged information will be recorded upon your request, and that you will be informed each time the tape recorder is on. Your request to turn the tape recorder off any time during the discussion will be respected. I will maintain anonymity and confidentiality, and your name or other demographic information that will clearly distinguish you; i.e. specific demographics, geographic location except by region, name of your facility, will not be recorded. No information about anyone with whom you interact will be recorded. If the interview is conducted over the phone, then this consent form will be read to you, and you will provide verbal consent, which will be taped.

I would be happy to answer any inquiries concerning the procedures.

The field of art therapy and Information Transfer will benefit greatly from your participation in this study on the work of art therapy, as we strive to gain an understanding how our theoretical perspectives translate into the practice performed in professional settings.

*I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach.*

---

 Participant

---

 Date



## APPENDIX D

### Demographics

Please note: The following outlines the demographics at the time the research data was gathered during the summer of 2000. Some of the demographic information may have since changed. Past work history of each participant is included in Chapter 3 and has not been duplicated here.

The following participating art therapists were observed:

**Amy** is a Caucasian woman in her mid-thirties. She is Canadian, but currently lives in the Northwestern region of the United States. She graduated with her art therapy/marriage and family therapy degree in 1995 from an approved program. She has her ATR as well as her MFT (license). She currently maintains a private practice, as well as works as an art therapist/marriage-family therapist in a local gay and lesbian community center, working with adults with dual diagnoses.

**Bonnie** is a forty-two-year-old Caucasian woman. She currently lives in the Northeastern region of the United States. She began her Master's degree in art therapy in the Northwest, but completed it on the East Coast in 1993. She has her ATR-BC. She currently works with adolescents in an in-patient and day treatment psychiatric care facility.

**Carl** is a twenty-five-year-old Hispanic man. He currently lives in the Southeastern region of the United States. He graduated with an MS in art therapy from an approved program in the Mid-west in 1999. He is currently working on his ATR as well as a license as a drug and alcohol counselor. He currently works for Occupational Health Services, providing day treatment care for drug and alcohol related issues as an art therapist.

**Debbie** is a forty-five-year-old Italian-American woman. She currently lives in the Southwestern region of the United States in a large, urban area. She graduated from a Master's degree program from an approved program on the East Coast in 1978. She has her ATR. She currently works as an art therapist for a short-term psychiatric inpatient hospital. She primarily works with adults.

**Erin** is a forty-four-year-old Caucasian woman. She currently lives in the Southern region of the United States. She graduated from an MA program in art therapy from an approved program in New England. She has her ATR and an LPC. She currently works in a community psychiatric hospital. She primarily works with adults with dual diagnoses.

The following participating art therapists were interviewed:

**Fern** is a fifty-year-old Caucasian woman. She currently lives on the East Coast. She graduated from an MS program in art therapy from an approved program in the Midwestern region of the United States. She has her ATR-BC. She has worked in several psychiatric facilities, and currently works as the Internship Coordinator/Instructor at an art therapy graduate program.

**Greta** is a sixty-seven-year-old Caucasian woman. She currently lives in the Midwestern region of the United States. She graduated from an approved program in the Southwest. She has her ATR-BC, MFT, CTS (Certified Trauma Specialist) and CGP (Certified Group Psychotherapist). She has a great deal of experience in the field, and currently considers herself a consultant, focusing on trauma, and has a private practice.

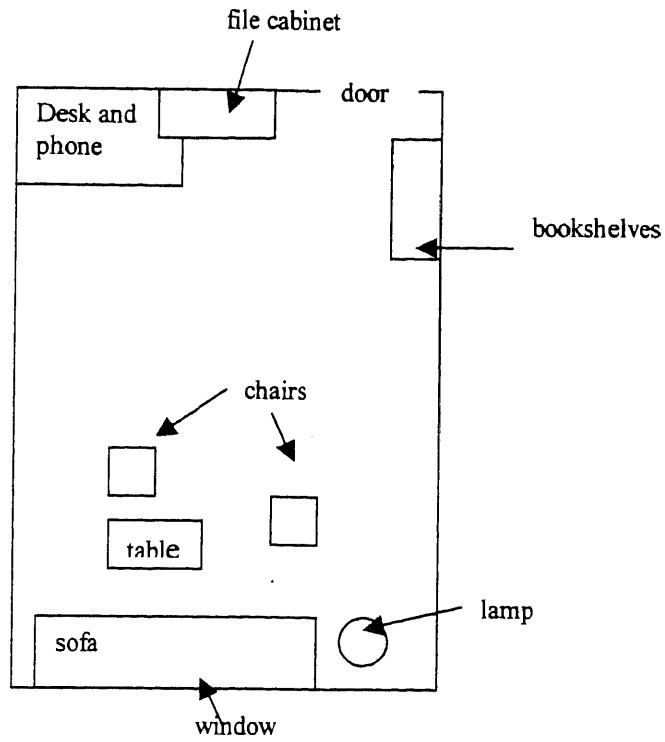
**Kara** is a fifty-four-year-old woman Caucasian woman. She currently lives in the Southwestern region of the United States. She received her MS degree in Psychology in the Northwestern region of the United States, and received her EdD from a University in the Northwestern region of the United States in 1995. She has her ATR-BC as well as a teaching credential. She is currently an assistant professor and program coordinator for an art therapy graduate program in the mid-Southeast.

**Lori** is a Caucasian woman in her mid-fifties. She currently lives in the Southern region of the United States. She received her masters degree from an approved program on the East Coast in 1975. She has her ATR, is trained as a hypnotherapist, and has gone back to school to receive a degree in Social Work. She currently works as an art therapist for a short-term psychiatric inpatient hospital where she primarily works with adolescents. She also has a private practice where she sees a few adult clients.

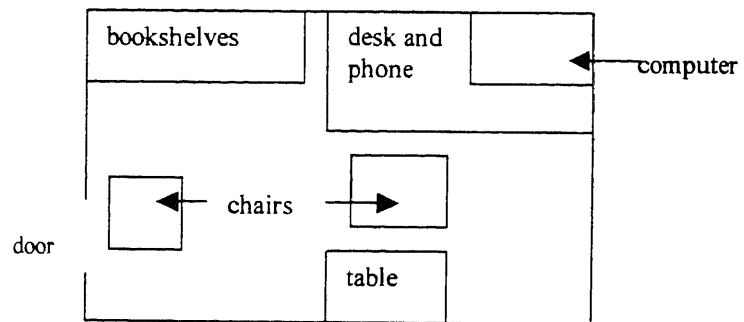
**Mary** is a Caucasian woman in her sixties. She currently lives in the Northern region of the United States. She received her Masters degree in education, but did not receive a degree in art therapy; there was no formal art therapy program when she was pursuing her education. However, she had been trained by two early pioneers in the mid-1960s. She has the ATR-BC and a PhD in clinical psychology. She is currently the director of a graduate art therapy program in New England. She also has a private practice.

**Nate** is a Caucasian man in his late forties. He currently lives in the Midwestern region of the United States. He received his MA from an approved program in New England in 1991. He has his ATR. He is currently the Rehabilitation Coordinator for Adolescent Services for a private psychiatric hospital.

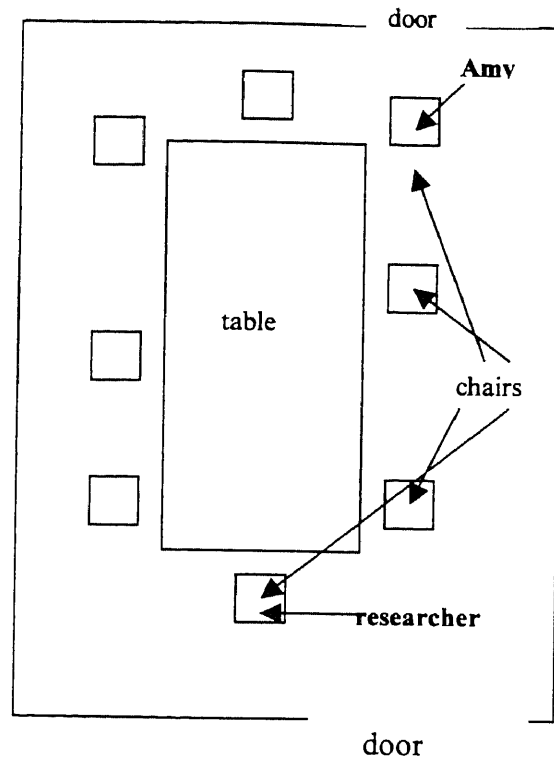
APPENDIX E  
Work Space Diagrams



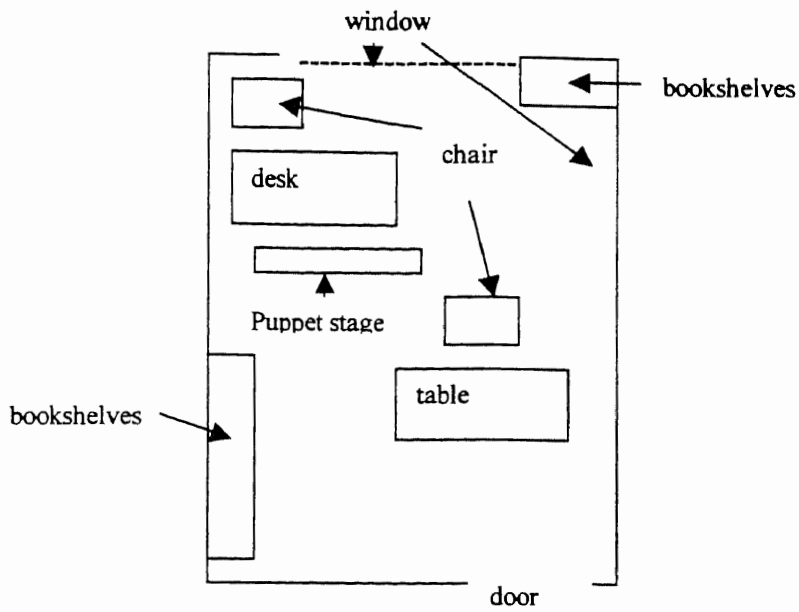
1a. Amy's private practice office



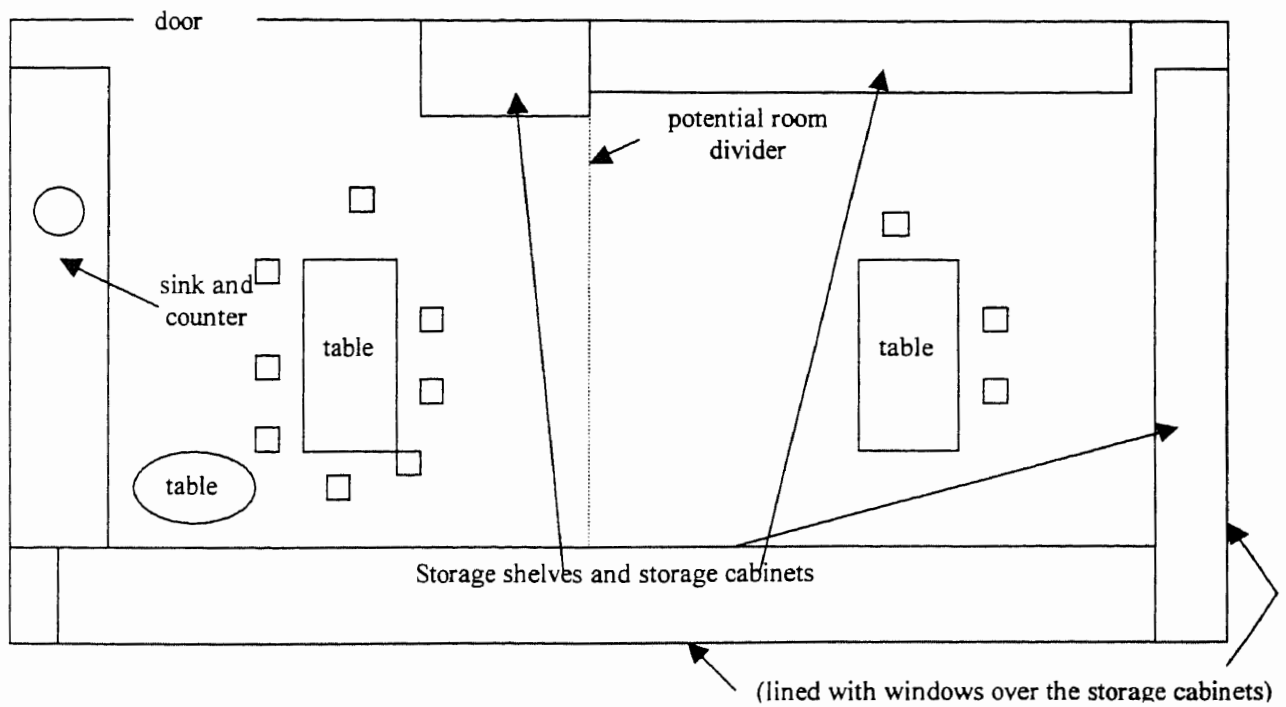
1b. Amy's office in the community center



