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Understanding the Roles and Uses of Art Making in Art Therapy

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UNDERSTANDING THE ROLES AND USES OF ART MAKING IN ART THERAPY

A DISSERTATION
(submitted by)

MARY ELLEN HLUSKA

In partial fulfillment of the requirements
for the degree of
Doctor of Philosophy

LESLEY UNIVERSITY
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Lesley University
Graduate School of Arts & Social Sciences
Ph.D. in Expressive Therapies Program

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[Signature]
ACKNOWLEDGEMENTS

I decided to get a PhD in expressive therapies, after working for many years in a research hospital. I was surrounded by people who were trying to understand why illness develops, how it is treated and how medicine impacts the psychological well being of people who are ill. I wanted to partake in this venture to help those who were not art therapists better understand how art therapy worked as an effective clinical method of support and treatment to those with emotional and physical illness. A wise women in my department told me that some people get PhD’s to increase personal status, in order to teach, or some because they truly believe in a topic and want to understand it better. I fall into the last category.

The act of art making has shaped both my career as an art therapist and my innate characteristics as an artist. Making art, while involving skills, is the embodiment of conceptual and communication in which a product of some sort is the result. Art making and the art therapist’s identity has always been a magical yet uncomfortable layering. The finalized identity of the art therapists is ever changing and never static. Sometimes that identity in its entirety is present, and at other times it is a fractious struggle to understand how each component creates to whole. Not unlike a dissertation, where one or two thoughts go through a process of construction and deconstruction, until all the pieces reconnect and become a final product. The product in the end looks professional and as finished as a sculpture on a pedestal. What is not visible is the tangled knot of threads, the struggle to connect pieces, the behind the scenes show and how it all comes together on stage as a dissertation.
A dissertation is only a partial fulfillment of tasks leading to the degree of doctor of philosophy. The developmental components of a Doctoral Degree may appear simple on paper but in actuality it is a materialization of intellectual, emotional, professional, clinical and personal efforts. Multiple supports are in place or develop along the way, some are surprises and others are of strong foundations. It is here that I would like to acknowledge and thank those who have supported me on this journey.

My special thanks to my dear friend Anne, who many years ago began the journey of art therapy with me at Hofstra University. Anne told me I was Kramer-esque in my approach and I whole-heartedly disagreed at the time. I doubted myself as an artist and had concerns that the therapist and artist would conflict somehow, as if one needed to trust the other. As my own professional identity developed, and that complex magical vortex of space that art therapy becomes, I realized, Anne was correct. Introducing my adolescent clients to artistic expression in the context of therapy, I rely on my artists and art therapist’s identity equally and Anne’s words come back to me all the time. Thanks Anne for knowing me better than I know myself! Thanks to my life long brothers and sisters, whom most people call friends, thank you for never questioning and always hanging on to our connection. It has meant the world to me. My cohort of ladies who were there in there during those crazy art making summers of residency. Together we nurtured each other, tending the fragile and the strong with equal muster. Thank you Cohort 3 members, Jill, Tammy, Susan, Lillian and Krystal, you will remain in my life as sisters of art and scholarship. You lift me up!

To my Patterson Park and Butcher’s Hill neighborhood and friends, I thank you for always supporting me. You made me relax and remember why I believe in
community as a supportive structure in my life. I will never forget my life in Baltimore, you all have taught me to be comfortable with myself as a thinker and as an artist. You have watched cats and dogs, listened to my accomplishments and frustrations and always, always encouraged me to remember why I began this journey.

Thanks and praises to my professors at Lesley University, who provided foundational support for me and helped clearly define my purpose during residency and beyond. Michele, Robyn, Mitchell, Julia, Phil, Shaun and Michaela, thank you for what you do and for supporting my belief in art therapy. I cannot imagine not having learned from the perspective of the multiple expressive therapies. The program truly has enriched my thinking and re-constructed my art therapists and artist’s identity and my desire to practice both. Thank you to Jennifer my external committee member whose wise perspective and belief in the field of art therapy has been instrumental to this process.

I would like to thank my Grandmothers Mary and Julia, both whom I lost during this journey. They both taught me by example that strong women are and can be successful if they hold onto their passions and pull strength from some inner mysterious place. Thank you to my brothers, in particular my brother Karl who from the beginning saw this role for me. You are so wise. Thanks to Joe for keeping it real and making me realize there is a world beyond where I sit and write this. For my silent brother Allen, who’s traumatic death when I was a child literally created my passion and inquiry into using art to express grief, loss, failure, happiness and success, so many years ago. Bittersweet is a word I definitely understand. I would not be a therapist if it were not for
him and certainly would not be an artist. Art was the strength that got me through many years of sadness and grief. Thank you for looking over me.

With boundless gratitude I thank my parents Ron and Pat, who have been there every step, holding me up to fulfill this promise to myself. Words cannot describe their patient, kind, and forthright position about my decision to get a doctorate; having been to my rescue more times that I can say. I hold their example of faith and hard work about ones ability to accomplish, overcome and succeed close to my heart. Thank you.
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ABSTRACT

This study looked at the role of art making in art therapy, specifically how art therapists value, understand, use, and make decisions regarding art in personal practice and in professional practice. The art-making aspect of art therapy is understudied considering it is art that differentiates art therapists from other helping professions that use art in practice. Additionally, the study sought to illuminate how art making informs both the artist and art therapist identities of professional clinicians. A mixed-methods design was employed to gather data based on inductive and deductive study methods. Constructivist philosophy provided a process for generating ideas and understanding art making as a structural component in art therapy.

One hundred and twenty two female and five male art therapists (4.5% of the membership of AATA) took an online survey. Participants were professional art therapists from the United States and around the world. Five participants volunteered to be part of personal interviews. One hundred and six participants were from North America; six were from Europe and proximate areas.

Findings indicated that art therapists value the use of art making but they often engage in theories, concepts, and techniques from other disciplines outside the creative arts therapies in order to create accessibility for clients. Participants identified conceptual methods of working, such as the Expressive Therapies Continuum (ETC), the concept of “art as therapy,” and media techniques. The theme of feminist theory was identified by participants and clearly described by others as a means to approach art therapy with vulnerable, or often marginalized populations of people. How art therapists look at art
making, its fundamental roles in therapy and art therapy education, and its use as a
unique professional practice skill must be considered for the future of the profession.
CHAPTER 1

Introduction

Professionals such as artists, art educators, and clinicians have long used art making as a means for both understanding and creating change in people’s lives. Each of these disciplines has a unique relationship to art, art making, and how it is used. The transition from the 19th to 20th centuries brought many new philosophies of thinking and acting, with new paradigms that directly influenced how art was used and experienced (Hartt, 1986). Historic influences of a postindustrial era made art accessible to a new cross section of people in Western society. As many authors have shown (Arnheim, 1974; Csikszentmihalyi, 1996; Dewey, 1934; Eisner, 2002; Hartt, 1986; Huntoon, 1949; Jones, 1983; Junge & Wadeson, 2006; Kramer, 1986; McNiff, 1981; Rubin, 1983; Ulman & Dachinger, 1975; Wadeson, 1980, 1985, 2001), people have been utilizing art as an effective means of communication far longer than the art therapy field has existed.

A relatively young field, art therapy has grown in the past 60 years under the nurturance and guidance of many professionals who came together with the idea that art offers unique healing benefits in the therapeutic setting. The nature of art therapy has changed from a focused method of calming, assessing, and understanding severely mentally ill clients (Junge, 2010; Kramer, 1986; Ulman & Dachinger, 1975) to the current psychodynamic (Langarten, 1981; Wadeson, 1980) and wellness models of therapy in community studios (Allen, 2013; Block, Harris & Laing 2011; Howells & Zelnick, 2009; Thompson, 2009; Vick & Sexton-Radek, 2008).

Although the core of art therapy is the belief that art making benefits the therapeutic mechanism of expression, transformation, and self-awareness, there has been
little art therapy research that explores and discerns the unique and specific role that art making holds within the profession. Art therapists often write about art making saying that it is more than a tool, that it embodies healing and has transformative properties (Allen, 1995; Malis, 2014; McNiff, 1981, 2012; B. Moon, 2009, 2012; Wadeson, 2001), yet there is little scholarly inquiry surrounding this claim. In the past, investigations have demonstrated clinical concepts or techniques in order to educate students and professionals, research the integration of art as an adjunct to psychotherapy, and call for social action and community building (Allen, 1992; Alexander, 2015; Langarten, 1981; Lusebrink, 1992, 2010; Malchiodi, 1997; B. Moon, 2012; Rubin, 1983, 2006; Ulman & Dachinger, 1975; Wadeson, 1980). Multiple books are available that share ideas surrounding technical uses of art, education, and ethics and ideas providing possible ground for theoretical constructs (Allen, 1995; Hinz, 2009; Knill, Levine, & Levine, 2005; Malchiodi, 2003; McNiff, 1981; B. Moon, 2009; C. Moon, 2010), but little research on these specific areas exists. It was my aim to add to this vital discussion by exploring the question of how, at this point in the field’s development, art therapists use, value, and understand art, both in clinical practice and in their personal art making practice.

Throughout the history of the field, there have been numerous editorials, articles, and viewpoints published with concern for the art in art therapy (Allen, 1992; Goebels, 1984; Lachman-Chapan et al., 1998; Wadeson, 1983). Allen (1992) in particular warned of the dangers of art therapists losing touch with the subtle processes that art making has to offer in order to establish the field as a respected clinical discipline. She wrote that the “most troubling aspect of clinified art therapy” is that “it neglects to employ the very
specialized knowledge that derives from our background in art making itself” (Allen, 1992, p. 23).

Evidence of questions surrounding what the specific role of art has been in art therapy is also apparent in editorials questioning art therapists’ professional identity and where art therapists fit into the history of both the helping professions and the world of art (Feen-Calligan, 2012; Fish, 2012; Riley, 1996; Rubin, 1983; Wadeson, 1985, 2001). Art therapists often refer to themselves as artists in the literature, implying that the creative nature and expertise of use of art materials make them unique in a field of psychotherapists and counselors (Barlow, 1987; Junge, 2010; Kapitan, 2009; Malchiodi, 2003; McNiff, 1981; C. Moon, 2010; Robbins, 1999; Schaewe, 2011; Wadeson, 2001).

Understanding the term artist and orienting it to the field with a consistent definition and understanding may be particularly helpful for art therapists. Merriam-Webster defines four types of meaning for the word artist: “(a) one skilled or versed in learned arts; (b) one who professes and practices an imaginative art [or] a person skilled in one of the fine arts; (c) a skilled performer; (d) one who is adept at something” (Artist, n.d.). This presents a rather simplistic definition of the term, referring to skill level and expertise. In the United States, professional artists, self-taught artists, and non-artists can become art therapists as long as they meet the studio requirement standards set by the American Art Therapy Association (2007). As a result there are broad ranges of understanding, skill levels of professional level art therapists, and how they use art in clinical and personal practice. Each student therefore comes to graduate education with different skill levels and understanding of art making (Levick, 1995). Several authors have casually referred to themselves as artists. As the field progressed, authors continued
to provide evidence that in the 60 years of its existence art therapy continues to struggle with its identity, straddling the realms of art, counseling, and psychology, grappling with its own distinctiveness as an individual field of study (Feen-Calligan, 2012; Gonzalez-Dolginko, 2000; Junge & Wadeson, 2006; Kapitan, 2008; Lachman-Chapan, 2000; Riley, 1996; Vick, 2000; Wadeson, 2002).