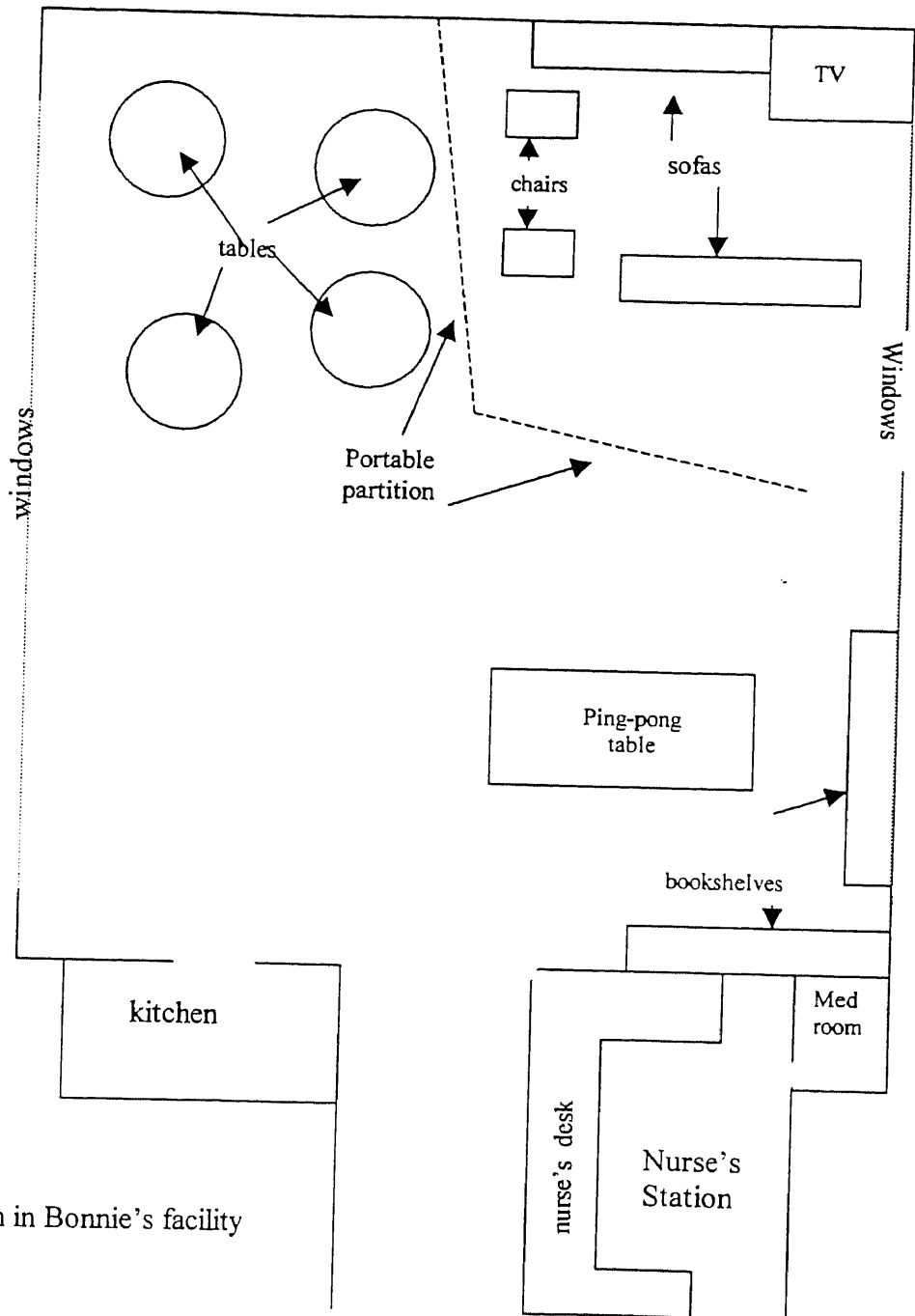
1c. Large room where Amy met with her treatment team



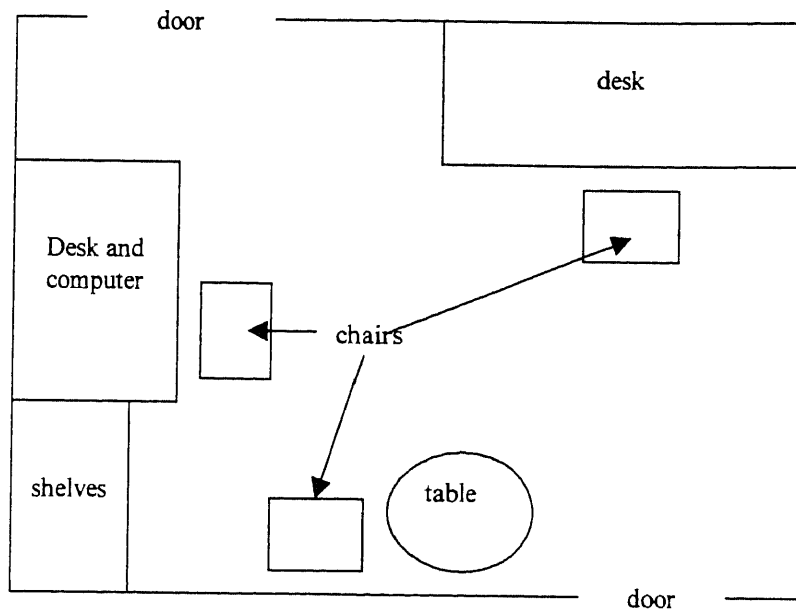
2a. Bonnie's office



2b. Art room next to Bonnie's office; occasionally art groups were held in here.

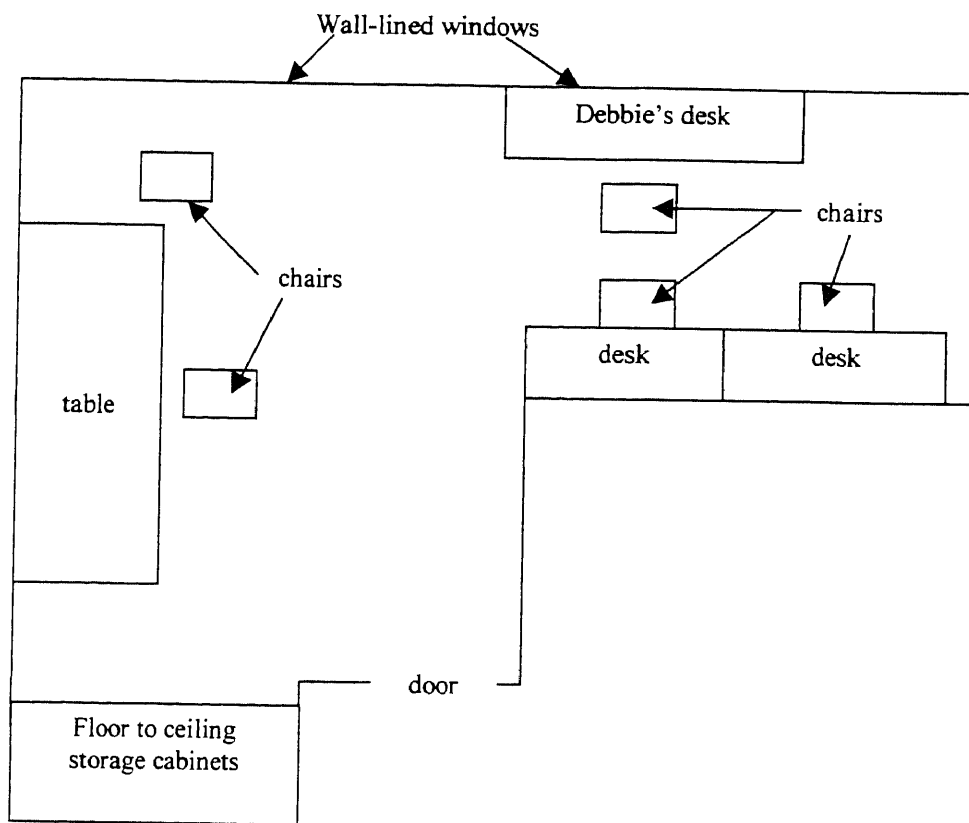


2c. Dayroom in Bonnie's facility

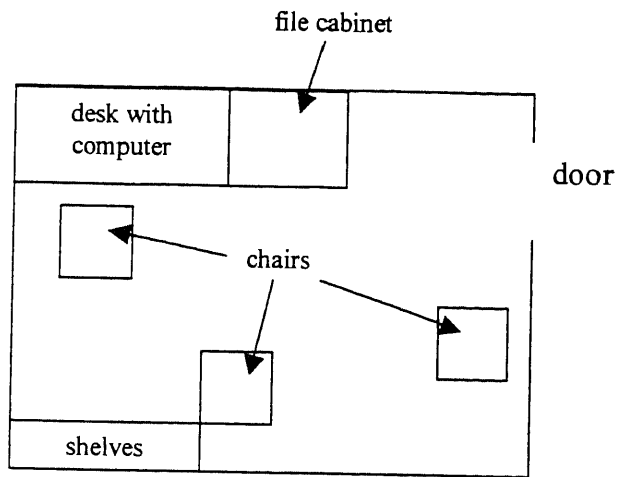


3. Carl's office.

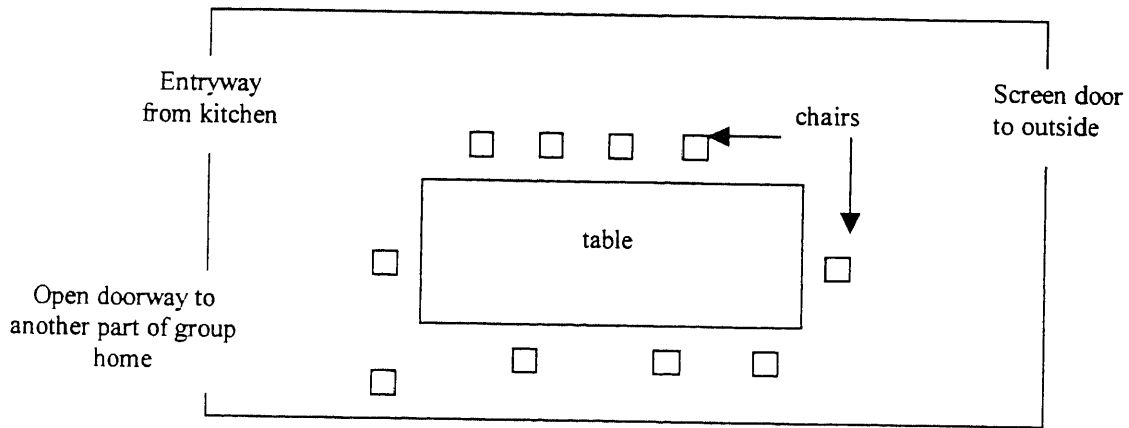




4. Debbie's office



5a. Erin's office



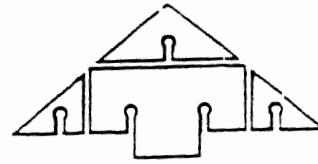
(Walls are covered with art projects)

5b. Room where Erin held group off grounds

APPENDIX F

Education Guidelines for Art Therapy Training  
1973

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American Art Therapy Association, Inc.

### GUIDELINES FOR ART THERAPY TRAINING

Training for art therapy is a recent development. The field came into existence through the pioneering efforts of independent practitioners, most of whom remain active today. The guidelines suggested below have reference to a rising generation of therapists who will acquire through education the knowledge and skills already developed by those whose professional experience antedates specialized training in art therapy.

The American Art Therapy Association cannot at this time evaluate or recommend any specific programs or courses directed to art therapy education. The Guidelines are offered to help educators plan effectively the development of new courses and curricula and to help students choose intelligently among existing educational opportunities.

#### General Criteria

The American Art Therapy Association endorses and encourages the development of master's degree programs or their graduate level equivalent (in terms of in-service training) as the educational medium for the training of professional art therapists. It also approves of undergraduate programs that prepare students in the basic areas of the fine arts and the behavioral and social sciences. Preparation in these two areas is the basis for specialized art therapy training in accordance with the Association's standards for graduate study.

#### Assistance to Undergraduates Interested in Graduate Art Therapy Training

Besides guiding interested students toward courses in the areas prerequisite to graduate study, educators in charge of undergraduate curricula can offer two other kinds of assistance, both designed to help students evaluate their own interest in therapeutic work. First, those who contemplate specialized graduate training in art therapy should be strongly encouraged to work as volunteers in agencies serving people with various kinds of handicaps. Second, self-evaluation may be further assisted by the offering of an undergraduate survey course in art therapy. Any such course should be taught by an experienced professional art thera-

pist and should emphasize the history and theory of art therapy. Reading of the basic literature should be required, with special emphasis on books and articles by leading art therapists.

Recommendations for Art Therapy Training Programs Leading to the Master's Degree

I. Faculty

There should be enough faculty members to provide advisory services and general supervision for each student. It would be unrealistic to expect a faculty member to carry responsibility for more than 10 students. A more favorable student/teacher ratio than 10/1 is recommended.

At least half the members of the graduate faculty should be eligible for registration by the American Art Therapy Association; this insures that they will have practiced art therapy at a professional level. Qualifications for art therapists among the faculty may further be defined by requiring that preceding professional experience they have the master's degree in art therapy or a reasonable equivalent, i.e. master's degree in another field plus special training in art therapy; or bachelor's degree plus several years of specialized independent study and field training under the supervision of a well-qualified art therapist; or eminence in the field.

Every effort should be made to create faculty positions for field supervisors.

II. Curriculum

It is unlikely that competence in a professional field can be acquired in less than two academic years.

Curriculum should proceed from the conceptual to the practical. The core of the curriculum should consist of a treatment of the history, theory, and practice of art therapy; experience with the techniques of practice; and a concern for the distinction between the diagnostic and therapeutic applications of art therapy. The core curriculum must also include supervised practical experience (see III below).

Special emphasis should be placed on the extensive history of the discipline, including reference to the works of forerunners and of early and contemporary practitioners. Attention should be paid to those bases of art therapy theory and practice that are found outside the field itself in the work of pedagogues, psychiatrists, psychologists, philosophers, and critics.

As the student progresses through the program there should be increased opportunities for specialization. Fields of specialization to be offered will depend, of course, on the particular

skills, interests, and experience of the art therapy faculty. However, it is urged that work with both children and adults given consideration in all programs. Specialization demands sequences of at least two courses within a given area.

Electives in art therapy: Professional training requires that a majority of credits be acquired in the field of art therapy. The development of specialization within a program will naturally lead to an appropriate group of elective courses. Courses allowing for individual study will permit students to concentrate on special areas of interest with the supervision and assistance of a member of the faculty. Opportunities of this nature provide a highly desirable element of flexibility.

Electives outside of art therapy: Provision should be made for the accumulation of degree credits in disciplines related to art therapy. Graduate courses in psychology, psychiatry, art education, counseling, and various special therapies are likely to be chosen frequently as nondepartmental electives. Less usual selections may be approved in view of the special interests of individual students. Such interdisciplinary study is to be strongly encouraged.

### III. Practical Training Opportunities

The major practical experience commonly called the practicum requires at least 2 workdays a week over a period of two semesters. Thus a minimum of 416 hours ought to be required. The same number of hours may be provided by concentrated summer work in a shorter period or by evening work over a more extended period.

In addition to the practicum, it is strongly urged that course instruction be enriched by opportunities to carry out exercises in clinical settings. In this way the academic and the clinical will be closely coordinated throughout the two years of training. For example, techniques learned in the first semester of the first year of training ought to be practiced from the start. Field work preceding or following the practicum in the same setting is highly recommended for the sake of a more sustained experience.

Close and timely supervision is crucial in the practicum. An art therapist experienced enough to qualify for the ATR is, of course, the supervisor of choice. Other clinical personnel such as social workers, psychologists, and psychiatrists may provide clinical supervision in the absence of an art therapist; however it is expected that art therapy faculty members will provide close off-the-job supervision in the latter case and general supervision for all students in the practicum.

In view of the applicability of art therapy to broad areas of rehabilitation and education, efforts should be made to provide placements not only in the conventional psychiatric institutional settings but also in such settings as schools; drug and alcohol rehabilitation programs; half-way houses for alienated adolescents, prisoners, and psychiatric patients; and community centers.

#### IV. Prerequisites

Of course the general university requirements for admission to a graduate program take precedence over all other requirements. However, it is essential that graduate students in art therapy have a background in human psychology, normal, abnormal, and developmental and in other aspects of the behavioral and social sciences that have bearing upon professional work in the field. In addition and of equal importance is a requirement for significant work in the visual arts. It is upon the foundation provided by competence in these two areas that graduate training in art therapy rests.

#### V. Facilities

Space, equipment, and supplies must be adequate for the courses offered. Particular attention should be paid to the development of a collection of case materials appropriate for didactic use.

Library: Training in art therapy requires the availability of a major collection of books and journals. Relevant works that can be made available by other departments need not be duplicated. For example, if the program is carried out in a university with a medical school, available books and journals covering psychopathology, psychodynamics, and individual, group, and family treatment methods will probably make it unnecessary for the art therapy department to maintain this portion of the collection. Art, art education, and psychology departments may also have works that otherwise would need to be included in the art therapy collection.

The basic works on the theory and practice of art therapy by art therapists must constitute the core of the art therapy department's own collection. It is desirable to maintain a collection of reprints of relevant papers from journals that are not readily available.

Adopted by the Executive Board, April 1973.

Robert E. Ault - President  
Felice Cohen - President-Elect  
Brother Arthur, CSC - Secretary  
Margaret C. Howard - Treasurer  
Elsie Muller - Chairman, Constitution Committee  
Helen Landgarten - Chairman, Finance Committee  
Mickie Rosen - Chairman, Membership Committee  
George Horaitis - Chairman, Publications Committee  
Elinor Ulman - Chairman, Education Committee  
Bernard Levy - Chairman, Public Relations Committee  
Hanna Kwiatkowska - Chairman, Research Committee  
Sandra Kagin - Chairman, Standards Committee

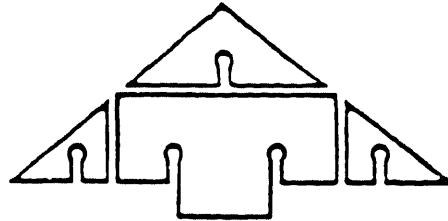
APPENDIX G

Education Guidelines for Art Therapy Training  
1993

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**American Art Therapy  
Association**  
1202 Allanson Road  
Mundelein, IL 60060  
(708) 949-6064



Effective Date January 1, 1993

**GUIDELINES FOR ACADEMIC, INSTITUTE  
AND CLINICAL ART THERAPY TRAINING**

*Revised October, 1989<sup>1</sup>*

The field of Art Therapy came into existence through the pioneering efforts of independent practitioners. The first formal training program was established in 1967, followed by a period of rapid growth of programs geographically dispersed across the nation. Administrators of these programs share a commitment to generating highly skilled professionals who enrich and enhance the mental health field. These Guidelines were developed to assist educators in planning and implementing effective programs of study, and to assist students in choosing among ever-expanding educational opportunities.

**INTRODUCTION**

Presented below are the revised and updated Guidelines for Academic, Institute and Clinical Art Therapy Training. Revisions have been made primarily to reflect the requirement for a Master's degree as a prerequisite for Art Therapy Registration effective January 1, 1993. This degree can be conferred in certain art therapy training programs or can be earned in another field as a prerequisite to enrollment in a post-graduate institute, clinical training or academically sponsored program in art therapy.

These revised Guidelines are effective January 1, 1993, and letters of intent will be taken by the American Art Therapy Association (AATA) from schools, institutes and clinical training programs allowing for a transitional period. The three year grandfathering period will also apply to students currently enrolled in art therapy educational programs, with respect to requirements for Art Therapy Registration.

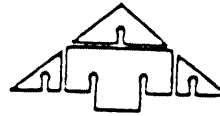
Recommendations for Art Therapy Training Programs  
Leading to a Master's Degree  
Page 4

Recommendations and Criteria for Post Graduate  
Clinical Training Programs in Art Therapy  
Page 7

Recommendations and Criteria for Post Graduate  
Academic and Free Standing Institute Training  
Programs in Art Therapy  
Page 9

Recommendations to Art Therapy Educators Offering  
Training to Individuals with Other Graduate Degrees  
Page 13

Recommendations to Undergraduate Educators  
Preparing Students for the Field of Art Therapy  
Page 13



THE AMERICAN ART THERAPY ASSOCIATION OFFERS EDUCATIONAL GUIDELINES BUT IS NOT RESPONSIBLE FOR MONITORING HOW THESE GUIDELINES ARE UTILIZED BY ART THERAPY PROGRAMS.

THOSE PROGRAMS WHICH HAVE RECEIVED APPROVAL BY AATA HAVE MET THE GUIDELINES AS PRESENTED ABOVE AS OF THE TIME OF SUBMISSION OF THE APPLICATION FOR APPROVAL.

CHANGES IN THE GUIDELINES FROM REVISIONS OF 1983 WILL TAKE EFFECT THREE YEARS FROM DATE OF ACCEPTANCE — JANUARY 1, 1990.

THEREFORE THE EFFECTIVE DATE OF IMPLEMENTATION OF THESE NEW GUIDELINES IS JANUARY 1, 1993.

In this document the title ATR refers to an Art Therapist actively registered with The American Art Therapy Association.