The area of exploration presented here asked how the making of art in art therapy can become an esteemed, grounding component of practice. The research design used here all for reflective inquiry regarding art as an essential building block in art therapy was undertaken to recognize the relationships art making has to the professional art therapist, as well as exploring how art therapists use their educational and lived experiences to inform professional and personal practice, and what other resources they use. Placing art making in the category of a given tool or technique may diminish its importance to fundamental understandings art therapists have about art therapy. Understanding how art therapists utilize and make decisions about art making warrants further study. It is imperative that art therapists grasp more about art as a core element rather than as a technique or skill to use in therapy. The increased need for state licensure as a means for employment requires identifying who art therapists are, what we do, and why we do it to those various governing bodies. Thus, research surrounding art making and its theoretical and practical implications for the field are necessary for the development of this profession.
CHAPTER 2

Literature Review

To date few research studies exist in regards to how the making of art functions within art therapy as a central ground for decision making in practice. In seeking out literature related to art making in art therapy, art therapy training and education, arts history, and arts pedagogy, I utilized several databases (EBSCO Host, PsychInfo, PubMed, MEDLINE, ERIC, Alt HealthWatch, ProQuest, Art Index Retrospective, and Art Full Text). Searches resulted in a broad category of editorials and viewpoints, peer-reviewed articles, books and historic documents, and archival material about art therapy and identity formation of the professional art therapist.

Background on the Role of Art Making in Art Therapy

Historic Parallels

The time in which art therapy became a field was a transitional period in history. There were many social, economic, and scientific changes between 1900 and 1945. The introduction of scientific technology such as X-rays opened up a new way of diagnosing and treating people with medicine. Seeing what could not be seen before allowed medical professionals to expand their knowledge and understanding of the human body. Previously, science was naturalistic, based on observation and theory (Iggers, 2005). Industry also changed as technological advances were used to develop manufactured or mass-produced goods, such as the Model T automobile. This meant that many goods were no longer just for the wealthy in society but were more affordable and available to the working class.
The turn of the century also brought changes as to how the human mind was viewed, with the development of the field of psychiatry through the work of Sigmund Freud. This was a new method of examining human behavior by deconstructing a person’s mind and trying to understand what caused odd or abnormal behaviors in people. Freud did not see his development of psychoanalysis as a new science; rather, he viewed the process as representational of natural life, developed to help his patients recover from neurosis (Moran, 2010).

Additionally, writers and fine artists were breaking from the classical *Ecole des Beaux-Arts*, or elite art institutions, creating groundbreaking works of fine or plastic arts, photography, film and literary works of art. New schools of art such as De Stijl and Bauhaus came into being, which looked at the production of art and what constituted art from a unique, constructivist point of view or all audiences rather than a privileged few (Hartt, 1986; Iggers, 2005). Artists in Europe such as Picasso, Mondrian, Duchamp, Klee, and Kandinsky moved away from the conservatory or classical styles, making strong political statements about the human condition and rebuilding what was thought of as art. American artists such as Bearden, O’Keeffe, Stella, and Hopper made art about the growing middle class, while photography and film opened up a fresh genre for artists such as Stieglitz and Cartier-Bresson who represented new ideas and presentations of art, changing perceptions and understandings of what was viewed as art (Altschuler & Blumin, 2009; Hartt, 1986).

In Chicago and in New York City from the 1920’s thru the late 1940’s, waves of African Americans left the more agricultural south, moving to large urban centers for more job opportunities, and increased economic status. The increase in economic status
allowed writers, visual artists, photographers, filmmakers, musicians and dancers to thrive. Additionally the industry surrounding the arts thrived with film production, magazines, newspapers and galleries growing in numbers. The move to New York in particular is well documented as the Harlem Renaissance, which took places from about 1920 thru the late 1940’s (Huggins, 2007). This period details the changes in status of African Americans, the surge of artists of color and how the accessibility of these arts to the public not only helped the community, but also was a gateway for artists to cross color lines (Rogers, 1998). Artist such as Josephine Baker, Marion Anderson, Wallace Thurman, Duke Ellington, Langston Hughes, Augusta Savage were just a few who gave voice to the populace and strengthened the economy, reaching far beyond the borders of New York. The later period of the Harlem Renaissance artists such as Romare Beardon, Faith Ringgold, Jacob Lawrence, Maya Angelo who would shape the art of the emerging black power movement of the 1960’s and 70’s in the United States.

All of these changes happened just as art therapy was beginning. Artists such as Jones, Levick, Ault, Cohen, Cane, and Ulman found work in the 1950s and ’60s with psychiatric patients, providing art making as a therapeutic treatment process (Junge, 2010; Junge & Wadeson, 2006; Levick, 1995; Wix, 2000). The development of art therapy occurred with the sickest of clients who were hospitalized in long-term psychiatric settings (Junge, 2010). In the 1950’s and 60’s both public and private institutions were available to care for clients who ranged from severally mentally ill to those who had intellectual disabilities. Private institutions, such as the Menniger Clinic, started using arts in mental health care as early as the 1940’s.
Early Developments in Art Therapy

The American Art Therapy Association was formed in 1969. However, as early as the 1930s there is evidence that the field of art therapy was in its earliest stages through the work of Mary Huntoon at the Menninger Clinic in Kansas (Huntoon, 1949; Wix, 2000, 2003). A trained professional artist, Huntoon worked doing art as therapy in the 1930s and ’40s with psychiatric patients, helping them by using studio art to identify as students of art, while introducing them to art as a means for self-expression and healing. Huntoon began this work with the support of the U.S. government through the New Deal program after returning from Europe, where she had worked as an artist (Altschuler & Blumin, 2009; Wix, 2000).

Like the New Deal before it, the GI Bill was introduced at the end of World War II and provided resources such as education and funding to budding artists in the United States, creating a wave of commercial artists, art educators, fine artists, and designers (Altschuler & Blumin, 2009; Huebner, 2008; Junge, 2010 Schrank, 2011; Smith, 2012). A world of industry and scientific discovery was made accessible to the public using the visual arts in advertising and education (Warhol, 1975). Art became modern and accessible to a growing middle class. Understanding, viewing, and experiencing art became part of the privilege of a growing middle class in the United States and Europe, impacting education, entertainment, style, and mental health care (Arnheim, 1974; Dewey, 1934; Langer, 1953, 1957 Lowenfeld & Brittain, 1987; Wertenbaker, 1967).

In the post–World War II era, professionals began to connect with one another to share experiences and information, making a case for their work as a profession (Junge, 2010; Junge & Wadeson, 2006; Levick, 1995; Ulman & Dachinger, 1975; Wadeson,
In an early article Huntoon (1949) specifically wrote about using art in a studio for the benefit of veterans suffering from what was then called battle fatigue after World Wars I & II. Huntoon (1949) described the benefits of “artsynthesis” as a healing mechanism, stating:

Graphic expression seems to escape the vigilance of the superego more easily than verbal or written expression, so that the aggressive and traumatic material may be depicted without the artist feeling culpable. However, after it has been put down graphically the artist may be able to recognize it because it is rendered in his own symbols (artsynthesis). (p. 201)

Art was on the minds and in the questions of philosophers and educators at the time art therapy was placed onto the table as a profession. Dewey’s (1934) *Art as Experience* influenced many writers, fine artists, and philosophers to understand the arts, aesthetics, and their purpose from different perspectives. Susan K. Langer was another of these philosophers. She wrote two books about the philosophies of art. In 1953 she published a book, *Feeling and Form* about the lack of serious philosophical thinking and absence of theoretical postures of art, observing that art was seen as superficial with the viewer often minimizing its complexities and thus not taking it seriously as an organized systematic motion of creative thinking. She asked why there was no existence, at the time, of a systemic philosophy of art, and reflected on the developmental lens thinkers of the day used to view art and the process of art making. The result was a schism between two paradigms within the field (arts learning and liberal arts education), creating a dichotomy between the two concepts. Langer questioned the philosophical meaning of art as a developmental progression from her earlier work, *Philosophy in a New Key: A
Study of Symbolism, Reason, Rite and Art, first published in 1949. When breaking down the paradigms that constructed education for professional artists, Langer (1953) concluded that the need to join liberal arts education (which she viewed as an established scientific entity) to the experiential nature of the arts process (viewed by the author as an naturally occurring or organic matter) led to an ultimate clash, further separating the two aspects seen in fine arts pedagogy. Langer wrote about this during the same span of time in which art therapy was born.

**An Emerging Vocation**

In 1995, art therapy pioneer Myra Levick wrote an article celebrating the 25th anniversary of the American Art Therapy Association (AATA) in which she reflected on her concerns for the value of self within the field and the importance of alliance with other disciplines. In her article she discussed identity formation with special regard for ethical considerations in art therapy. Levick wrote of the history of AATA leading to the establishment of sound ethical and educational standards in order to substantiate professional identity. She also expressed concern for the use of practice methods that moved outside the medical model. The article included personal experiences and observations as well as factual information and quotes taken from peer-reviewed material available at the time.

Levick (1995) an artist, working in mental health and, the first president of AATA called what she and others she recruited were doing art therapy. The founder of the Creative Arts Program at Hahnemann University, Levick reflected on the historical changes in mental health treatment and their impact on the development of the of art therapist. Strong ethics, she maintained, were beneficial when setting up educational and
professional guidelines, no matter what the orientation to art therapy. Having begun her career in acute mental health care with the support of psychiatrists and medical doctors, Levick reflected on the symbol of a bridge between the soft nurturing aspects of art therapy and the industry of medical care. She stated that art therapists must connect with the cultural changes in health care in order to remain valid and in the foreground of treatment. Additionally, she wrote about the benefits and sacrifices she encountered, while working as an art therapist, in the atmosphere of a medical school:

On the one hand we were accepted as professionals, practitioners of a new and exciting discipline. On the other hand we were never intended to hold positions of authority. We reported to the director, our supervisors, all psychiatrists. The biggest plus was and is the fact that our students were taught the same principles of ethical responsibility that were taught to medical students and psychiatric residents. (Levick, 1995, p. 284)

Levick wrote about the many changes within the profession since its formation in the 1940s, ’50s, and ’60s, reflecting that art therapists generate their intentions from various philosophies or orientations. She stated, “The pioneers of the field conceptualized art therapy in the 1940s as a non-verbal means of psychotherapy. In the 1990’s there are art psychotherapists, art therapists and others who say psychotherapy as a base is out” (Levick, 1995, p. 290). She concluded that eclecticism was too broad and lacked strong foundational philosophies and ethics, stating that art therapy must remain loyal to its base in psychotherapy in order for art therapists’ identity to remain intact.
Questions of Identity in Art Therapy

Identity is associated with what makes individuals unique and recognizable. A collection of individuals who share qualities, have similar values or objectives identify as a group (Identity, n.d.). The characteristics that allow art therapists in the United States to be recognizable as a group are basic—one must have knowledge of art, psychology and the application of counseling techniques.

In the 1980s and 1990s art therapists broadened their core beliefs to include branches of psychoanalysis such as Jungian, Gestalt, and Adlerian philosophies, some also incorporating methodologies such as humanistic psychology, behavioral therapy, existential therapy, family systems therapy, and Rogerian or client-centered therapy as a basis of psychodynamic practice (Junge, 2010; Langarten, 1981; Malchiodi, 2003; Wadeson, 1980; Wedding & Corsini, 2014). Postmodern ways of thinking provided another viewpoint, adjusting the relationship to the medical model that early therapists modeled practice on (Kapitan & Newhouse, 2000; Venture, 1977). Discussions are present in more recent literature concerning identity as an element that distinguishes the roles of art in psychotherapy and counseling versus the experiential arts for healing in a studio as part of practice (Malis, 2014; Rosen & Atkins, 2014).

In a dissertation, Malis (2014) focused on the topic of art therapists’ identity by interviewing five professional art therapists about the impression that art making had on their professional practice. The author sought to understand the lived experiences of the participants and how art making assisted in identity formation throughout the careers of these individuals. Malis employed a qualitative methodology of research based in feminist philosophy called the “listening guide” (Gilligan, 2015). This method is based
on finding or discovering connections between participants’ words, sounds and the relationships between them, both in conversation and in resulting transcripts (Gilligan, 2015, p. 69). Malis described this process as a “path to rather than a fixed method of interpretation” or understanding of the data (2014, p. 82). The study explored relationships between educational and studio course work, personal and professional ideas of identity, and art making practices. Malis also looked at the distinct identifiers of the modern art therapist and their impact on identity.

Malis (2014) discussed the aesthetic values art therapists hold in professional and personal art making practice in relationship to identity. Three significant outcomes were found when data were looked at in synthesis: (a) aesthetic appreciation, (b) aesthetic regard, and (c) shared experiences. These outcomes were examined and concentrated into categories of regard, appreciation, and shared experiences (Malis, 2014, p. 162). Together these results were seen by Malis as representing a close connection between aesthetics and art therapy; specifically, “aesthetic of care is embedded in each art therapist’s identity through their practice of art therapy and is linked to their professional identity” (2014, p. 163). The aesthetic nature of art making becomes a relational characteristic then, to the identification of artist and the identification of art therapist.

Malis (2014) found that relationships were a pivotal aspect of the participants’ association to art making as they worked at clinical practice and in their own personal art making practices. Malis sought to understand the participants relationship to art in their individual practice with clients, but also how they related to personal art making was seen as an important finding of her study. Aspects of art therapist identity and artist identity were explored in connection to participants’ educational past and specific areas of
graduate study, as well as their relationships with art therapy supervisors. Relationships to the visual art-making process developed as a theme in Malis’s study, most notably art as a manner of self-reflective inquiry. Substantial data emerged in regards to both the content and material choices, recollecting past relationships. Using I-statement poems as described by Gilligan, the researcher was able to understand the voice of the participants while grouping themes together based on the resulting relationships.

The question of art therapist identity and counselor identity served as broad points of interest, resulting in two central themes in Malis’s (2014) data. The themes were “attitudes towards art therapy” and “challenges faced by art therapists in multirole positions” (Malis, 2014, p. 108). Hierarchical structures of employment impacted the identity of participants. Data indicated that relationships between I statements having to do with art therapy and counseling were a blend of both negative statements, “of being, devalued, misunderstood, undervalued and excluded,” (p. 108), and positive statements of “inclusion, support and value” (p. 108). Findings indicated that dual relationships of art therapist and counselor continue to challenge art therapists, as does having to choose the value of one or the other. Negativity and despair with regards to the lack of control over how their roles were defined while at work impacted the participants’ sense of identity.

The continuing struggle of having to define and redefine identity continues to be a contention in the profession, as illustrated by Randick and Dermer in 2013. In a non-research article published in *Art Therapy: Journal of the American Art Therapy Association*, Randick and Dermer looked at art therapy in schools and the necessity of art therapists to meet the needs of the American School Counselors Association’s standards
of evidence-based practice. Identity becomes an issue for school art therapists who need to educate those around them as to how art therapy is different than school counseling. Overlap in role delineation may be an issue between art therapists, counselors, and art educators if the art therapist does not set a standard of practice and distinguish identity early on. The art therapist’s role in schools is clearly different. The authors wrote:

We describe school art therapists as therapists or counselors who provide intervention and prevention services that enable students to identify their subjective inner worlds (feelings, thoughts, beliefs, dreams, and internal conflicts) through the creative process. The images that are created become the vehicle through which transformation and insight begins. (Randick & Dermer, 2013, p. 34).

Art therapists obtain their own credentialing through the Art Therapy Credentials Board, but may also require additional course work in order to meet the credentialing requirements of the American School Counselors Association. According to the authors, each state and school district has different requirements, making it difficult to know what requirements are needed in order to have art therapy in schools.

Randick and Dermer (2013) wrote about the benefits of art therapists in school systems, where educational systems provide more than an education but also have programming for child and family wellness through mental and physical health services. They stated that art therapy is an added service, explaining, “Art therapy can be used in in-depth interventions, planning, evaluation, assessment, and consultation services with a variety of populations to address multiple concerns” (Randick & Dermer, 2013, p. 30). The American School Counselors Association has a structured format of care in order to
meet both academic and emotional needs of children. Randick and Dermer reported that art therapists were able to address issues and adapt in a flexible manner to the sometimes rigid, scheduled day that schools provide children.

Identity was an important enough topic that several issues of *Art Therapy* have been dedicated to the controversy. The studio model of art therapy offered art therapists the ability to look outside of the medical model in terms of how they personally and professionally make art therapy welcoming to those who are not seen in hospitals but are equally marginalized. Allen (1995, 2008), along with Block, Harris and Laing (2005), embraced the studio as an important component of art making in art therapy, and both have done research on the studio in art therapy practice.

The topic of dueling paradigms is hard to identify in the art therapy literature as a distinctive topic of conversation, such that perhaps it may be like the elephant in the room; or, having a clear understanding of a topic’s presence without being able to clearly distinguish its meaning because to talk about it is uncomfortable (Elephant in the room, n.d.). Research-based literature proximate to understanding what paradigms guide art therapists, what theories are accessible and how those theories are utilized in daily practice would prove most valuable in establishing a clear foundational understanding of the field.

**Different Views on the Purpose of Art Making in Art Therapy**

Considering the fact that art making forms the very basis of the art therapy discipline, it is surprising that there is not more research that investigates the role art making plays in art therapy. The art therapy literature suggests that art therapy as a profession has been affected by a range of philosophical views on what the role of art
should be in art therapy, some of which have had a direct impact on how art therapists are educated, as well as how they practice as professionals today (Allen, 1992; AATA, 2007; Bloomgarden & Shwartz, 1997; Brennan, 2011; Cahn, 2000; Deaver & Shiflett, 2011; Elkis-Abuhoff, Gaydos, Rose, & Goldblatt, 2010; Franklin, Farrelly-Hansen, Marek, Swan, & Wallingford, 2000). Much of the current literature that exists investigates art making in the context of program development (Block et al., 2005; Langner, 2009; Matton & Plante, 2014), in case studies of specific clinical applications or clients (Czamanski-Cohen, 2010), and as a philosophical ground for an art therapist’s scope of practice (Bloomgarden & Shwartz, 1997; Fish, 2012; Nolan, 2013; Wix, 2010).

In particular, there are two major philosophies on the role of art making in clinical practice within art therapy. One is an experiential philosophy that sees the act of making art as something that facilitates positive change in a client’s life (Allen, 1995; Block et al., 2005; Kramer, 1986). The other is a psychotherapeutic philosophy that sees art making as a tool for assessment, diagnosis, or the development of coping skills in order to provide insight into behavior, self-expression, and healing (Briks, 2007; Cohen, Mills, & Kijak, 1994; Langarten, 1981). In exploring how art making is utilized by art therapists in clinical and personal practice, it is important to first take a careful look at these two philosophies.

**Experiential Approaches in Art Therapy**

On one end of the spectrum of philosophies on the role of art making in art therapy is the philosophy that art making is an experiential method, which when facilitated by an art therapist helps a client find meaning and intention in both the process and the product. In a groundbreaking work by Kramer (1986) the art-making process
was used to help children in crisis express and understand the strong emotions that they were experiencing. It involved the use of a variety of art materials, the sensory use of such materials, and attention to the physical nature and discipline of art making in order to symbolically develop an aesthetic presence (Marakova, 2012). Kramer (1993) called it “art as therapy” (p. xiii). In an article framing her concepts, Kramer (1986) referred to art making experiences metaphorically as the “third hand” of the art therapist, writing, “the ‘third hand,’ [is] a metaphor I have coined to describe an area of the art therapist’s functioning wherein artistic competence and imagination are employed in the empathetic service of others” (p. 71). Although Kramer emphasized the art-making process in clinical work, she was also trained in psychoanalysis and was particularly interested in the psychoanalytic concept of sublimation. Kramer believed that sublimation occurred naturally through the art process.

Kramer was not alone in her thoughts about the benefits of the experiential art experience as a valuable process for healing. Prior to Kramer, Huntoon (1949) used art in a supervised studio environment at the Winter Veterans Hospital in Ohio. Treating veterans suffering from what was then called battle fatigue and other emotional consequences of war, Huntoon encouraged various art processes, guiding them to meet the prescribed need of the clients as guided by the psychiatrist. At the veterans hospital the hierarchy of care dictated treatment, where formal referrals were made for studio art interventions toward the goals of expression and increased vocation, supervised by an artist. The process was supervised and guided, however, Huntoon wrote that each client “was given individual attention in order to discover in what manner art could function to bring about the prescribed aim, and in what medium the individual could best handle the
emotional problem” (1949, p. 1). Little additional documentation exists about Huntoon’s work; however, in her article she reflected on the studio as a supervised, self-discovery process that allows clients, or “students,” to safely develop a method of outward expression. Although it was guided, the process appears to have been experiential in that it promoted self-discovery to build skills while aiming to meet specific treatment goals under the supervision.

This method of using art experientially is commonly, but not necessarily, used in the art therapy open studio approach (Block et al., 2005; Vick, 2000; Vick & Sexton-Radek, 2008; Wix, 2010). Block et al. (2005) researched the art studio as way to reach out to at-risk youth through the Open Studio Project in Illinois. Materials were made available for clients to explore, use, and learn about. Clients worked at their own pace, exploring creative writing and art making while receiving support and guidance from the art therapist (Block et al., 2005).

The research was deemed a pilot study and the art studio partnered with neighborhood organizations and churches to become a safe place for youth to make art without judgment, discovering new aspects of self. The participants were exposed to the arts process within the studio environment once per week for 12 weeks, experiencing and learning about various types of arts media, building skills, and developing a sense of meaning and intent (Block et al., 2005). After creating art the participating youth sat, wrote, and reflected on the art-making process and the product they created in a process called “witnessing” (Block et al., 2005, p. 33). The individuals worked at their own pace, coming together at the end to talk about the process and share in a group. Fine artists often gather to sit with and provide critiques each other’s work and discuss the process of
their work in a similar manner. In this case the authors reported that critical examination and sharing of ideas occurred, but safety measures were put into place, similar to those put into place in traditional group therapy, so that boundaries were respected. The study was highly successful; evolving into more than 20 programs for youth in Illinois and garnishing increased community support.

In general the goals of open studio art therapy span from simple relaxation and self-expression to developing an increased sense of identity and using the arts process to symbolize one’s journey of healing and wellness (Czamanski-Cohen, 2010; Henley, 1995). Models vary depending on clients’ needs and goals, but maintain the theme of community. Efforts have been made by art therapy researchers to understand the purpose of studio or community art centers and how they are outside or within the realms of practice as outlined in AATA’s (2013) ethical standards. Vick and Sexton-Radek (2008) studied aspects of the studio in art therapy, comparing its usage in art therapy practice in the United States to that in Europe.

Vick and Sexton-Radek (2008) surveyed 22 community arts or therapeutic arts programs, 12 from throughout Europe and 10 from the United States. Fifteen participating organizations responded, with eight from the United States and seven from Europe. The researchers found that overall, the programs had more similarities than differences. Most interesting was that programs were referred to as “not art therapy” for several reasons (Vick & Sexton-Radek, 2008, p. 7). Staff were not always educated as nor credentialed as art therapists and work was not “interpreted.” The authors stated that this was in reference to diagnostic skills. They noted similar false impressions in regard to the purpose of art therapy, writing, “This of course is a misconception most art
therapists frequently encounter, stemming from a narrow and outdated understanding of the field, at least as it has come to be practiced in the United States” (Vick & Sexton-Radek, 2008, p. 7). The authors described, “blurred lines” of what is art therapy and what is psychological testing. They wrote that one respondent described their clients as not being ill; therefore, they did not provide therapy.

The first portion of Vick and Sexton-Radek’s (2008) survey surrounded the categorization and requirements of the participants in order to be part of programming. The survey asked questions about program structure, the length of time participants were in the program, and if there was a predetermined status of individuals attending the program; clients had a range of developmental, physical, and psychological disabilities. Individuals attending all programming met some sort of prerequisite determination ranging from spiritual needs, homelessness, and mental health needs such as increased self-efficacy and community networking to “at-risk” status and a non-specific determination in one European studio. Participants were referred to in many different ways, such as artists or clients, but also as “people who make things” (Vick & Sexton-Radek, 2008, p. 6).