Students who will complete their educational and experience prerequisites for Art Therapy Registration after January 1, 1993 should familiarize themselves with the Revised Standards and Procedures for Registration which become effective on that date. In these revised Registration Standards, the number of Professional Quality Credits (PQC's) awarded vary with the type of educational program completed and whether the program is approved by AATA. In addition, all education submitted for PQC's must be from an academic program accredited by a regional or national commission or association, or from an institute or clinical training program approved by a state or national agency, board or commission.

For students completing their registration requirements prior to January 1, 1993, the earlier (1983) Standards and Procedures for Registration apply, with PQC's not stipulated by the type of educational program or its AATA approval status.

**GENERAL CRITERIA**

The American Art Therapy Association has taken the position that academic preparation for the profession of art therapy is achieved at the Master's degree level. Consistent with that policy, the Association has developed recommendations and criteria for the following education options in art therapy:

1. Master's Degree in, or Specialization in, Art Therapy (accredited institutions)
2. Certificate Programs - Post Graduate
  - a. Institutes in Art Therapy
    1. Post-Graduate - academic
    2. Post-Graduate - free standing
  - b. Post-Graduate Clinical Training in Art Therapy
3. Individuals with Other Graduate Degrees (from an accredited institution)

**I. PREREQUISITES**

Prerequisites for a education options in art therapy shall include fifteen (15) semester credits in studio art and twelve (12) semester credits psychology, including developmental and abnormal.

**II. CORE CURRICULUM**

Art therapy core curriculum in all education options must be taught, supervised or advised by an ATR and presented in a sequential manner. Instruction in all education options is required in the following areas: psychopathology, diagnosis and assessment, cross-cultural issues, and ethics and standards of practice.

**III. SUPERVISION**

One hour of supervision for every ten (10) hours of practicum must be provided by an ATR unless arrangements are made with AATA prior to beginning practicum. Supervision may take place on or off site.

THE AMERICAN ART THERAPY ASSOCIATION OFFERS EDUCATIONAL GUIDELINES BUT IS NOT RESPONSIBLE FOR MONITORING HOW THESE GUIDELINES ARE UTILIZED BY THE ART THERAPY PROGRAMS.

## RECOMMENDATIONS FOR ART THERAPY TRAINING PROGRAMS LEADING TO A MASTER'S DEGREE

### I. PREREQUISITES

The general university requirements for admission to a graduate program take precedence over all other requirements. However, it is essential that graduate students in art therapy have significant work in the visual arts, and it is recommended that the presentation of portfolio be required. In addition, and of equal importance, is a background in human psychology, normal, abnormal and developmental, and in other aspects of the behavioral and social sciences that have bearing upon professional work in the field. (See I under GENERAL CRITERIA). Competence in these two areas serves as a foundation for graduate training in art therapy.

### II. FACULTY

There should be enough faculty members to provide courses, advisory services and general supervision for each student. A student/teacher ratio of 7:1 is recommended as favorable for instruction and supervision to meet these guidelines. It is strongly recommended that the Director of the art therapy program be an ATR.

At least half the members of the graduate faculty should have practiced art therapy at a professional level. The qualifications of the faculty members outside the art therapy field will hinge upon the nature of approved elective courses and on the professions of those field supervisors who are not art therapists. General university requirements for graduate school faculty take precedence over other requirements.

### III. CURRICULUM

Training for art therapy demands at least two academic years of graduate study. Over fifty (50) per cent of the course work, and no less than 21 graduate credit hours should be in principles of art therapy and skills as described below.

#### A. Core Curriculum\*

The required course of study should consist of the history, theory and practice of art therapy experience with the techniques of practice, a concern for the distinction of the appropriate therapeutic application of art therapy with different populations, psychopathology, assessment, and diagnosis, ethical issues and standards of practice, considerations of cross-cultural issues. The core curriculum must also include supervised practical experience, see G below. A research component should be provided and opportunity for individual research projects is recommended.

#### B. History of the Discipline

Emphasis should be placed on the history of the discipline including reference to the works of early and contemporary practitioners. Attention should be paid to those principles of art therapy found outside the field, the work of artists, educators, psychiatrists, psychologists,

philosophers, and critics. Different theoretical viewpoints should be presented. 164

#### C. Electives in Art Therapy

The development of specialization within a program will naturally lead to an appropriate group of elective courses. Courses allowing for individual study will permit students to concentrate on special areas of interest with the supervision and assistance of a member of the faculty. These opportunities provide a highly desirable element of flexibility.

\*The core curriculum is consistent for all training programs: Master's, Institute and Clinica

#### D. Art Therapy Experience

Opportunities should be provided for students to undergo the direct experience of the therapeutic process, as a means toward both personal growth and the development of skills needed by art therapists. Encouragement should be given to students who wish to engage in more extensive self-exploration, however, a clear distinction between teaching and therapy should be maintained. Students desiring personal therapy should engage only therapists who have no teaching, supervisory or administrative responsibility within the training program.

#### E. Electives Outside of Art Therapy

Provision should be made for the accumulation of degree credits in disciplines related to art therapy and guided by faculty advisors. Normally studio art courses are regarded as undergraduate prerequisites rather than as sources of graduate credit.

#### F. Specialization

As a student progresses through the program, there should be increased opportunities for specialization with a variety of populations. Fields of specialization to be offered will depend of course on the particular skills, interests and experience of the art therapy faculty. However, it is urged that work with both children and adults be given consideration in all programs. Specialization demands sequences of at least two courses within a given area.

#### G. Practical Training Opportunities

Training in the field is discussed under two headings: fieldwork and practicum (sometimes called internship).

##### 1. Fieldwork

It is strongly urged that classroom instruction be enriched by fieldwork. Approaches and ideas discussed in the classroom should be tested in practice from the beginning stages of the program. The academic and clinical studies should be closely coordinated throughout the two years of training. Fieldwork preceding or following the practicum in the same setting is often valuable for the sake of more

sustained experience. To provide contact with a broad variety of clients, total field experience should usually take place in several different settings. The number of hours to be spent in fieldwork may be more flexibly determined than practicum hours.

## 2. Practicum

A minimum of 600 hours of supervised art therapy experience is required, half of which must include group, family and/or individual client contact using art therapy. The remaining hours include related activities such as conference with supervisors, case review, record-keeping and participation in staff meetings.

These hours may be provided by sequential, concentrated assignments in a short period and by assignments over a more extended period. Long and short term therapy should be provided. Close and timely supervision is crucial in the practicum. An experienced ATR is the supervisor of choice. Other clinical personnel such as social workers, special educators, psychologists, and psychiatrists may provide general supervision only in the absence of an ATR.

In view of the applicability of art therapy to broad areas of rehabilitation and education, efforts should be made to provide placements not only in the conventional psychiatric institutional settings, but also in other settings such as nonpsychiatric hospitals, correction agencies, schools, substance abuse rehabilitation programs, halfway houses for alienated adolescents and psychiatric patients, community centers and other similar facilities.

Credits for either fieldwork or practicum are determined by institutional requirements for completion of the training program and may or may not constitute a part of the art therapy curriculum credits.

## IV. EVALUATION

Program directors and staff should provide the opportunity and educational environment for the development of skills/competencies necessary for professional work in art therapy through ongoing evaluation of theoretical knowledge and clinical experience.

## V. FACILITIES

Space, equipment and supplies must be adequate for the course offered. Particular attention should be paid to the development of written and graphic case materials appropriate for didactic use.

The basic works on the theory and practice of art therapy by therapists must constitute the core of the art therapy department's own literature collection. It is

desirable to maintain a collection of reprints of relevant papers from journals, magazines, research studies, and similar publications that are not otherwise readily available.

Training in art therapy requires the availability of a major collection of books and journals in the designated library. Relevant works that can be made available by other departments need not be duplicated. For example, if the program is carried out in a university with a medical school, available books and journals covering psychopathology, psychodynamics, and individual, group, and family treatment methods will probably make it unnecessary for the art therapy department to maintain this portion of the collection. Art, art education and psychology departments may also have works that would need to be included in the art therapy collection.

## RECOMMENDATIONS AND CRITERIA FOR POST GRADUATE CLINICAL TRAINING PROGRAMS IN ART THERAPY

### GENERAL CRITERIA

The following criteria refer specifically to clinically based training programs for students who are working toward or have already earned a Masters degree. The special value of clinically based education lies in the relationship between the didactic and experiential components of the training program. Clinical settings provide the opportunity to apply theoretical coursework under direct supervision of those responsible for the didactic content. It is suggested that the clinical program be housed in a hospital setting with an affiliation with an accredited academic institution to provide the Masters degree.

These criteria are designed to assist in the development of clinically based education opportunities in accordance with standards endorsed by The American Art Therapy Association, Inc.

### I. PREREQUISITES

A Bachelors degree in art, psychology or a related field including a strong foundation in drawing, painting and sculpture as evidenced by an art portfolio. The student should also have a strong foundation in human psychology (normal, abnormal and developmental) and in other aspects of the behavioral and social sciences that have bearing upon professional work in the field of art therapy. (See I under GENERAL CRITERIA.)

### II. STAFF

It is strongly recommended that the director be a Registered Art Therapist who has art therapy experience in a clinical setting. The director is primarily responsible for the administration and coordination of the didactic and practicum training. One half of the director's time (twenty hours weekly) should be spent in work directly related to the training program.

It is recommended that art therapy courses be taught by Registered Art Therapists. Every effort must be made to engage qualified professionals in areas such as psychology, social work, education, psychiatry, and art to conduct didactic sessions relevant to art therapy.

It is recommended that there be at least one Registered Art Therapist supervising every four students. The clinical supervisors are primarily responsible for the practicum component of the training program. These persons may also conduct didactic sessions (e.g., lectures, seminars, workshops).

### III. CURRICULUM - COURSEWORK AND PRACTICUM

A minimum of 2000 hours of didactic/practicum study is required for the acquisition of professional competence. The didactic and clinical components are closely integrated and take place concurrently.

The curriculum for a comprehensive clinical training program should consist of carefully planned coursework in the history, theory and practice of art therapy in combination with supervised clinical experience with a broad range of ages and diagnostic groups.

#### A. Didactic Coursework

A minimum of four hundred (400) hours of didactic coursework is required which will follow the core curriculum. Two hundred (200) of the hours must consist of the principles of art therapy. (See III - A, under Masters Degree Programs).

#### B. Practicum

Closely supervised clinical experience with clients/patients in psychiatric, rehabilitation and education settings with both children and adults; including all aspects of work directly related to client/patient contact (e.g., preparation, conference record-keeping, staffing, supervision). A Registered Art Therapist is the supervisor of choice. Other clinical personnel such as social workers, special educators, psychologists, and psychiatrists may provide general supervision (one hour of supervision for every ten (10) hours of client contact in the absence of a qualified art therapist).

If the institution housing the training program offers a limited service addressing the needs of a specific population (e.g., psychiatric, developmentally disabled, geriatric), it is required that clinical rotations be provided in settings with other populations. A minimum of 1600 hours of practicum is required, at least 800 of which must include group, family, and/or individual client contact using art therapy.

### IV. EVALUATION

Program directors and staff should provide the direct opportunity and educational environment for the development of skills/competencies necessary for professional work in art therapy through ongoing evaluation of theoretical knowledge and clinical experience.

### V. FACILITIES

Space, equipment and supplies must be adequate for courses offered and number of students enrolled. Particular attention should be paid to the development of a collection of base materials (slides, tapes

and films, and other related media for appropriate didactic use.

Training in art therapy requires the availability of a major collection books and journals. The basic works on the theory and practice of art therapy by art therapists must constitute the core of the art therapy library collection, along with works specifically relevant to the clinical setting. It is desirable to maintain a collection of reprints of relevant papers from journals, magazines, research studies, and similar publication that are not readily available. Pertinent works that can be made available by cooperating university, medical or public libraries need not be duplicated. This should include books, research journals and other publications on psychopathology, individual, group, and a family treatment methods, physiological disorders, and similar areas.