Vick and Sexton-Radek (2008) found that programming in Europe had fewer credentialed staff than in the United States and was far less structured. The researchers reported that the purpose of each studio or community center varied a great deal. In Europe and in the United States, studios offered opportunities for time-limited participation (workshops or specific classes) as well as opportunities for ongoing participation, sometimes for years. Staff people were seen as facilitators, but had a broad range of titles such as manager, leader, and artist. The authors were careful to recognize
that some survey responses were in Dutch, German, and French; this might have affected the translation of titles. Centers varied in their purpose or services ranging from education to art therapy, but also offered many other services such as education regarding daily living skills. Serves were reported as being quite diverse. Community studios in the United States were more often structured around art therapy whereas European centers reported a variety of services, not all pertaining to art therapy. European studios were described as vocational in their purpose, meaning they were designed to increase the skill level of participants.

There were significant findings for participant involvement in the decision-making process of the studio. Vick and Sexton-Radek (2008) found overall that studios were not designed with a hierarchical structure. The role of therapist as a principal decision maker in the relationship was diminished both in the United States and in Europe. This is a common thread throughout the literature when depicting studio or community-centered arts programming that has the purpose of wellness.

**Psychotherapeutic Approaches in Art Therapy**

Psychodynamic theories of art therapy are at the other end of the spectrum of philosophies on the role of art making in art therapy, stressing the use of art making under the constructs of psychotherapy and utilizing a range of models from psychoanalytical to cognitive. This philosophy is anchored in the hierarchy of the medical model. Art psychotherapy can have several goals, ranging from assessment and diagnosis to the development of coping skills in order to provide insight into behavior, self-expression, and healing (Froeschle & Riney, 2008; Langarten, 1981; McNiff, 1981; Rubin, 2006; Wadeson, 1980). The art-making task often drives this activity, providing
diagnostic information on which to base treatment goals (Briks, 2007; Cohen et al., 1994; Malchiodi, 1997, 2003). It is difficult to discern how many art therapists consider their practice of the medical model (Elkins & Deaver, 2015). The art psychotherapy model has given birth to several diagnostic measures that are well-respected, taught in graduate art therapy programs and used in some settings. Of those that have been establishes, two of these measures have been validated: the Formal Elements of Art Therapy Scale (FEATS; Gantt & Tabone, 2012), and the Diagnostic Drawing Series (DDS; Cohen et al., 1994).

Common Ground

The act of art making is the shared concept between these two different philosophies of art therapy. The act of art making itself forms disciplined ground from which art therapists develop (AATA, 2013). If it were not for art making, surely the field would not exist as a separate profession, for many types of non–art therapists use art in their practices (Coholic, 2011; Harter, 2007; Monti et al., 2006). As Vick (2000) explained:

Delineated in the earliest days of the profession, the continuum stretching from “dynamically oriented therapy” to “art as therapy” continues to be a dominant model in art therapy practice. Although serviceable and surprisingly adaptable, it is still a paradigm linked to the medical model concepts of identifying and treating pathology. (p. 4).

Two ways of thinking about art making and its applications to clinical therapy practice create a distance from one point to another, like a bridge. But between those opposing sides, are there other models or ways of synthesizing the two? Allen (1992) warned that
a “clinified” art therapy practice is something that can be done by any type of therapist or professional interested in helping a client because it relies solely on discussion about the art product. Is the clinified art therapist stuck on one side of the span of ideas? Allen (1992) further stated that what makes art therapists unique is their knowledge about and understanding of the art-making process. Art making therefore becomes a unique conduit that helps clients communicate in a manner that may be less threatening than verbal or traditional therapy models. Understanding more about art making may be the intersection of these differing models of practice.

If art making is a unique aspect of the art therapist identity, then do we art therapists also have an artist identity? In an editorial, Wadeson (2001) questioned art therapists’ relationship to their artist self and how it relates to art making as a personal tool for processing, as opposed to the art processes that are used with clients. She questioned whether the manner with which art is used changes within the context of personal art making and art making as used in clinical practice. Wadeson (2001) discussed art as a “visual voice” for artists, one that affirms their identity and skill level. She contended that art therapists relate to art differently and have a different purpose for it. She stated that art therapists need not nor do they have visual voice or expert skill level, but do need to be able to relate to other people in order to practice. Art therapists’ relationship to art is a paradox, she wrote: “As we plunge more deeply into ourselves in our art, we are at the same time connecting with what is more universal, something that speaks to others” (Wadeson, 2001, p. 67).
**The Role of Art in Related Fields**

Related fields have undergone similar inquiry into the epistemology of how the arts impact practice and the purpose of that practice. Researchers in fine arts education (Cunliffe, 2001; Eisner, 2002), music therapy (Aigen, 2007), and even psychology (Harter, 2007) have studied the phenomenon of using the arts in healing. Aigen (2007) discussed the plural aesthetics of music and how this feature helps define multiple levels of meaning and interpretation of music in therapy. Maclagan (2001) discussed psychoanalytic theory, questioning the role of aesthetics in the art product and its production. Exploring how other disciplines develop skills in the arts in order to build competencies in their fields of study may provide art therapists with insight into the polarizing viewpoints that are witnessed in art therapy with regards to the role of art.

Brown (2008) used an arts-based inquiry to study the importance of art making with creative arts therapists outside of clinical practice. A dance/movement therapist, Brown employed a postmodern arts-based structure to study creative arts therapists’ expressive responsive dialogue to the question, “What is the relationship between your artistic pursuits outside of work and your work as a therapist in the hospital?” (2008, p. 201). In doing this the investigator aimed to add to the current body of literature surrounding arts based inquiry, but also develop an understanding of the structures arts-based methodology offers creative arts therapists. Brown’s discipline of dance requires practice in order for dance/movement therapists to be clinically present for their clients, pointing to the question of whether other creative arts therapists partake in their discipline as practice in order to be present for clinical work. The aesthetic of the arts experience
was important to Brown, as the reflexive method of data collection and open means of interpretation had varying views per artist and specialty. Brown stated:

It is this “practice” that I argue all creative arts therapists need to keep during their clinical work. In my twelve years of experience I have found that many students and colleagues have not kept a regular practice of going to the art, dance, or music studio to create their works of art. (2008, p. 202)

Brown’s (2008) research took place over a 2-year period of time that included 45 participants, representing three separate groups of therapists broken down into three subgroups. The participants were considered co-researchers and worked at three separate hospitals in New York. The co-researchers broke their groups up into those who practiced their art outside of work and those who did not. In doing this the researcher hoped to have the participants who did not make art outside of practice serve as an audience and rate arts-based performances by the remaining participants. Thus the audience’s role of co-researcher become an additional active voice in the process, adding rigor to the data collection and analysis.

Throughout the span of Brown’s (2008) study, the groups divided in an almost as needed basis by subject or by types of responses to form additional subgroups that worked with one another. Initially the participants were asked to create individual, artistic responses to the question, “What happened to you when you stopped making art?” (Brown, 2008, p. 203). The responses could include drawing, poetry, movement or dance, dramatizations, or poetry. Participants then shared their responses with the group. Later collaborative creation took place as the groups worked together to create an artistic response that offered a meaningful representation of the experience.
Brown (2008) reported on data she observed and experienced as the researcher and by the co-researchers as the groups organically moved from one question to another, creating layers of data. Brown sought to explore her two main research questions, looking for impact, aesthetic representation, strength of meaning, and who acted with reflexivity; Brown herself and that of the co-researchers. Understanding how creative art therapists relate to and create artwork, as well as the meaning of art, was revisited in each stage of the research in order to reach conclusions or significance. Data were represented by video, writing, and images of the responses.

The method of Brown’s (2008) study was important in that the layers of responses by the participants as co-researches provided a rigorous review of material from various viewpoints. By changing the way data are created, gathered, and reviewed, the researcher created an atmosphere of connection with the participants, allowing them to be part of the overall meaning of the study. Brown found that the art making took on another layer of meaning for the therapists involved. In response to the first question Brown uncovered themes of degrees of transformation, spirituality, wholeness, and connections with each other and their arts, as well as reaffirmation of the use of art as a cleansing body and as means for containment. The second question, which took a long time for the participants to distill and understand, resulted in themes of “depletion, anger, apathy, disconnection from ourselves, our work, our patients” (Brown, 2008, p. 207). Brown’s study found that creative arts therapists must have a connection with the arts process outside of clinical work as a means to instill and affirm their identity as an artist and therapist.
Other expressive arts therapies fields may provide insight into the core concepts of the art therapy field. Furthermore, researching art making as the core component of the profession of art therapy may increase the self-efficacy of the art therapists, affirming their identity as artists and art therapists. Best practice methods that include art making may unify various philosophies, providing a sense of self-worth professionally and personally, bringing meaning and worth to the profession.

**Art Making in Practice**

Early in the development of art therapy as a professional discipline, researchers explored the use of art making to learn about or experience its meaning (Henley, 1995; Jones, 1983). In more recent years, books have been written exploring the practical and theoretical use of art materials in art therapy (Hinz, 2009 C. Moon, 2010; Rubin, 2011). Looking at how art making is valued by students and taught by educators and professionals may help the profession to secure a sense of identity. The American Art Therapy Association’s (2007) Masters Education Standards recommend each graduate program require a portfolio of artwork from applicants in addition to academic work prior to being accepted by the program. Additionally, students are encouraged to make art in order to help them process the emotions they feel as they interact with clients for the first time, (AATA, 2007).

Professional life brings on many new challenges for the newly graduated art therapist. New art therapists not only must earn professional practice hours toward their credentialing as Registered Art Therapists (ATR) and Registered and Board-Certified Art Therapists (ATR-BC), they may also need to take further course work in order to be
eligible for licensure. Licensure in the United States varies from state to state, and in Canada may vary from one province to another. The ability to collect supervision hours toward board registration and certification can be a challenge. Not all facilities may have a pool of art therapists available or eligible to be considered a supervisor. This has direct impact on employment.

The need for certification was documented early on in art therapy’s existence. Wilson, Riley, and Wadeson (1984) described the necessity of supervision and developed a plan of approach meant as guidance for art therapy supervisors. The authors were art therapy educators and provided supervision to graduate students and new professionals seeking their ATR credentialing. The authors presented the supervisory relationship as being composed of beginning, middle, and termination phases (Wilson et al., 1984, p. 100). Clear boundaries must be set so that self-examination does not take on aspects of the personal therapy relationship. The beginning phase involves setting goals and teaching the supervisee how to ask questions and improve the relationship to the supervisor. The authors wrote, “The supervisor serves as a model of the reflective, thoughtful art therapist who continually examines and questions his/her own work and its results” (Wilson et al., 1984, p.100). The middle phase is significant because the attention goes from questioning the supervisor to questioning and learning about the supervisee’s relationship to the client. Specific attention to connecting art expression and theory occurs in the middle phase, as well as awareness of the subtle challenges new therapist may encounter.

The final phase of supervision as described by Wilson et al. (1984) encounters the difficulty of separation from clients and speaks to the therapeutic relationship, the
transference and counter transference that may occur, and how supervisees may handle it. Wilson et al.’s publication was not a research article but it is a good example of how art therapists approached supervision from the perspective of a medical or psychotherapeutic model. There was no mention of the use of art making to assist supervisees in processing the emotional aspects of supervision; supervision was described in this article as purely being a dialogue.

Current literature points to the use of art making in supervision. Although there are articles written, I found little peer-reviewed research on how many clinical art therapy supervisors use art making in supervision (Deaver & Shiflett, 2011; Fish, 2012; Yoo, 2011). According to Fish (2012), in order to help process emotions, response art in supervision can be a useful tool. In an editorial, the author suggested that an ongoing dialogue using art making can be helpful to students and professionals for processing, but also to empower their connection with art making. Using a series of vignettes, Fish discussed the use of response art for personal processing, for countertransference, and to develop increased empathy. Fish wrote, “Response art can help the therapist live and work in balance by containing difficult material from therapy. It can support empathetic engagement and illuminates countertransference” (2012, p. 142).

In a dissertation, Yoo (2011) explored art making in supervision; more specifically the empathetic responses of supervisors in art therapy supervision. Participants’ uses of art making with supervisees as well as their own experience of using art making in supervision were explored. A mixed methods study, Yoo used the concept of triangulation to understand the relationships between two separate procedures (a survey and interviews). The triangulation concept allowed the researcher to understand
the results from each study tract separately. Yoo sought to understand the meaning of empathy through art making and how the participants approached the empathy experienced using art making in supervision.

Yoo (2011) surveyed 229 professional art therapists, asking them questions pertaining to art making in supervision. Seventy-eight percent of participants used art making as part of supervision with students, and 72% of art therapists used art making in their own supervisory experiences. Fifty-six percent used art making as an assignment outside of supervision. The survey reported significant findings in that 84% of supervisors used art making with students “to deepen supervisees’ understanding about their clients through responsive art” (Yoo, 2011, p. 50). Also noteworthy were that 83% used art to help develop a sense of self-care, and 60% of participants reported that they used it to help students perceive how to use art with clients.

**Educational Requirements and Expertise**

Since art therapists can enter the field from a variety of scenarios with a broad degree of experience in the arts, understanding how other art therapists were trained, the requirements or standards of practice before, during, and after they received their master’s degree was a component of this study. According to the American Art Therapy Association’s (2007) Masters Education Standards, 18 semester hours of art or art studio–based courses are a prerequisite to entering an approved graduate program. Section two of the standards dictates that additional types of training or expertise can be considered and can be or regulated by each approved program:

Equivalency of non-academic studio art experience or art therapy based coursework may be specified in the graduate program’s literature. It is imperative
that the applicant evidence a range of experience using a variety of art materials and processes. (AATA, 2007, p. 2)

There are equal expectations for prerequisites in psychology (18 credit hours). There is no minimum number of arts-based credits required to graduate from an approved program. Students are encouraged to maintain contact with art materials:

- Maintain contact with the discipline of art making. Explore the impact of art processes and materials through ongoing participation in personal art making.
- Strengthen connection to the creative process, understanding of personal symbolic language, and arts based learning allowing for the opportunity to integrate intellectual, emotional, artistic, and interpersonal knowledge. (AATA, 2007, p. 2)

The Canadian Art Therapy Association does not require specific credit hours in studio art as a prerequisite (CATA, 2015). The standard of practice outlines necessary requirements for a master’s degree or diploma in art therapy. Accreditation is structured differently by each province and is based directly on standards of practice detailed by the Canadian Art Therapy Association (CATA, 2015, p. 2). Prospective students may have an undergraduate degree in art, psychology, counseling, or social work. They may also demonstrate how an alternate degree qualifies them for graduate studies by participating in an assessment of learning skills. Prospective students must show evidence of “interest and rudimentary understanding of the creative process in the visual arts. This may be in the form of a portfolio, interview or be ascertained via a clear discretionary process” (CATA, 2015, p. 2). Specific skills are not required but creativity and understanding are essential. The Canadian standards have adopted a post-master’s certificate to prepare clinicians for work as art therapy educators or supervisors. Guidelines for post-
certification are more detailed, requiring a master’s in a licensed profession, meeting course requirements, and acquiring 700 internship hours. No specific number of art or studio course work is required.

Art therapists in the United States are encouraged to maintain a connection to art making once they have graduated from a master’s program and gained their board certification once in practice. AATA (2007) does not have post-master’s requirements in art making. The Art Therapy Credentials Board (2011), a separate entity, only requires accredited art therapists follow the code of ethics and maintain this accreditation by acquiring a minimum of 100 continuing education credits and paying a fee. Board-certified art therapists must earn 10 continuing education credits per 5-year recertification period, participating in educational activities such as art methods or techniques, and 10–20 continuing education credits per 5-year rotation for exhibiting artwork, depending on when recertification is due. By comparison, a minimum of 6 continuing education credits per each year of the 5-year cycle are required for ethics; no minimums are stated for psychological theories and practice, art therapy theories and practice, art therapy assessment, client populations, multicultural competencies, and professional issues.

Details as to what constitutes and defines the identity of art therapist is described by the ATCB on their website, “Art therapists are trained in both art and therapy. The process isn’t an art lesson—it is grounded in the knowledge of human development, psychological theories and counseling techniques” (What is Art Therapy, 2016b). Art therapists do not need to be trained as artists yet some are, however they are required to have enough skill in art to make the process accessible to a variety of clients and situations. Art theory, or more than a foundational understanding of materials and their
usage is not detailed in the general description of an art therapist in the US by AATA or ATCB. AATA is more specific characterizing the art therapists as a professional who facilitate clients utilizing, “…art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem” (What is Art therapy?, 2016). By comparison Art educators specifically teach skills, theories of color, composition and conceptual thinking in order for students to develop the advanced skill set and to earn the right to be called an artist (Black, 2000; Phelan, 1981).

In 2015 Elkons and Deaver reported on the 2013 ATA Membership survey. The survey acted as a census in that it surveys the membership to understand trends within the association. The survey is available to the membership on their website, as are surveys from previous years. Demographics, job title, primary job setting, type of licensure and specializations are reported. The survey was sent by email to nearly 3370 members with 703 responding (p.61). The report compares the 2013 results to previous surveys from 2011, 2009 and 2007. Questions in regard to art making were not reported and raw data or copies of the survey are not available, so it is unknown if there were any questions in regards to art making or the role art making has in the therapy practice. Forty-seven % of participants indicated a job title of ‘Art Therapist’ out of a response rate of 94%. Responses surrounding “primary job title” indicated that 21.3% of participants worked in an “Independent Practice/Office”, 14.8% reported their job setting as “other”, while 10.3% worked in “clinical outpatient mental health” and “hospital, adult inpatient psychiatry” (p. 63). Private practice was not reported because the response rate was less
than 10%. Given that art therapy began in acute mental health care it is surprising that “other” had more responses than the traditional psychiatric setting reported.

**Summary of Literature**

In summary the use of the art making in professional or clinical practice and as a method of personal expression was looked at in order to determine what role art making has and how it is used to by art therapists. It is important to recall that art therapy was born in the sweet spot of history, as the art world became accessible to the common man, moving away from aristocracy, towards representations the growing middle class of consumerism. The purpose of art changed from classic embodiment of society, to more abstracted concepts that included modern, individualistic interpretations and responses to society.

The advent of psychoanalysis and the offspring that developed from it created new understanding of mental health in general, offering ways to look at and treat persons with emotional distress. This brought attention to a small group of women and men, who worked under the radar, using art as a method of treatment, focus and self-discovery in health facilities, to understand and help those afflicted with mental illness. As artists their skills were brought into to help with patients who suffered from incidental traumas such as battle fatigue (now Post Traumatic Stress Disorder) and chronic psychiatric issues that impaired judgment or thinking processes (Hunton, 1949; Junge, 2010; Junge & Wadeson, 2006; Levick 1975; Ulman &Danchinger, 1975).

Psychoanalysis became the foundational philosophy or way of thinking for the field of art therapy. At that time, with an emphasis on uncovering or exposing
what happened to cause symptoms and art making somehow made this process safer, containing the emotion to a page or a form, providing the patient with a means to communicate their suffering (Malchiodi, 2003; McNiff, 1981, 2012; Rubin, 1983). The new field of art therapy organized itself around two main principles, art psychotherapy and experiential therapy done in a studio using process driven manner. Fundamental questions were continuously raised, challenging the purpose of art therapists, their identity and the profession of art therapy as it struggles with accreditation and recognition (Allen, 1992, 2008; Lachman-Chapan, Jones, Sweig, Cohen, Semekoski, & Flemming, 1998; Lachman-Chapan, 2000; Wadeson, 1983, 1985, 2002).

These questions created the need to provide research based evidence validating the art therapy as a unique profession among helpers. Art educators have a rich background in research, developing grounding methods or philosophies of teaching (Cunliffe, 2001, Eisner 2002). Other creative arts therapies have done research, examining the fundamental aspects of practice that authenticates the arts in therapy. In music therapy, Aigin's (2002) work on the multiple aesthetics of music, introduced the idea of a complex, multi-faceted systems, creating validation to the field. Art therapists must continue to research all components of art therapy in order to validate and provide an equal ground for practice, no matter what the orientation. There is no exact method of practice in art therapy, it is not a one size fits all application and varies depending on the therapist’s skill and knowledge and the clients needs.
CHAPTER 3

Method

The study used a mixed methodological approach based on constructivist philosophy in order to explore the position art making holds within art therapy. Creswell (2014) described mixed methodology as the use of both inductive inquiry and deductive analysis in order to understand complex layers of data and the relationship between these layers. This inquiry was approved by the Lesley University Institutional Review Board.

A mixed method design lends itself to the understanding of how the complexities of art are reflected as art therapists prepare for clinical practice, and how elements are represented in their own art-making practices. This type of research structure allows for concurrent and sequential data collection and analysis, providing rigor to the research in the form of organized outcomes and flexibility as a research problem is scrutinized from various levels of understanding (Denzin & Lincoln, 2005). Concurrent processes in this study were documented or mapped out so that content was under a constant state of checks and balances; each data range supported the others and was equally important as analysis unfolded. Two tracts were designed for the identified inquiry here, consisting of an anonymous, online survey and personal individual interviews. Staggering the start of the survey component and the interviews was done so that interviews could be collected, as surveys were completed. Participants who offered to be part of the survey sent an inquiry in groups of ten via email by Blind Carbon Copy. Interviews began approximately two months after the survey was launched and from this point on data was collected concurrently. Survey participants were recruited via flyers, email and word of mouth.
Methodology was key during this data collection, adding a systemic, rigorous analysis of the topic. Art making is a complex process that can involve abstract concepts, several degrees of sequential procedures, symbolic representation, and possibly aesthetic value, all occurring concurrently. It represents various levels of thinking and physical coordination, from cognition and task orientation to the development of emotional expression and conceptual meanings. Through rigorous methodology this study aimed to examine art making as it is used, valued, and understood by art therapists. Understanding the role of art making through my interpretation of the data as the researcher, as well as through the participants’ points of view, brought phenomenological context and understanding to the process of art making. The descriptive data provided a breakdown of data sets and an incremental examination of the relationship the data pools had with one another. Total numbers of participants’ responses were reported. Cross tabulations of data were also used to understand correlations.

**Participants**

Participants were recruited using five methods: (a) a flyer placed on a bulletin board at the annual AATA conference in July of 2015, inviting participation; (b) directly approaching art therapists personally during an AATA conference social hour; (c) a posting on the social media sites Facebook and LinkedIn; (d) word of mouth through local professional organizations; and (e) the snowball method. The snowball method recruited participants through e-mail and social media connections. An e-mail requesting participation was sent to art therapists known to me personally. A link was provided in the e-mail and on social media sites, so that these therapists were able to forward it on to other art therapists they knew; thus, more participant responses were collected as the e-
mail was forwarded, adding to the participant group. (See Appendix A for the recruitment flyer and Appendix B for the recruitment e-mail.)

Criteria for participation in this study were that participants must have had completed their master’s degree or equivalent in art therapy and be a member of an accredited national art therapy governing board. Examples of such governing organizations are the American Art Therapy Association (AATA), The German Art Therapy Association (DGKT), the Australian New Zealand Art Therapy Association, The British Association of Art Therapists (BAAT), and the Canadian Art Therapy Association (CATA). The International Expressive Therapies Association (IEATA) is another example of possible governing organizations. Participants could be retired and/or not working for other reasons. Students were not eligible to participate.