Clinical training programs may be developed in hospitals or any institutional setting where art therapy is practiced and where criteria can be adequately met and assessed.

### RECOMMENDATIONS AND CRITERIA FOR POST GRADUATE ACADEMIC AND FREE STANDING INSTITUTE TRAINING PROGRAMS IN ART THERAPY

#### GENERAL CRITERIA

The following criteria refer specifically to Institute training programs which are based in private professional training and/or service institutes and which provide student practicum (clinical) experience in a variety of settings in the community. These programs offer a comprehensive course of professional study in art therapy for students who have already earned a graduate degree in a related field.

The special value of institute training lies in 1) the small and flexible nature of such programs which makes possible highly individualized training, often particularly appropriate for students with advanced training in related fields and/or with special backgrounds and interests, 2) the emphasis on experiential involvement in the art therapy process and 3) psychotherapy requirements. Underlying the philosophy of institute training is a strong commitment to the belief that to be a competent therapist one must undergo self-exploration through personal psychotherapy. In this training mode, learning from the role of the client and the use of the treatment process is an invaluable and necessary aspect of professional institute training.

The following criteria are designed to assist in the development of institute based professional training opportunities in accordance with standards endorsed by The American Art Therapy Association. In addition, the institute should have an affiliation with an accredited institution or approval by a professional state board.

#### I. PREREQUISITES

A minimum of a Masters degree in art, psychology, or a related field is required. A foundation in the visual arts is essential. The presentation of an art portfolio is required. A foundation in human

psychology (normal, abnormal and developmental) and in other aspects of the behavioral and social sciences that have bearing upon professional work in the field of art therapy is essential. (See I under GENERAL CRITERIA).

## II. STAFF

### A. Program Director

The director should be an ATR with direct clinical experience. The director is primarily responsible for the administration and coordination of the didactic and practicum training.

### B. Teaching Staff

There should be a student/teacher ratio of 7/1. A minimum of one full time and one part time faculty is recommended.

The faculty of art therapy courses should be a Registered Art Therapist wherever possible. The qualifications of faculty members outside the art therapy field will reflect expertise in their specific fields.

### C. Clinical Supervisor

It is recommended that there be at least one ATR supervising every four students. Other clinical personnel such as social workers, special educators, psychologists, and psychiatrists may provide general supervision in the absence of an art therapist at the practicum site. However, all students should receive close supervision by the institute art therapy faculty. Supervisors who have shown consistent support to an institute by 1) accepting students for placement and supervision, 2) providing consistent supervision to students and 3) being responsible to the institute for the coordination of student programs, may be considered faculty of the Institute.

## III. CURRICULUM - COURSEWORK AND PRACTICUM

Institutes must offer a balanced curriculum consisting of coursework that follows the recommended core practicum (clinical) experience, and professional growth through experiential involvement in the art therapy process. Training must be for a minimum of fifteen (15) months of full time study or its equivalent on a part time basis.

### A. Coursework

Core curricula for academic institute programs must comprise a minimum of twenty-one (21) graduate credit hours in art therapy courses. Eighteen (18) of the twenty-one (21) graduate credits must consist of the principles of art therapy. Core curricula for free standing institute programs must consist of a minimum of 480 hours of coursework in art therapy. Two hundred and fifty (250) of the hours must consist of the principles of art therapy.

Coursework is conducted through small seminar-style classes. It must include the historical and theoretical foundations of art therapy, personal investigation and direct experience of the creative/therapeutic process

and their relationship and clinical application; areas for specialization (e.g., art therapy with children, with adults); opportunity for investigation of related areas (e.g., principles of individual and group psychotherapy, family therapy, and other relative arts therapies, theory of creativity, management of private practice); professional and ethical issues; opportunity for independent study and research; and community outreach and involvement.

The art therapy coursework should place special emphasis on the extensive history of the discipline, including reference to the works of early and contemporary practitioners. Attention should be paid to those bases of art therapy found outside the field itself in the work of artists, educators, psychiatrists, psychologists, philosophers, etc. Different theoretical viewpoints should be presented.

It is strongly urged that courses and seminars be enriched by field work. Approaches and ideas discussed in the classroom should be applied and observed in practice from the start. To provide contact with a broad variety of clients, field experience should take place in several different settings. The number of hours to be spent in field work may be more flexibly determined than practicum hours.

### B. Practicum

A minimum of 700 hours of supervised practicum (clinical) experience is required, including a minimum of 70 hours of supervision. At least 50% of the practicum is direct therapeutic contact with clients. An ATR is the supervisor of choice. Other clinical personnel such as social workers, special educators, psychologists and psychiatrists may provide general supervision in the absence of an art therapist. The didactic and the clinical components of the program should be closely coordinated. The practicum should include supervised contact with clients as well as related activities (e.g., conferences with clinical supervisors, record-keeping, and participation in staff meetings). The institute should provide individualized program planning to ensure each student a practicum experience sensitive to his/her needs as a developing professional. Students should be introduced to more than one area of clinical practice including both children and adults. In view of the applicability of art therapy to broad areas of rehabilitation, education and psychotherapy, efforts should be made to provide placements not only in psychiatric institutions, but also in medical hospitals, corrections agencies, schools, substance abuse rehabilitation programs, half-way houses and community centers. In any of these clinical sites the art therapist trainee should have the opportunity to function as the primary therapist or member of the treatment team.

When students are employed in a setting in which they use art therapy, this site may be considered as part of the practicum. However, separation of the student's role and employee's role as well as supervision on the site must be approved by the program director.

Clinical supervision may take place on or off site. It must include one (1) hour of supervision for every ten (10) hours of direct service. Supervision by an ATR is required. This supervision should be close and timely and include exploration of client/therapist interaction and other issues as they relate to each student's professional development.

#### IV. EVALUATION

A formal evaluation process should be an ongoing part of the program. Extensive evaluation of the practicum should take participation of the student and the on-site supervisor and any other supervisory personnel. Evaluation of professional growth and theoretical knowledge should include regular assignments of papers, case presentations and reports.

A structure for annual program evaluation by students and faculty should be a regular part of each institute's program.

#### V. PERSONAL PSYCHOTHERAPY

Opportunities may be provided for students to undergo the direct experience of the therapeutic process, as a means toward both personal growth and the development of skills needed by art therapists. Encouragement may be given to students who wish to engage in more extensive self-exploration; however, a clear distinction between teaching and therapy should be maintained. Students desiring personal therapy must engage only therapists who have no teaching, supervisory, or administrative responsibility within the training program.

#### VI. FACILITIES

Space, equipment, and supplies must be adequate for courses offered and number of students enrolled. Particular attention should be paid to the development of a collection of case materials, slides, tapes and films appropriate for didactic use.

An institute should maintain a library of the scope and depth necessary for the professional training of art therapists. Training in art therapy requires the availability of a major collection of books and journals of the profession and related fields. The basic works on the theory and practice of art therapy by art therapists must constitute the core of the library, along with works specifically relevant to the clinical setting. It is desirable to maintain a collection of reprints of relevant papers from journals that are not readily available from cooperating university, medical and public libraries.

#### RECOMMENDATIONS TO ART THERAPY EDUCATORS OFFERING TRAINING TO INDIVIDUALS WITH OTHER GRADUATE DEGREES

Educators in charge of post graduate programs can offer art therapy training opportunities for students who already have a graduate degree from an accredited institution in a related field. This training in art therapy may lead toward registration. Prerequisites must include significant work in the visual arts and it is recommended that the presentation of a portfolio be required. A background in human psychology (normal, behavioral and developmental) and in other aspects of the behavioral and social sciences which have bearing upon professional work in the field should also be included. (See I under GENERAL CRITERIA).

To be consistent with recommended requirements for graduate studies in art therapy, professional training for post graduate candidates seeking credentials toward Art Therapy Registration must include no less than twenty-one (21) credits in art therapy training, following the core curriculum, of which 18 credits must consist of the principles of art therapy. The art therapy must be a major component of each course. A minimum of 700 hours of supervised art therapy experience is required, including group, family and/or individual client contact using art therapy. This practicum will be evaluated as three (3) credits of the twenty-one (21) credits towards qualifying for registration. The supervisor of choice is an ATR. The art therapy courses should be offered in a sequential order and cover the child and adult population in individual, group and family treatment. Students seeking Art Therapy Registration after achieving twenty-one (21) credits in this manner must be responsible for presenting documentation that confirms the above parameters for courses, practicum and supervision. The post graduate programs should provide certificates that attest to course content and credit hours.

\*Credit hours are defined as graduate semester credit hours (15 class hours = 1 semester credit, three quarter credits = 2 semester credits).

#### RECOMMENDATIONS TO UNDERGRADUATE EDUCATORS PREPARING STUDENTS FOR THE FIELD OF ART THERAPY

In addition to guiding interested students toward courses in the areas prerequisite to graduate study, educators in charge of the undergraduate curricula can offer two kinds of assistance, each is designed to help students evaluate their own interest in therapeutic work. First, preparation may be assisted by the offering of an undergraduate survey course in art therapy. This course should be taught by an experienced Registered Art Therapist and should emphasize the history and theory of art therapy. Reading of the basic literature should be required, with special emphasis on books and articles by professional art therapists and an overview of professional responsibilities and ethical standards for mental health. In addition, students may take the art and psychology courses which are prerequisite for graduate training in the field. Second, those who contemplate specialized graduate training in art therapy could have a limited field experience.

The field experience, which utilizes creative expression and not art therapy techniques, may be conducted in appropriate agencies with various special populations. Direct and close supervision by a qualified ATR is recommended. Where no ATR is available, direct supervision may be provided by other professional clinicians. It may also be appropriate to introduce undergraduates to studio techniques suitable for use with special populations. The student would utilize the therapeutic quality of art but not the specific techniques of the art therapy modality. It is emphasized that independent contact with clients is considered advanced course work appropriate only at the graduate level.



THE AMERICAN ART THERAPY ASSOCIATION OFFERS EDUCATIONAL GUIDELINES BUT IS NOT RESPONSIBLE FOR MONITORING HOW THESE GUIDELINES ARE UTILIZED BY ART THERAPY PROGRAMS.

THOSE PROGRAMS WHICH HAVE RECEIVED APPROVAL BY AATA HAVE MET THE GUIDELINES AS PRESENTED ABOVE AS OF THE TIME OF SUBMISSION OF THE APPLICATION FOR APPROVAL.

CHANGES IN THE GUIDELINES FROM REVISIONS OF 1983 WILL TAKE EFFECT THREE YEARS FROM DATE OF ACCEPTANCE — JANUARY 1, 1990.

THEREFORE THE EFFECTIVE DATE OF IMPLEMENTATION OF THESE NEW GUIDELINES IS JANUARY 1, 1993.

In this document the title ATR refers to an Art Therapist actively registered with The American Art Therapy Association.



APPENDIX H

Education Guidelines for Art Therapy Training  
1999 (for 2002)

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## VI. FACILITIES AND EQUIPMENT

- A. The program must have regular access to the following facilities:
1. classrooms for academic courses;
  2. studio space for working with art materials; and
  3. offices and conference rooms for faculty study and student advisement.
- B. The program must have regular access to the following equipment:
1. audio-visual equipment for classroom instruction.
  2. studio art equipment and special supplies;
  3. office supplies for documents needed in instruction and record keeping; and
  4. computer equipment and Internet access.
- C. Both students and members of the art therapy faculty must have access to a collection of art therapy literature including texts, books, and journals.