The target number of participants was 745 participants for the online survey (10% of eligible professional art therapists based on AATA membership), and up to 10 participants for the personal interview. A total of 137 survey responses were collected with a completion mean of 75%; a total of 95 participants fully completed the survey. The final question was eliminated because it did not collect data, so the survey was considered finished when 96% of the questions were answered. Forty-eight participants indicated that they were interested in the individual interviews and were contacted by e-mail twice. Four participants returned interview consent forms and were then eligible to be interviewed. Interviews occurred over a period of 3 months. All interview participants were female, over 30 years of age, and actively working in the field. One participant identified as African American, two were Caucasian and one was native North American. One of these participants was from Canada. A fifth participant
was dropped from the interview process because the consent form was not returned to the researcher.

The survey was initially available online for 8 weeks. This was extended an additional 3 weeks to accommodate the process of snowball collection and to allow the survey to reach as many participants as possible. The survey was offered in the summer, so initial responses were slow.

**Procedure**

Data were collected using Qualtrics, a professional online survey platform that is available to students at Lesley University (http://www.qualtrics.com). See Appendix C for details on the survey questions that were used. The form was sent directly to me by Qualtrics upon completion via e-mail and categorized by time zone and IP address.

Individual interviews were conducted either in person or via Skype and varied between 50 and 90 minutes. Interview data were collected through digital voice recordings and transcribed for analysis. Additional data were recorded consisting of personal observations made during the interviews. A field notebook was used to record written observations, quotes, and drawings about the research process and personal thoughts on analysis. Data were kept in a locked file cabinet in my home to assure the safety and anonymity of the participants involved.

Art therapists who participated in the personal interview process were considered co-researchers, in that both the researcher and the participants drove the interview questions. Informed consent was obtained from all individuals who participated in this study in order to protect their anonymity. Consent to record dialogue via a digital voice
recorder was also obtained from participants for use in the individual interviews (see Appendix D).

The personal interviews were semi-structured and open-ended. Each interview went in a slightly different direction based on the dialogue and experiences of the participants. The initial structure was provided by the original survey, with open-ended inquiry into the use of art making in clinical and personal practice, graduate level educational experiences, identity, and the use of art therapy theory and its applications to clinical practice. Attempts were made to cover each of these topics over the course of the interviews; however, due to the flexibility of a participant-driven method, not all areas were covered equally. The impact of learned experiences of art making and how these experiences were used to inform decision making were also points of inquiry. Inquiry into fine art, psychotherapeutic theoretical philosophies and concepts, and multicultural applications of art and art therapy were explored during the some of the interviews.

**Data Analysis**

Analysis of online surveys was completed using the Qualtrics data analysis tools. Correlations and cross tabulations were done to understand the relationship between two or more factors, and to test the significance of such comparisons. The survey included a number of text answers and was rich with data that needed to be sorted and organized in a qualitative manner. In this sense the study had (a) descriptive survey responses, (b) qualitative data from the text answers in the survey, (c) audio data from the interviews in the form of transcripts, and (d) field notebooks and voice recordings that included notes, images, and observations by the researcher.
A rubric was used to organize data from both the individual interviews and text answers in the online survey (see Table 1). The rubric provided guidelines but did not deter from spontaneous and flexible questioning afforded by the phenomenological framework. The rubric also served in organizing the primary themes of data. Additional coding of subthemes was created from the primary group, to sort data. Data were also obtained from the transcribed voice recordings, as well as the information and observations from the field notebook.

Table 1

*Data Rubric*

<table>
<thead>
<tr>
<th>Applications of practice</th>
<th>Art therapy theory</th>
<th>Fine arts theory</th>
<th>Learned experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Area of practice</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate level educational practices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional practices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal practices</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Broad themes were generated from transcripts, field notebooks, and audio recordings and were placed in brackets. Data were reviewed or analyzed continuously so that the generalized themes constantly produced offshoots or detailed aspects of the broader categories. The offshoots represented distilled ideas or codes, drawn from the original bracketed items and constructed new representations of the data (Charmez, 2005). This allowed for the development of categorical layers describing the essence of
the data’s meaning. Each bracket was relatable to the original broad themes but offered new viewpoints or aspects to build on until saturated. Bracketing offers visual and contextual analysis methods so that tracking or mapping the progression or regression of themes can be organized and process-oriented (Holstien & Gubrium, 2005, pp. 507–510).

Subthemes were sorted both categorically and visually, emphasizing importance and relevance through word cloud applications and other graphic depictions of text. A series of word cloud applications helped sort the strength of certain themes in a method that was both numeric and visual. Words that were used the most are represented as largest in the word cloud, decreasing in size to words used only twice. I removed extraneous words such as the, as, a, and other words that make up sentence structure. Items that were mentioned at least twice were included in the word cloud analysis.

**Errors and Disclosures**

Two errors in the structure of the survey were found while the survey was live. Responses about identification labeled “other” were provided for which, when checked, a text box would appear for the participant to provide details. The text box did not appear so the 61 participants that provided details about their alternative identification were not able to write in details. It is unknown how this impacted the study’s understanding of identification.

Second, the survey was complete at 100% and included a final module thanking the participants. Qualtrics automatically generates a thank you module when the very last question is complete. Therefore the additional thank you module provided by me was considered by the program to be a question, and was not completed by some participants.
Participants, who responded to the last question, inviting participation in the personal interview, did not open the final module (thank you) and therefore completed the survey at 96%. This did not affect the data collection.

Additional errors were reported by participants, but not found, although Qualtrics was consulted and the live survey reviewed. Several participants wrote in to report that certain areas of the survey did not allow for multiple responses, even when they were asked to pick “all that apply,” such as in the section labeled “Please indicate any other arts you participate in,” which had to do with artist education and training. The multiple choice errors were investigated while the survey was still live but were not found; the checkboxes in question were found to be working.

Finally, it is important that I disclose that at least two of the personal interview participants were close to me in that they have been friends and/or we have worked together in some capacity. One participant was an acquaintance and has provided professional workshops and presented at conferences that I have attended. The fourth participant and I had never met or had contact prior to the interview.
CHAPTER 4

Results

A total of one hundred and thirty-seven participants responded to the survey. There was a drop out rate of 31%, meaning not all participants completed the entire survey. Some respondents did not answer specific questions. All but three survey questions had response rates of 50% or more. The three questions not responded to were; question ten that provided a space to explain how participants identified as ‘other’ (as previously discussed); question seventeen which was “I do not make art at this time” had a 0% response rate. Number twenty-two, which was a box for participants to provide contact information if they chose to participate in the personal interviews, had a 35% response rate or 48 total responses.

Demographics

Participants in this study included 122 females, five males, one person who selected “other.” Fifteen participants did not complete the demographics section of the survey. Ages of participants ranged from one person under 25 to two participants indicating that they were over 71 years of age (see Figure 1).
Figure 1. Age of Participants

Ethnically 78% ($n = 101$) of participants identified as Caucasian; six identified as Asian or Pacific Islander (4.3%); five (3.6%) identified as Black or African American; five identified as Hispanic or Latino (3.6%); three identified as multiracial (2.1%); five (3.6%) selected the “other” option; and three declined to answer. The participants who selected “other” specified the following ethnicities in the write-in field: Native North American, biracial, Jewish, European Catholic and Slavic, and European. In comparison the 2013 AATA survey of 703 members reported that 87% were Caucasian, .9% were African American, 2.7% were Asia/Pacific Islander, 3.7% were Hispanic or Latino, .7% Native American, 1.7% multiracial and 2.4% other.

Participants were asked to identify their geographic location. Ninety-five of the participants were from the United States, 11 were from Canada, and six were from Europe and surrounding areas, including Belgium, Denmark, the Netherlands, Luxembourg, Scotland, and Slovenia. In addition, one participant was from Thailand and another was from Hong Kong.
Education and Credentialing

The survey asked participants what their highest educational degree was. One hundred and twenty-five participants answered this question. The possible answers provided on the survey were Bachelor of Arts (BA), Bachelor of Fine Arts (BFA), Master of Arts (MA), Master of Science (MS), Master of Fine Art (MFA), Doctor of Philosophy (PhD), and “other.” Participants were trusted to be honest about their survey replies. In response to the highest degree achieved, two participants responded as having a BA only. Given the broad scope of participants who indicated as having achieved either BA or BFA only were eliminated. These responses were filtered out, automatically, ending the survey at this point for the two participants. Credentialing from outside of the United States that was described in any way other than the previous mentioned categories were given the opportunity to answer to “other.” Those participants could continue with the study. Twenty-one participants selected “other,” nine of whom specified the graduate level degree Master of Professional Studies (MPS) as their highest degree. There were 13 PhDs and four participants who reported having a master’s degree in counseling. There was one MFA, 59 MAs, and 29 MS degrees. Several participants responded in greater detail under “other” in order to clarify their degree status in the country or province they lived in, or to include a degree that was in process, such as an All But Dissertation (ABD) status for doctoral studies.

One hundred and seven participants reported their credentialing and applicable licensure. Licensure is generally a regulated credential and is different than credentials provided by member groups or accrediting associations. Credentialing choices were based on the categories set by the Art Therapy Credentials Board, the credentialing
organization in the United States. The category “Other credential or licensure” was provided for participants who live outside the United States or have alternative credentialing from another governing body. A total of forty-five participants responded to ‘Other credentialing or license’. Enough room was provided for an explanation, given the reach of this study. Participants used this field to report on a wide variety of identifiers for credentialing. Several included the names of the credential and governing groups, others were not specific or represented credentialing in process but not yet acquired. This included Canadian Certified Art Therapist, an Advanced Art Therapy Diploma from approved universities in Canada, and a diploma of authority to practice in Belgium. Still others included previous educational degrees, such as MA, PhD or Diploma, in addition to an art therapy degree. One person wrote “none.” In this text box and was excluded.

Forty-four participants also included additional licensure in the “other” field, such as Licensed Social Worker, a terminal license in the state of Illinois for Licensed Clinical Professional Counselor (LCPC), Licensed Marriage and Family Therapist (LMFT), Licensed Addictions Counselor, and a Licensure in Psychology. Participants listed anticipatory licensure for state or other accrediting bodies. Many participants wrote in specific board-certified accreditation or a certification in a specific area of study or specialty. Some of these included a certified hypnotherapist, a Certified Soul Collage provider, several certified alcohol or drug counselors in their states, a certified group specialist, and several board-certified supervisors. Still others indicated that they were soon to achieve a board certification and/or registration hours in art therapy from the Art Therapy Credentials Board; these were not included in the total responses.
Thirty-two participants reported that their credentialing was Art Therapist Registered (ATR), 47 reported that their credentialing was Art Therapist Registered–Board Certified (ATR-BC), and one participant was an Honorary Life Member (HLM) of AATA. HLM is not a credential that indicates professional practice status; however, it is a credential of high regard, given to art therapists who have made a significant contribution to the field. Thirty-two participants reported being a Licensed Professional Counselor (LPC) and 37 participants reported having specific state licensure.

Identity

In the section about art therapist identity, one question contained a flaw in that it did not allow for an explanation of “other.” (Question 8, sub questions a and b of Appendix C, p.96-97). Participants were asked how they identified: as “an art therapist only,” “equally as an artist and art therapist,” or if they identified differently. More than half of respondents (n=63) chose the option “yes”, identified differently, but had no way to provide an answer, leaving a void in the study thus affecting outcomes. Figure 2 illustrates the total number responses provided for the three questions regarding Art Therapists' identity.
A total of 71 participants responded to statements that specified how they identified as a professional artist (who has had formal training in fine arts, in theory, and skill development), or as a self-taught artist (who has had informal education and some classes to develop skills). Nineteen individuals identified as self-taught artists, and 52 identified as professional artists. Sixty-six participants chose not to answer this question. An additional choice of identifying differently than the above was offered, but had no responses. Qualtrics was consulted while the survey was live in order to be sure this portion of the question was working correctly because of the lack of response. (see Figure 3).
The participants were asked if they were ever conflicted in their role as artist or art therapist, and 122 participants responded. Sixty of 122 participants responded “no” that they were not conflicted in their roles as artist \((n=61)\) and art therapist \((n=66)\). Overall there were slight differences between the numbers of participants who responded to this question, for both artist and art therapist. More exploration on the dual relationship of artist and art therapist should be done in order to understand this ambiguity (see Figure 4).