## VII. STAFF SUPPORT

Secretarial, clerical, and other administrative support must be available to the director and faculty of the art therapy program.

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AMERICAN ART THERAPY ASSOCIATION, INC.

## EDUCATION STANDARDS

For Programs Providing  
Art Therapy Education

Effective Date: July 1, 2002

## MISSION STATEMENT

The American Art Therapy Association, Inc. (AATA) is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing.

Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

## EDUCATION COMMITTEE STATEMENT OF PURPOSE

The Education Committee's purpose is to serve the art therapy profession and general public by:

1. establishing and promoting standards for education;
2. supporting the development of educational programs and encouraging diversity among these programs;
3. fostering communication among educators; and
4. providing information to the public regarding educational standards and opportunities.

## INTRODUCTION

Art therapy education came into existence through the pioneering efforts of independent practitioners. Standards were developed to assist educators in planning and implementing effective graduate level programs of study. Originally, AATA established Education Standards for clinical, institute and Master's degree programs. Today, one set of standards is recommended for all graduate level programs.

Professional entry to the field of art therapy requires, at a minimum, a Master's degree.

Students are advised to familiarize themselves with the current standards and procedures of the Art Therapy Credentials Board, Inc. (ATCB) including but not limited to *Adopted Revised Standard* and *Procedures for Registration*.

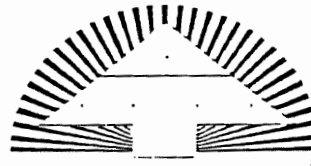
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This document will be effective July 1, 2002 and replaces the Education Standards which were effective April 30, 1994.

In this document the title ATR signifies that an art therapist is currently registered with the Art Therapy Credentials Board Inc. (ATCB).

In this document the title ATR-BC signifies that an individual is currently registered and, in addition, Board Certified through examination by the Art Therapy Credentials Board Inc. (ATCB).



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**EDUCATION STANDARDS**  
**For Programs Providing Art Therapy Education**

The American Art Therapy Association, Inc. (AATA) grants approval for educational programs preparing students for practice as art therapists. Approved programs must meet the following standards adopted by the AATA. These standards are predicated on the view of the AATA that preparation for the practice of art therapy is achieved at the Master's degree level.

**I. PROGRAM ACCREDITATION**

All education must be offered in an academic program accredited by a recognized national, regional, or state accrediting body.

AATA offers educational standards under which graduate level art therapy programs may apply to the AATA Education Program Approval Board (EPAB) for approval.

Those programs which have received approval by AATA have met the standards as of the time of their application for initial approval or re-approval.

**II. ADMISSION OF STUDENTS**

- A. The program shall require that each student admitted to the program must hold a Bachelor's degree from an accredited institution in the United States, or have equivalent academic preparation from an institution outside the United States.
- B. The program shall require that each student, before admission to the program, must submit a portfolio of original artwork, which is evaluated by the faculty of the art therapy program as demonstrating competence with art materials in preparation for the program.
- C. The program shall require that each student admitted to the art therapy program must successfully complete not later than one (1) year after entering the program (and including credits taken before admission)
  - 1. a minimum of fifteen (15) semester hour credits (or twenty-two (22) quarter-hour

- credits) of study in studio art; and
- 2. a minimum of twelve (12) semester hour credits (or eighteen (18) quarter-hour credits) of study in psychology which must include developmental psychology and abnormal psychology.

**III. FACULTY**

The program must demonstrate that the numbers of faculty members and their assignments adequately provide for course teaching, student advisement, and supervision of students

- A. The director of the program in art therapy must
  - 1. be a full-time appointee of the institution housing the program; and
  - 2. be a Registered and Board Certified Art Therapist (ATR-BC).
- B. All members of the graduate faculty teaching art therapy core curriculum courses (IV.B.1.) must be Registered Art Therapists.
- C. At least one-half of the art therapy faculty must have practiced art therapy within the most recent five (5) year period.

**IV. REQUIRED CURRICULUM**

- A. A minimum of 45 graduate semester credits is required for graduate level art therapy education (60 graduate semester credits may be required for licensure or clinical education standards in some states.)
- B. Required Content Areas
  - 1. Required art therapy content areas:  
A minimum of 24 semester credits in art therapy courses is required. Faculty members who hold an ATR are eligible to teach the following content areas. The course of study must be sequential and include the following components:
    - a. history of art therapy.
    - b. theory of art therapy.
    - c. techniques of practice in art therapy.

- d. application of art therapy with people in different treatment settings;
  - e. art therapy assessment;
  - f. ethical and legal issues of art therapy practice;
  - g. standards of practice in art therapy;
  - h. cultural diversity issues relevant to art therapy practice; and
  - i. thesis or equivalent.
- 2 Required related content areas:  
These content areas may be taught by faculty from related fields and/or faculty members who hold an ATR.
- a. psychopathology and diagnostics
  - b. human growth and development
  - c. group dynamics
  - d. research
  - e. studio art
- 3 Practicum/Internship
- a. Practicum/Internship:  
Each student must be required to successfully complete supervised practice as follows:
    - 1) a minimum of seven hundred (700) hours of supervised art therapy practice.
    - 2) a minimum of 350 hours of supervised practice in which the student must be working directly with patients in individual, group, or family formats.
    - 3) the balance of the supervised hours must include discussion of student work with the supervisor(s) and related activities including, but not limited to: case review, record keeping, preparation, and staff meetings.
  - b. Supervision:  
Supervision may take place on- or off-site
    - 1. Art Therapy Supervision
      - a. Individual Supervision: For every

- ten (10) hours of client contact, there must be one (1) hour of supervision by a registered art therapist (ATR); or
  - b) Group Supervision: The ratio of eight (8) students to one (1) ATR supervisor may not be exceeded for group supervision. There must be two (2) hours of group supervision for every ten (10) hours of client contact
- 2) For every ten (10) hours of related activity, there must be one (1) hour of supervision by either a Registered Art Therapist (ATR) or a qualified professional with at least a Master's degree in a related discipline.

- C. Specialization:  
The art therapy program must provide opportunities for specialization in competency areas such as variations in patient age, practice setting, and type of intervention (individual, group, or family).

## V. EVALUATION

### A. Student Evaluation

- 1. Each student must be evaluated regularly on achievement and progress in course work and clinical competencies.
- 2. The program must maintain a record of the evaluation of each student in each course and in supervised practice.

### B. Program Evaluation

- 1. The program must maintain and follow a regular procedure by which the courses, practical training, instructors, supervisors, and administrators are evaluated by students and graduates. Recommendations for change are to be solicited, gathered and considered.
- 2. The evaluations of the program must be used to modify the program so as to promote its improvement and to implement recommendations as appropriate.

## APPENDIX I

## ATCB

Art Therapy Credentials Board

**Requirements for Registering Option C:****A master's degree in a related field and additional graduate coursework in art therapy****Education required (documented by submitting official transcripts and Practicum Verification Form)**

- A master's degree in a related field and additional post-graduate coursework in art therapy.
- The curriculum must include a minimum of twenty-one (21) graduate semester credit hours (or thirty-one (31) quarter-hour credits) in art therapy core curriculum. Credit will not be recognized for courses that cover the same general topic taken at different institutions. If applicants begin art therapy courses prior to the completion of the master's degree, they must clearly document to the art therapy credits are in addition to the credits for the master's degree.
- The art therapy core curriculum must include the following sequential course of study: history of art therapy; theory of art therapy; techniques of practice in art therapy; the application of art therapy with people in different treatment settings; psychopathology; assessment of patients and diagnostic; ethical and legal issues of art therapy practice; standards of good practice in art therapy; and matters of cultural diversity bearing on the practice of art therapy.
- An additional fifteen (15) semester credit hours (or twenty-two (22) quarter credit hours) in studio art and twelve (12) semester credit hours (or eighteen (18) quarter credit hours) in psychology must be documented. These may be undergraduate or graduate credits. Those students wishing to fulfill some or all of the studio art requirements outside of traditional academic course settings must document 45 clock hours of studio time as equivalent to one semester credit hour.
- A minimum of six hundred (600) hours of supervised art therapy practicum must be documented. At least 50% of the practicum hours must include direct provision of art therapy services to individuals, groups, or families with the remaining hours including supervision, case review, record-keeping, preparation, staff-meetings, etc. An ATR or an ATR-BC must provide practicum supervision. One hour of supervision must be provided for every 10 hours of practicum.

**Post-Education Experience Required (documented on Experience Verification Forms)**

- A minimum of 2,000 hours of supervised direct client contact hours using art therapy must be documented. Hours used to complete administrative tasks cannot be included for purposes of obtaining ATR.

- A minimum of 200 hours of supervision must be documented. At least 50 of the supervision hours must be provided by an ATR. Any remaining hours must be provided by a licensed or credentialed practitioner with a master's degree in a related mental health field.
- To obtain experience in a private practice setting, the applicant must be a licensed or certified practitioner in another psychotherapeutic discipline. All private practice experience must be supervised by an ATR.

**References (documented using the Reference Form and an attached letter)**

All applicants must submit three professional reference forms from a combination of the following:

- At least one ATR who can support the applicant's competency for Registration as an Art Therapist.
- An applicant's supervisor who possesses a credential or state license and who is familiar with the applicant's work performance and applied art therapy skills.
- A professional selected by the applicant who can provide a professional reference pertaining the applicant's work performance and applied art therapy skills.
- Supervisors completing the Experience Verification Form can also complete a Reference Form. If using this option, the supervisor **MUST** complete both forms **AND** send in a letter of reference.

## APPENDIX J

Table 1.

When the art therapists graduated compared to when their education programs were approved.

Participants	Year Participant Graduated	Year Participants' Education Program Received National Approval	Did Participant Graduate From an Approved Program?
Amy	1995	1979	Yes
Bonnie	1993	1979	Yes
Carl	1999	1991	Yes
Debbie	1978	1980	No
Erin	1982	1979	Yes
Fern	1992	1991	Yes
Greta	1975	1979	No
Kara*	N/A	N/A	No
Lori	1975	1984	No
Mary*	N/A	N/A	No
Nate	1991	1979	Yes

\* Did not attend a formal art therapy graduate degree program



APPENDIX K

Art Therapy Registration Guidelines  
1973

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ADOPTED  
STANDARDS AND PROCEDURES  
FOR  
REGISTRATION

AMERICAN ART THERAPY ASSOCIATION

APRIL, 1973

1. All applicants must accumulate 12 Professional Quality Credits (hereafter abbreviated as "PQC") to become Registered Art Therapists.
2. All applicants must have a minimum of 1200 hours active work experience, cumulative or consecutive, for which they will be awarded 2 PQC's.
3. All applicants must be Active Members in good standing of the American Art Therapy Association during the fiscal year in which application is made.
4. All applicants must submit one (1) letter of recommendation from a Registered Art Therapist or an Art Therapist eligible for registration.
5. All applicants have the option of submitting a Qualifying Report, for which they may receive 1 PQC at the discretion of the Standards Committee.
6. Applicants must accumulate 4 PQC's to become Certified Art Therapy Aids.

Professional Quality Credit Awards

1. Education. A maximum of 10 PQC's may be awarded for education, accumulated as follows:
  - A. Master's degree in art therapy.....10
  - B. Grad level in-residence internship equivalent to the master's degree in art therapy.....10
  - C. Bachelor's degree plus graduate work in art therapy for a minimum of one academic year.....8
  - D. Master's degree in a related field.....8
  - E. Bachelor's degree in art therapy.....6
  - F. Bachelor's degree in related field.....5
  - G. Study in the field of art therapy through In-Service Training, or apprenticeship with a qualified art therapist (which is not part of a degree related field experience) for a period of 6 months or 600 in-work hours.....1
  - H. Associate Arts degree in art therapy.....3
  - I. Associate Arts degree in related field.....2

## 11. Experience

- A. An applicant who has been a practitioner of art therapy, either within an agency or self-employed, or both, for a period of 1200 in-work hours, cumulative or consecutive, will be awarded a minimum of 2 Professional Quality Credits per each 1200 hrs.

1200 hours = 2 PQC's

- B. An applicant may be awarded one (1) additional Professional Quality Credit per year for each calendar year of practice in which he is in (1) a supervisory capacity; (2) a training capacity; or (3) a research and/or development capacity (as determined by the information given in the application form).

## 111. Professional Activities and Publications

An applicant who has made outstanding contributions to the field of art therapy, as adjudged by the Standards Committee of the American Art Therapy Association, may be awarded up to a total of 5 Professional Quality Credits for all such contributions. Such outstanding contributions may include, but are not limited to (1) publications in professional journals; (2) publications of major works such as books authored or edited; (3) Development of or trainer in special institutes; (4) lectures and presentations before professional groups; and (5) innovative contributions to the advancement of art therapy.

Certified Art Therapy Aid

An individual may be eligible for certification with the American Art Therapy Association as an Art Therapy Aid by accumulating 4 Professional Quality Credits as follows:

- (1) An applicant with an Associate Arts degree in art therapy may be awarded 3 PQC's.
- (2) An applicant with an Associate Arts degree in a related field may be awarded 2 PQC's.
- (3) An applicant who has completed an in-service training program granting a certificate or other documentation for an art therapy aid may be awarded 2 PQC's.
- (4) An applicant may be awarded 1 PQC per year for each year, or its equivalent in-work hours (1200) he has served as an art therapy aid under the supervision of a registered art therapist.
- (5) An applicant must submit the detailed recommendation of his supervisor along with his application form.
- (6) An applicant must have a minimum of one year's experience or its equivalent in-work hours before making application, and be a member of the AATA during the fiscal year in which application is made.

## CODE OF ETHICAL RESPONSIBILITY OF THE AMERICAN ART THERAPY ASSOCIATION

## CANON I.

The art therapist maintains objectivity, integrity and competence in meeting the highest standards of his profession.

## CANON II.

The art therapist does not misrepresent his professional qualifications, affiliations and purposes.

- A. The art therapist performs only those functions for which he is qualified.
- B. The art therapist uses the initials ATR after his name only with official recognition from the American Art Therapy Association.
- C. The art therapist is ethical in respecting and safeguarding the professional works and original ideas of another, and gives full credit and citation for such works and ideas when used in publication under his name.

## CANON III.

The art therapist protects the public from those not qualified to practice by reason of a deficiency in education, competence, emotional stability, or ethical standards.

- A. The art therapist promotes and encourages improvement in pre-and-post-registration training and education.
- B. The art therapist serves (upon request) on committees or boards of the American Art Therapy Association having disciplinary responsibilities.
- C. The art therapist does not suppress favorable or unfavorable information in regard to a question of qualifications of another art therapist.
- D. The art therapist assists other art therapists in meeting the highest standards of the profession.

## CANON IV.

The art therapist maintains confidentiality of information in relationship to the needs of his client and within the limitations prescribed and proscribed by his professional environment.

- A. The art therapist protects the identity of his client from public disclosure.
- B. The art therapist obtains consent from the client for the use of any information, verbal, written, or pictorial, acquired within the professional relationship for purposes of publication or education, after fully disclosing to the client the nature of the use of such materials.
- C. The art therapist communicates confidential information to other professional personnel, receives from, and uses confidential information of other professional personnel only according to the regulations and procedures of the agency with which he is affiliated, or at the discretion of the professional with whom he is consulting.

CANON V.

The art therapist promotes, encourages and facilitates public awareness and understanding of the profession with dignity and discretion.

- A. The art therapist avoids sensationalism in relaying public information of the profession.
- B. The art therapist provides no information to the general or lay public by means of public lectures or demonstrations, newspapers or magazines articles, radio or television programs, mail, or similar media which may be construed as diagnosis or treatment.
- C. The art therapist adheres to professional rather than commercial standards in making known the availability of his service.
  1. The art therapist makes no direct solicitation for clients.
  2. The art therapist does not impair confidence in the profession by competitive or commercial advertising of his services.
  3. The art therapist may be identified in the classified section of the telephone directory, in the building directory where he conducts his practice, on his letterhead and professional card, by his own name, limitation or specialty of practice (if any), place of practice, business and, if he wishes, home telephone.
  4. The art therapist in private practice may send professional announcements of the availability of his services to other art therapists, professionals in related fields, friends and relatives when he opens his practice or at such time subsequent if he moves to a new location.
  5. The art therapist does not advertise his services through such media as newspapers, radio, television, telephone, or mail.
  6. The art therapist does not contrive a referral system with or among other professional personnel for purposes of receiving or giving fees for such referrals.

## GUIDELINES FOR PREPARATION OF OPTIONAL QUALIFYING REPORT

Since art therapists are highly diversified in their professional functioning, the subject matter (theoretical and practical) of the Qualifying Report is left to the applicant. It should, however, reflect work of his original conception, development, and application. If the content of the Qualifying Report is a case study, the identity of any and all subjects (clients), in accordance with Canon IV, Section A, must not be disclosed. Further, in accordance with Canon IV, Section B, explanation of the use of all material related to the client(s) and the consent of same is the responsibility of the applicant.

All publication rights to the Case Report remain with the applicant, however, one copy shall be retained by the American Art Therapy Association as a permanent part of the Archives of the Association.

Required Features to be Included in Report

1. An operational definition of art therapy, stating in full the assumptions upon which the applicant's definition and subsequent theoretical developments are based.
2. A full description of the materials and methods used and rationale for use.
3. An adequate search of the literature relevant to the development and description of the material, with full citation in footnotes and bibliography.
4. The narrative portion of the Qualifying Report should not exceed 20 pages, typed and double spaced.



## APPLICATION FOR REGISTRATION WITH THE AMERICAN ART THERAPY ASSOCIATION

A. Personal Information

1. Name: \_\_\_\_\_
2. Mailing Address \_\_\_\_\_
3. Birthdate: \_\_\_\_\_
4. Telephone \_\_\_\_\_
5. Are you currently an active member of the AATA? \_\_\_\_\_
6. When did you become an Active Member? \_\_\_\_\_

B. Academic Background - Attach official transcript from each college or university attended as Addendum A.

1. High School Diploma: Yes \_\_\_ No \_\_\_ Equivalent \_\_\_

2. College or University Location Degree Date Major Minor


3. Total number of graduate hours: \_\_\_ QTR \_\_\_ SEM \_\_\_

4. Number graduate hours in art therapy \_\_\_ QTR \_\_\_ SEM \_\_\_

5. Number undergraduate hours in art therapy \_\_\_

C. Field Work (Practicum, In-Service Training, Apprenticeship, Internship)  
in art therapy

1. Number of hours in field work \_\_\_\_\_.

2. Location: \_\_\_\_\_  
Name of Facility City State

3. Describe nature of services provided by facility: \_\_\_\_\_

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4. Name of immediate Supervisor: \_\_\_\_\_

5. Title of immediate Supervisor: \_\_\_\_\_

6. Is immediate Supervisor an A.T.A.? \_\_\_\_\_

7. Did you receive any certificate or documentation of training? \_\_\_\_\_

If so, enclose copy as Addendum B.

8. Describe the nature of your field work. Attach as Addendum C.

D. Professional Experience in Art Therapy - Agency

Supply the following information for each position held, beginning with current or most recent position (include consultant work).

1. Place of employment: \_\_\_\_\_

Name of Agency

2. Address: \_\_\_\_\_  
Street City State Cap



16. Do you take part in the training of others? \_\_\_\_\_ If so, describe nature of training, number of students, and hours spent in training.
  
17. How long have you been training others? \_\_\_\_\_
18. Do you conduct research related to A.T.? \_\_\_\_\_ If so, describe nature of research, nature of your participation, and number of hours you are or have been involved in it.
  
19. Are you or have you been involved in the development of any new programs in or related to art therapy? If so, describe in full.
  
- D. Professional Experience in Art Therapy - Self-Employed -supply information for each place of practice.
  1. Address or location of practice: \_\_\_\_\_
  2. Date practice initiated: \_\_\_\_\_
  3. Are you working in cooperation or association with any other professionals? If so, describe nature of association.
  
  4. How are clients referred to you? \_\_\_\_\_  
\_\_\_\_\_
  5. How do you decide whether or not to accept a client?
  
  6. To whom do you report client's evaluation and progress? \_\_\_\_\_  
\_\_\_\_\_
  7. How do you make your services known?

(Application for Registration with AATA page 4)

8. If you have professional cards, letterhead stationary, billing sheets, etc., attach sample of each.
9. Are you listed as an art therapist in the telephone directory of the area in which you practice? \_\_\_\_\_
10. Are you listed in any other directories? \_\_\_\_\_ If so, indicate how you are listed and where.
11. Do you have an occupational license in the city or state in which you practice? \_\_\_\_\_ If so, for what occupation? \_\_\_\_\_
12. Are you in any other way licensed by the city, municipality, county, or state in which you practice? \_\_\_\_\_
13. Do you carry any malpractice or liability insurance in your professional capacity? If not, are you in any way covered or protected from malpractice or liability, and how?
14. What is your standard fee for individual treatment, group treatment?  
\_\_\_\_\_
15. Do these fees vary? If so, how and for what reason (s)? \_\_\_\_\_  
\_\_\_\_\_
16. Do you require the client to participate in any other professional services in conjunction with your treatment? \_\_\_\_\_ If so, describe the nature of these services.
17. Total number of calendar months during and in which you have been engaged in the practice of art therapy: \_\_\_\_\_
18. Total number of hours you have been engaged in the practice of art therapy (include hours in therapy and the recording of case data)  
\_\_\_\_\_

F. Professional Activities and Publications

1. List all publications related to art therapy:
2. List most important art therapy lectures and presentations given before professional groups (give name of group, title of presentation, and date):

3. Patient or client exhibition record (give place, date, and nature of exhibit):
  
4. List most important radio and television presentations (give place, date, and nature of presentations):
  
5. List the more important workshops and/or special institutes related to art therapy which you have conducted or in which you have participated (give place, date, nature of workshop or institute, and nature of your involvement):
  
6. Describe all other personal endeavors which you feel have contributed to the advancement of art therapy.

## APPENDIX L

**ART THERAPY REGISTRATION GUIDELINES-2001****ATCB**

Art Therapy Credentials Board

**Requirements for Registering Option A:****A master's degree in Art Therapy from a program approved at the time of your graduation by AATA's Educational Program Approval Board**

Education required (documented by submitting official transcripts)

- An official transcript verifying a master's degree from an AATA approved program automatically meets the ATR educational requirements.

Post-Education Experience Required (documented on Experience Verification Forms)

- A minimum of 1,000 hours of supervised direct client contact hours using art therapy must be documented. Hours used to complete administrative tasks cannot be included for purposes of obtaining ATR.
- A minimum of 100 hours of supervision must be documented. At least 50 of the supervision hours must be provided by an ATR. Any remaining hours must be provided by a licensed or credentialed practitioner with a master's degree in a related mental health field.
- To obtain experience in a private practice setting, the applicant must be a licensed or certified practitioner in another psychotherapeutic discipline. All private practice experience must be supervised by an ATR.