![Figure 3. Artists Identity](image)

Figure 3. Artists Identity

![Figure 4. Role Conflicts](image)

Figure 4. Role Conflicts
Cross Tabulation of Age, Identity, and Conflict

Cross tabulations were done to better understand the relationship between the age of participants, and data from the previous section that looked at art therapist identity, artist identity, and conflicted identity. Associations between age and identification both as an artist and an art therapist were not significant. Relationships between conflicted identity as an art therapist only (Chi Square= 5.93 p< .20) and equally as an art therapist and artist (Chi Square=2.89 p< .58) were not statistically significant. Results regarding age and whether or not participants were conflicted about role conflicts as art therapist (Chi Square=13.79 p-value < .09) and artist (Chi Square=14.28 p-value < .07) were not statistically significant. Table 2 displays the cross tabulation of age, identity and conflicts. Nineteen people responded both “yes” and “no” as to whether or not they had conflict identifying as an artist, while 16 participants reported “sometimes”. More research into how art therapists’ balance and differentiate their roles as artists is warranted.
Table 2

Cross Tabulation of Age, Identity, and Conflict

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>&lt; 25</th>
<th>25–40</th>
<th>41–55</th>
<th>56–70</th>
<th>&gt;71</th>
</tr>
</thead>
<tbody>
<tr>
<td>I identify as an art therapist only</td>
<td>Yes</td>
<td>1</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td>45</td>
<td>28</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>I identify equally as an art therapist and an artist</td>
<td>Yes</td>
<td>0</td>
<td>30</td>
<td>22</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>1</td>
<td>24</td>
<td>16</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>I am sometimes conflicted in my role as an artist</td>
<td>Yes</td>
<td>1</td>
<td>19</td>
<td>9</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td>19</td>
<td>22</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>0</td>
<td>16</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>I am sometimes conflicted in my role as an art therapist</td>
<td>Yes</td>
<td>1</td>
<td>17</td>
<td>7</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
<td>22</td>
<td>21</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>0</td>
<td>15</td>
<td>9</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Theoretical Preferences in Clinical Practice

Theory was divided up into two categories: art therapy theories or concepts and other theories or concepts. Examples were given for each. Participants were asked the frequency with which they use art therapy theories or other theories in practice. Forty-one percent (n = 114 responded) of participants reported that they incorporated art therapy theory or concepts in daily practice “most of the time” and 43 percent responded that they incorporate other theories into daily practice “most of the time” (see Table 3).
In two separate questions, participants were provided the opportunity to write in art therapy theories they use in a text box. Boxes were provided for participants to identify art therapy theories or concepts they incorporate into practice and to write other theories they may use in practice. Responses varied from actual theories to daily practice techniques, material choices, and assessments used for both categories. The results provide insight into what art therapists consider as theories.

Participants wrote in techniques used in therapy, paradigms, pseudo theories, non–art therapy concepts of practice, and/or therapy concepts. “Art as therapy” was written in as a theory and falls in the Experiential Art Therapy realm, so was included in the analysis given the number of responses. There were several acronyms written by participants that represented training as well as tools used: Cognitive Behavioral Therapy (CBT), the Expressive Therapies Continuum (ETC), and the Diagnostic Drawing Series (DDS). Collage, which is a technique often used in art therapy, was written in as a theory, as was sublimation, which is a concept of psychoanalytic theory. The word trauma was written in as a theory, as was the word studio. The names of authors such as Kramer, who is a seminal author within art therapy, and others, such as Lusebrink,
Kwiatkowska, and Rubin, whose work was important to development of the field, were also written in. Still other authors were written in as art therapy theorists who were from related fields like art education and psychology, most notably art educator and seminal author Lowenfeld, who was written in three times.

A word cloud program was used to develop a figure displaying the art therapy theories and concepts reported as being used by the participants (see Figure 5). In a word cloud the larger letters correspond with the most frequent responses, and the smallest letters represent the least frequent responses. There were 68 responses, with some responses having more than one answer included in each text box. In terms of frequency, the most common responses to the question “please name any art therapy theory or concepts that you use in practice” were the ETC ($n = 23$), “art as therapy” ($n = 12$), Gestalt ($n = 8$), Jungian ($n = 7$), psychodynamic ($n = 6$) and CBT ($n = 6$). Interestingly, psychoanalysis was only mentioned three times, as was an important component of psychoanalytic theory, sublimation.

Participants were also asked what other theories or concepts they use in clinical practice. Examples were provided. The total number of theories written in the provided text box included a broad range from psychotherapeutic theories based in analysis and person-centered and humanistic psychology to mind/body work and journal keeping. Several authors of modern theoretical concepts, such as Rogers and Adler, and past foundational authors such as Jung, were written into the text box. Also included were authors of contemporary philosophies of thinking, such as Wilbur. Wellness models were included as an addition to the therapy process, such as the incorporation of Buddhist philosophy, Reiki, shamanistic practices, and “stretching.” Modern concepts in the
treatment of trauma and mood in therapy, such as Eye Movement Desensitization and Reprocessing therapy (EDMR) and Natural Vision Improvement Therapy (NLI) were mentioned, as was “visiotherapy.” A clear definition of art therapy theory may impact future studies given the broad range of answers provided in the text answer (in the previous section).

Figure 5. Word Cloud of Reported Art Therapy Theories

I created another word cloud to illustrate the text answers to the question “please name any other theoretical concepts, from other disciplines, you incorporate into art therapy, using answers that were written in at least twice (see Figure 6). The larger numbers correspond with the most responses and the smallest letters with the least responses. Effort was made to sort out the various acronyms reported in the text box. Several acronyms could not be found during an Internet search or were found but not linked to helping professions or wellness.
CBT was mentioned the most times \((n = 33)\), followed by mindfulness \((n = 19)\), Dialectical Behavior Therapy (DBT; \(n = 17\)), Gestalt \((n = 7)\), and play therapy \((n = 7)\). Jungian theory, positive psychology, and trauma had four mentions each. Person-centered therapy was reported four times, and client-centered had three mentions. Psychoanalysis had a total of three mentions, as did sublimation.

![Word Cloud of Reported Other Theories](image)

**Figure 6. Word Cloud of Reported Other Theories**

**Cross Tabulation of Age and Art Therapy Theory**

The use of theory was cross tabulated to the reported ages of the participants \((N = 114)\) to understand which age group most uses theory in practice (see Table 4). A slight difference in the whole number totals was found for use of theory and the age of the participants. Twenty-one participants ages 25–40 use art therapy theory “most of the time”, while only 9 participants ages 41-55 and ten participants ages 56-70 used theory “most of the time”. Future studies regarding how the use of theory changes as art therapists develop into professionals over the years
This study was designed to understand art therapists’ use of materials to make art in clinical practice. Table 5 provides details on these results. Participants were asked the frequency with which they use both basic and complex levels of materials. Examples were provided. Questions were based on complexity, comfort of introducing supplies to clients, and whether client population or work environment dictated supply use. Not all participants responded to this block of questions. In response to how often they used basic art supplies, a little less than half, or 48% ($n=55$) of participants responded that they use basic supplies “most of the time”. Nearly equal responses were reported for two groups who used more complex materials in clinical practice. Forty-two percent ($n=54$) responded they use complex materials “never,” while 49% ($n=56$) responded “sometimes,” Thirty-two percent ($n=37$) participants reported that they are limited in the

**Table 4**

*Cross Tabulation of Age and Theory Use*

<table>
<thead>
<tr>
<th>Age</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 25</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>25–40</td>
<td>0</td>
<td>3</td>
<td>16</td>
<td>21</td>
<td>11</td>
</tr>
<tr>
<td>41–55</td>
<td>0</td>
<td>1</td>
<td>16</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>56–70</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>&gt; 71</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Art-Making Practice and Training**

**Use of Art in Clinical Practice**
types of supplies due to population or environment. Environment or population was
group together in this survey, future inquiries should be done to determine what
influenced this response more, client population or physical working environment. The
influence of budgeting on clinical practice is unclear. Thirty-seven percent \( (n=42) \) of
participants of this study were “sometimes” impacted, while 29\% \( (n=33) \) were “rarely”
effected by budgeting. It was interesting that 7\% \( (n=8) \) responded “always” for this
question. Participants were also asked whether their personal comfort with a material
influenced their decisions in a clinical setting. Only 1.75\% \( (n=2) \) were “always”
uncomfortable introducing new or complex supplies to clients, while 26\% \( (n=30) \)
reported that they are “sometimes” uncomfortable in this area.

Table 5

*Art Therapists Use of Materials*

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I use basic art supplies and simple processes with clients in my clinical practice.</td>
<td>16</td>
<td>55</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use complex art materials and processes with clients in my clinical practice.</td>
<td>4</td>
<td>30</td>
<td>56</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>I am limited in the supplies that I can use in my practice because of population or environment.</td>
<td>12</td>
<td>29</td>
<td>37</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Budgeting prevents me from expanding to more complex art materials and processes.</td>
<td>11</td>
<td>33</td>
<td>42</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>I am uncomfortable introducing new or complex processes to my clientele.</td>
<td>38</td>
<td>39</td>
<td>30</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>
Use of Art in Personal Practice

**Frequency of use.** The participants were asked several questions about their art training and their personal art making practices, including frequency of use (see Table 6). Questions differed from the previous section in that they asked how often participants engaged in their personal art making. Statements had a frequency scale labeled “never, rarely, sometimes, most of the time, and always.” Sixty-seven participants or 62% chose “never” for the statement, “I do not make art at this time” indicating that the art therapists in this study do engage in art making. Thirty-six percent ($n=41$) of participants reported that the most frequently that they make is several times per month. When asked if they engaged in art making on a daily basis, 33.9% ($n=38$) of participants reported they “sometimes” do, but only 2.6% ($n=3$) of participants chose “always” to best describe daily art making.

The participants were also asked to respond to a statement asking if they were involved with any community organizations, or groups that promote the arts or increasing skills in the arts using the same frequency scale. Thirty-five percent ($n=41$) of participants reported that they “never” or do not belong to a group that meets specifically to make art, while 40% ($n=45$) answered “never” for giving away art to charitable causes. At least some of the participants, 29% ($n=33$) may occasionally participate in exhibiting their artwork.
## Table 6

**Frequency and uses of personal art making**

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I engage in personal art making on a daily basis.</td>
<td>6</td>
<td>31</td>
<td>38</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>I engage in personal art making a few times per week.</td>
<td>8</td>
<td>19</td>
<td>36</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td>I engage in personal art making several times per month</td>
<td>2</td>
<td>13</td>
<td>25</td>
<td>31</td>
<td>41</td>
</tr>
<tr>
<td>I belong to a group that meets and engages in art making (guild, art classes,...)</td>
<td>41</td>
<td>32</td>
<td>28</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>I frequently exhibit my art work.</td>
<td>37</td>
<td>38</td>
<td>33</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>I give away my art work to charitable causes.</td>
<td>45</td>
<td>28</td>
<td>33</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>I do not make art at this time.</td>
<td>67</td>
<td>4</td>
<td>16</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Personal Comfort level with art making.** Participants’ comfort level and frequency of use was explored, as well as how participants approached extending their skills. They were asked to chose a statement that best identified their comfort with materials. Participants who answered these questions \( n = 113 \) reported their frequency and how they engage the community for five statements. Responses can be seen in Table 7. Significance results indicated that participants incorporate other arts modalities in their personal practice “most of the time” \( n = 55 \).
Table 7