References (documented using the Reference Form and an attached letter)

All applicants must submit three professional reference forms from a combination of the following:

- At least one ATR who can support the applicant's competency for Registration as an Art Therapist.
- An applicant's supervisor who possesses a credential or state license and who is familiar with the applicant's work performance and applied art therapy skills.
- A professional selected by the applicant who can provide a professional reference pertaining the applicant's work performance and applied art therapy skills.
- Supervisors completing the Experience Verification Form can also complete a Reference Form. If using this option, the supervisor **MUST** complete both forms **AND** send in a letter of reference.

### **Requirements for Registering Option B:**

#### **A master's degree in Art Therapy from a program NOT approved at the time of your graduation by AATA's Educational Program Approval Board**

Education required (documented by submitting official transcripts and Practicum Verification Form)

- The curriculum must include a minimum of twenty-one (21) graduate semester credit hours (or thirty-one (31) quarter-hour credits) in art therapy core curriculum. Credit will not be recognized for courses that cover the same general topic taken at different institutions. If applicants begin art therapy courses prior to the completion of the master's degree, they must clearly document to the art therapy credits are in addition to the credits for the master's degree.
- The art therapy core curriculum must include the following sequential course of study: history of art therapy; theory of art therapy; techniques of practice in art therapy; the application of art therapy with people in different treatment settings; psychopathology; assessment of patients and diagnostic categories; ethical and legal issues of art therapy practice; standards of good practice in art therapy; and matters of cultural diversity bearing on the practice of art therapy.
- An additional fifteen (15) semester credit hours (or twenty-two (22) quarter credit hours) in studio art and twelve (12) semester credit hours (or eighteen (18) quarter credit hours) in psychology must be documented. These may be undergraduate or graduate credits. Those students wishing to fulfill some or all of the studio art requirements outside of traditional academic course settings must document 45 clock hours of studio time as equivalent to one semester credit hour.
- A minimum of six hundred (600) hours of supervised art therapy practicum must be documented. At least 50% of the practicum hours must include direct provision of art therapy services to individuals, groups, or families with the remaining hours including supervision, case review, record-keeping, preparation, staff-meetings, etc. An ATR or an ATR-BC must provide practicum supervision. One hour of supervision must be provided for every 10 hours of practicum.

Post-Education Experience Required (documented on Experience Verification Forms)

- A minimum of 2,000 hours of supervised direct client contact hours using art therapy must be documented. Hours used to complete administrative tasks cannot be included for purposes of obtaining ATR.
- A minimum of 200 hours of supervision must be documented. At least 50 of the supervision hours must be provided by an ATR. Any remaining hours must be provided by a licensed or credentialed practitioner with a master's degree in a related mental health field.
- To obtain experience in a private practice setting, the applicant must be a licensed or certified practitioner in another psychotherapeutic discipline. All private

practice experience must be supervised by an ATR.

References (documented using the Reference Form and an attached letter)

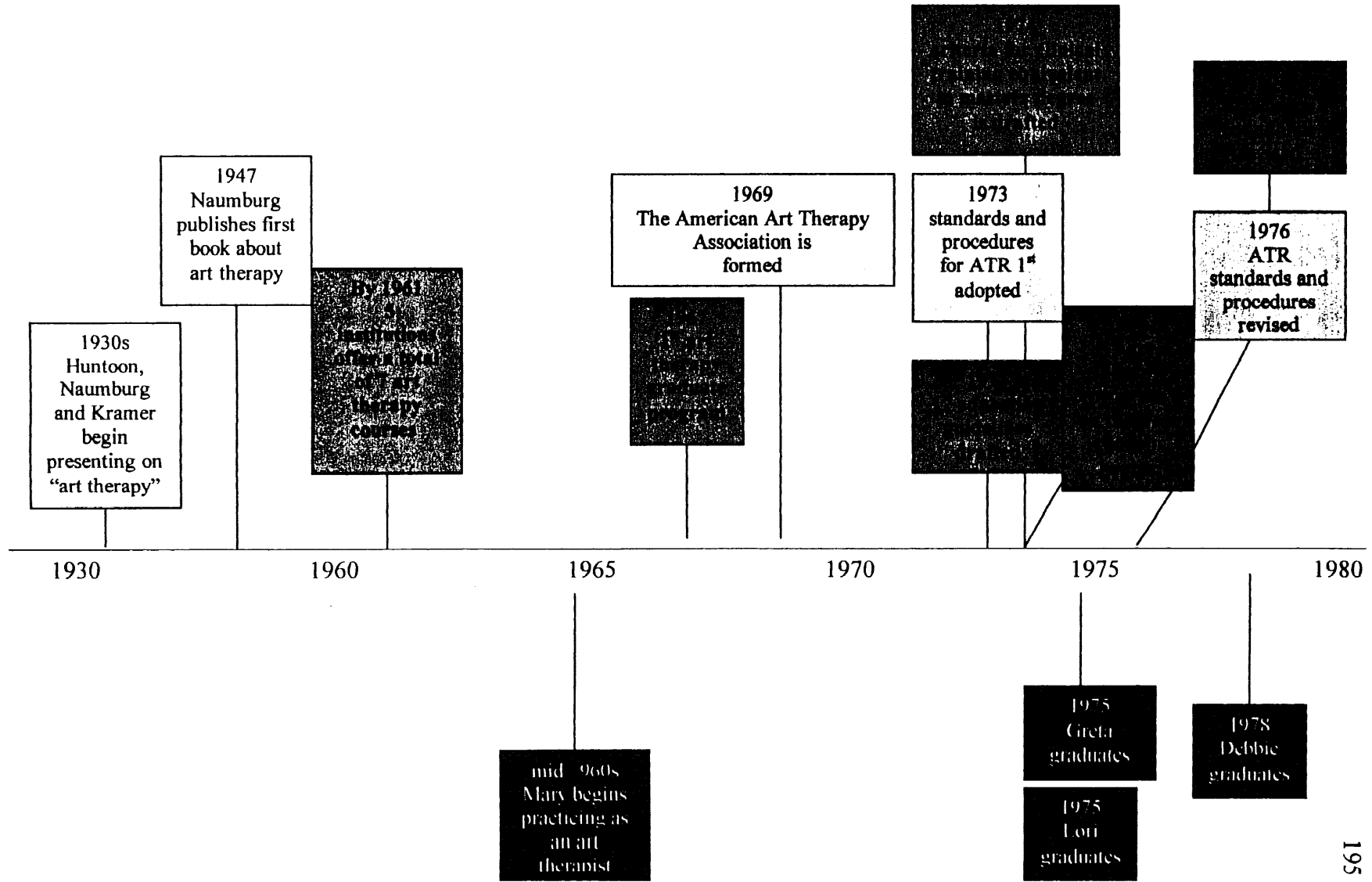
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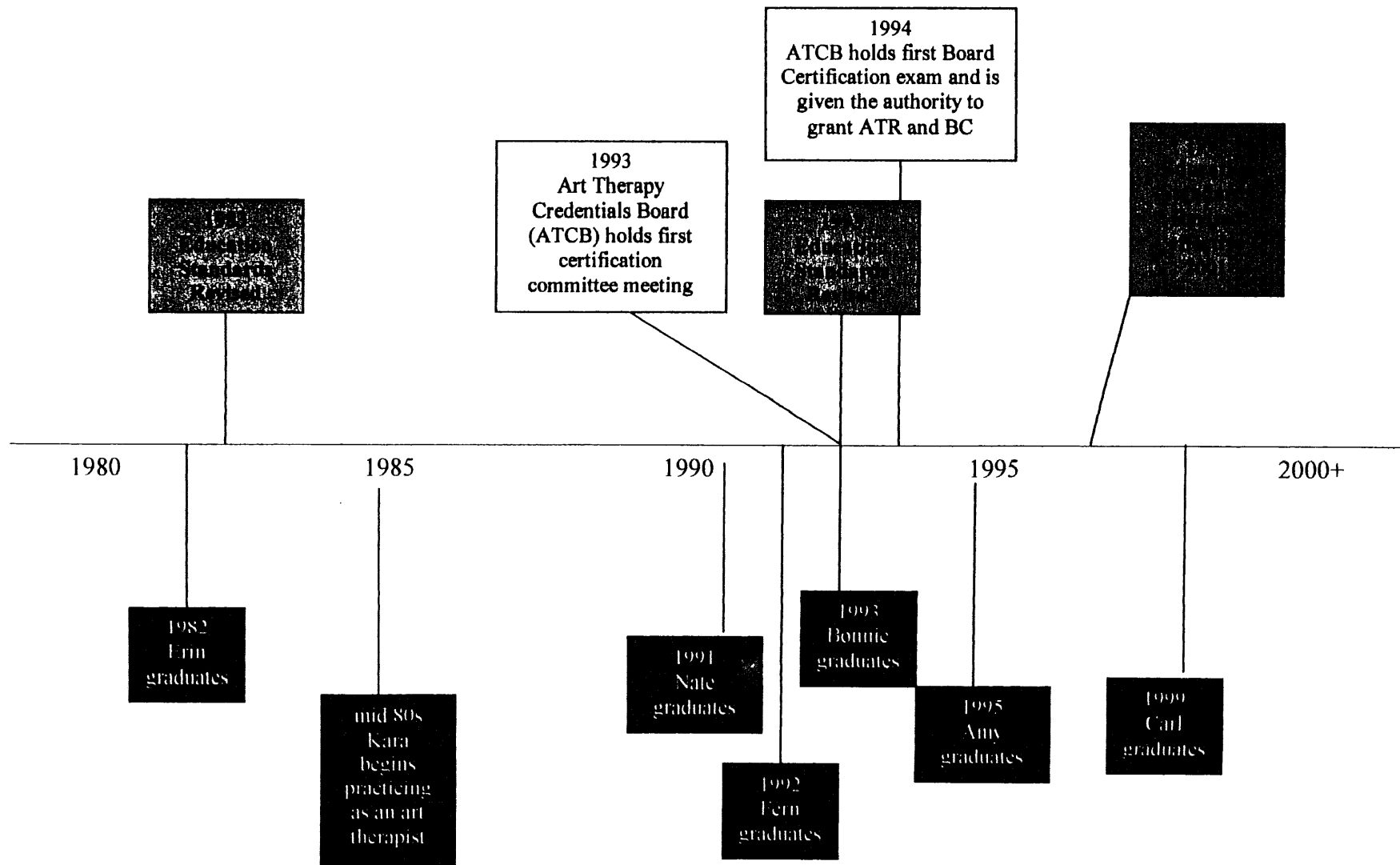
- At least one ATR who can support the applicant's competency for Registration as an Art Therapist.
- An applicant's supervisor who possesses a credential or state license and who is familiar with the applicant's work performance and applied art therapy skills. A professional selected by the applicant who can provide a professional reference pertaining the applicant's work performance and applied art therapy skills.
- Supervisors completing the Experience Verification Form can also complete a Reference Form. If using this option, the supervisor **MUST** complete both forms **AND** send in a letter of reference.



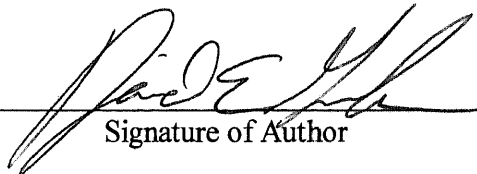
APPENDIX M

Time Line





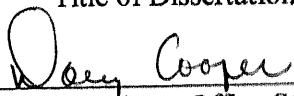
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Signature of Author

9-11-01  
Date

**The Work of the Art Therapist: An  
Interactionist Perspective**

\_\_\_\_\_  
Title of Dissertation

  
Signature of Graduate Office Staff member

12-4-01  
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