*Personal Comfort Level*

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I use basic art supplies and simple processes.</td>
<td>0</td>
<td>3</td>
<td>27</td>
<td>55</td>
<td>28</td>
<td>113</td>
</tr>
<tr>
<td>I incorporate unconventional materials and processes.</td>
<td>6</td>
<td>24</td>
<td>43</td>
<td>28</td>
<td>12</td>
<td>113</td>
</tr>
<tr>
<td>I incorporate other arts.</td>
<td>7</td>
<td>23</td>
<td>50</td>
<td>19</td>
<td>14</td>
<td>113</td>
</tr>
<tr>
<td>I am adventurous in my art making.</td>
<td>1</td>
<td>17</td>
<td>55</td>
<td>25</td>
<td>15</td>
<td>113</td>
</tr>
<tr>
<td>I take classes to facilitate art making.</td>
<td>18</td>
<td>45</td>
<td>43</td>
<td>5</td>
<td>2</td>
<td>113</td>
</tr>
</tbody>
</table>

**Types of personal art making.** Respondents were given multiple-choice answers and were able to choose multiple items from this list. A text box was provided to write in other types of art making. Several participants reported that they could not pick more than one answer. I investigated this while the survey was live and in its early stages, and it is not sure why this error occurred. Thirty-one participants wrote in multiple responses under “other” rather than choose from the multiple-choice answers and while responding reported their frustration. This affected the accuracy of participation and skewed the results. Write-in answers varied from the original choices to creative endeavors that are sometimes not considered art, or are in a “gray” area because of their creative nature. Answers to the question “indicate any other arts you engage in” are presented in Table 8.
I created a word cloud to illustrate common answers for all responses including the response of “other” \((n = 31);\) see Figure 7. Participants were given the opportunity to write in “other” arts modalities they have used. In some cases participants repeated one of the choices provided but added details or expanded upon their choices, thus creating overlap in total responses. For example, a specific type of singing was added in the case of one respondent. The word cloud contains exact for cases where the respondents provided lists of words, I chose to include some of those items separately and some combined; for example, “writing” was provided by many participants in addition to “creative writing.” \textit{CreativeWriting} was put into the word cloud as a unison phrase or word so it could be differentiated from the word \textit{writing}. The cloud contained 112 words; the most common were writing \((n = 11)\) and dancing \((n = 11)\), followed by singing \((n = 5)\), photography \((n = 4)\), poetry \((n = 4)\), and playing an instrument \((n = 3)\). Other answers ranged from digital media exploration, blogging, music, sewing and other types of fiber arts, and being outside in nature. Yoga, Native rituals or ceremonies, and other culturally specific art forms were also written in.

Table 8

\textit{Use of Other Arts Modalities}

<table>
<thead>
<tr>
<th>Answer choices</th>
<th>Response</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative writing, poetry</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>Play a musical instrument</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Singing</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dancing</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Culturally specific art</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td></td>
</tr>
</tbody>
</table>
Cross Tabulation of Theories and Other Arts Modalities

A cross tabulation was done to understand the relationship between the use of theories and the use of other arts modalities (see Table 9), specifically, the relationship between the use of “other” arts modalities in personal practice, the use of art therapy and “other” theories in clinical practice. Participants reported using other arts modalities “sometimes” \((n = 50)\), using other art therapy theories “most of the time” \((n = 41)\) and “sometimes” \((n = 40)\), the use of theories or constructs “most of the time” \((n = 43)\) in greatest numbers. The cross tabulation, although statistically insignificant, did indicate a relationship between these areas. There were 20 participants who reported using “others”
theories in personal practice, while twenty-four participants incorporated “other” arts, while also incorporating “other” theories into clinical practice.

Table 9

*The Use of Theory and Other Arts Modalities*

<table>
<thead>
<tr>
<th>Survey item</th>
<th>Response</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>The incorporation of “other arts” into personal practice</td>
<td>Never</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>2</td>
<td>3</td>
<td>14</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Most of the time</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4</td>
<td>10</td>
<td>34</td>
<td>43</td>
<td>22</td>
</tr>
<tr>
<td>The incorporation of art therapy theories into clinical practice</td>
<td>Never</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Rarely</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
<td>2</td>
<td>5</td>
<td>14</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Most of the time</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Always</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>4</td>
<td>10</td>
<td>35</td>
<td>43</td>
<td>22</td>
</tr>
</tbody>
</table>

**Education and Training**

This study also investigated the type of training or education that participants had received in making art. Bias is always present in research and this inquiry is no exception. Art therapists as indicated earlier have strong opinions in regard to art making and the philosophical basis they practice from. Bias towards the impact training has had about art making was likely here given the passion in which respondents answered the
question. The survey asked participants about their training in several ways. One way was to ask about what types of training the participants had received, such as formal educational training, self-taught, or informal classes. Table 10 shows the results. Categories were: foundational course work in design and fine arts, education that allowed for self-structured programming, course work in art history to inform art-making philosophy, formal focus on fine art skill development, or entirely self-taught. A total of 137 participants responded to this block of statements, with 76 participants reporting that they had strong foundational course work in design and fine arts.

Table 10

<table>
<thead>
<tr>
<th>Training in Art</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundational course work in design and fine arts</td>
<td>76</td>
<td>66%</td>
</tr>
<tr>
<td>Self-structured program</td>
<td>32</td>
<td>28%</td>
</tr>
<tr>
<td>Expansive course work in art history in order to develop art making philosophies</td>
<td>64</td>
<td>56%</td>
</tr>
<tr>
<td>Focus was strictly on the development of skills as a fine artist</td>
<td>23</td>
<td>20%</td>
</tr>
<tr>
<td>Self-taught</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>29%</td>
</tr>
</tbody>
</table>

Thirty-two participants chose to write in answers in the text box provided. The text box was used as a manner of providing the participants with an opportunity to add additional choices or to elaborate on their choices. A word cloud was considered but because the descriptions of arts training were either very vague or so complex and rich, breaking down the words to a specific structure would have taken value from the responses.
Most interesting of these were the number of fine or commercial artists, designers, and art educators who had formal arts training from a previous career \((n = 9)\). Nursing, psychology, and training in anthropology were also written in as a previous career. Three participants went to a specialized high school for performing arts, or continually made or were involved in the arts from high school through graduate programming, but not necessarily course work. Participants reported volunteering for arts events or belonging to community arts centers. Several participants began graduate studies in art education but changed to art therapy. Art therapists in this study reported taking course work in arts to enrich or develop new skills.

**Qualitative Data**

The qualitative process will be described by content area in order to break down the data into detailed areas. Details about the analysis process will be conveyed to display the rigorous method of deduction using visual mapping and webbing techniques. Broad themes that emerged from the analysis process will be discussed by topic. Subthemes and other distinct matters of interest will be built into content areas.

**Participant Interviews**

Forty-eight participants volunteered to be interviewed and were sent consent forms via e-mail. Four responded by returning their preferred contact method (phone or Skype) and a completed interview consent form. In order to maximize the opportunity to be interviewed and give all participants a chance to respond, interview availability was extended by 2 months from the time the survey was distributed, in order to ensure that all participants who provided contact information saw the invitation. This was the only change to the personal interview process. To protect the participants’
anonymity, pseudonyms have been assigned: Ava, Brenda, Carmen, and Dolly. To
further protect the identity of the participants, certain details of these results are reported
using general terms. These sections involve details about cultural information, locations,
specific specialties in art therapy, and specific professional or educational experiences.

Two of the interview participants were Caucasian, one was African
American, and one was Native North American; all were female. All interviewees were
licensed through state or provincial governing bodies as art therapists and/or licensed
professional counselors and had been in the field. Dolly and Carmen were the oldest
participants and had graduated from their art therapy graduate studies in the late 1980s;
Ava and Brenda graduated in the mid ’90s.

Communication took place by telephone or Skype; the goal of the interviews was
to understand how art therapists from this sample approach art making in personal and
professional practice. All interviews were recorded from speakerphone on a digital
recording device. Three interviewees were from the United States and one was from
Canada. The process was fluid and allowed for inquiry into areas of practice, application
of learned experiences, and theoretical constructs that support art making both in personal
and professional practice. Each interview began with the same question, “What is your
role in the art therapy community?” Examples were provided when necessary in order to
clarify what this meant and included roles of an educator or a clinician. After the initial
question each interview process was unique and went in different directions as far as
questions and content.

Ava is a full-time art therapy educator and Carmen had been an art therapy
educator in the past. Three of the participants were supervisors to art therapy interns or
professionals. Three participants worked clinically while simultaneously maintaining other roles. For example, each art therapist did clinical work either in private practice or at a facility while also teaching or presenting at conferences or workshops. Two participants had written books or book chapters about specific areas of art therapy.

Three participants had experience providing art therapy workshops to some degree, at both local and national levels of exposure. Workshops were geared both for professionals and to provide information to the public on how art therapy can help them with a specific topic. One participant provides workshops for both art therapists and non–art therapy clinicians (social workers and licensed counselors) so that they can understand how their role is different than a professional art therapist, and so those professional boundaries are respected.

Themes

Broad themes emerged and each had developmental aspects to them. They were: (a) education and the need to incorporate multiple paradigms of learning to enhance practice, (b) reciprocal learning from the client–therapist relationship, (c) understanding one’s relationship to self and how life experience impact personal and professional practice, (d) the development of personal art making as a vital aspect of art therapist identity, and (e) the studio as an authentic living space. Experience was a factor in how the participants responded.

Education. All four participants discussed graduate educational experiences. Carmen and Dolly reported having attended graduate school in the mid to late 1980s, whereas Ava and Brenda attended in the 1990s at very different types of graduate programs. Some programs were large and well established and some no longer exist.
Ava, Carmen, and Dolly were from the United States and attended schools on the east coast in a similar geographic location. Brenda was from Canada, attended an approved program for postgraduate certification in art therapy, and is a member of the Canadian Art Therapy Association (CATA). Of the participants from the United States, all three live in states that have art therapy–specific licensure and are also licensed as clinical professional counselors (LPC) or the equivalent. The broad theme of education was broken down into subthemes, which included uses of art making during graduate education, the theoretical basis of the educational experience, and how that experience impacted current philosophies or methods of practice.

**Art making during graduate education.** Three participants in this study reported that they had needed to take prerequisite art courses prior to entering their graduate art therapy program. One participant had an undergraduate fine art and dance degree and was admitted to graduate training based on her understanding of the creative process. All four participants described art making in graduate art therapy programming as a technique that was part of course work in order to exemplify the use of materials within the therapeutic context. All four were clear that this experience was about using art to understand the fundamentals of art making uses in the therapy setting. Examples provided by the participants included art for group dynamics, relationships with clients, development, and techniques to develop therapy dynamics. Attention was not necessarily paid to specific art-making skills, although one participant reported that the arts electives she took provided her with skill development and mentoring provided by the art educator, and were a very important part of her art therapy education.
Brenda was the only participant who considered herself to be a formally trained artist prior to becoming an art therapist. Carmen and Dolly had formal education in the arts from prior educational experiences, specifically undergraduate majors in fine art or art education, or beginning graduate work in art education only to change to art therapy. Each of these participants did not think of themselves as artists during their graduate training. Each spoke about their love for art making and being creative throughout their lives. Ava had experience making art without formal instruction in a degree program, but had taken course work to understand the fundamentals of specific skills and as a prerequisite to graduate training in art therapy. Ava had always been involved in art making and creative endeavors prior to, during, and after graduate education but did not consider herself trained as an artist. Her interest in art making has grown since working as an art therapist. The same participant took prerequisite arts course work in order to qualify for her graduate art therapy program.

All four interview participants reported that art making associated with the graduate art therapy experience was presented as a strategy to learn concepts. For example, certain art-making tools or techniques were used to develop and understand the nuances of “group art therapy” course work. Similarly, three participants focused on child art therapy and the various materials that enhance development. Dolly said, “Art was always referred to in the relationship, to what you were learning. So if you were learning about schizophrenia, you know you would be looking at images that would be about that.” Art processes helped exemplify the therapy concepts and philosophies they learned in graduate school.
Dolly also expressed frustration that art was not as important in her program and that it was used as a technique. This directly affected how she used art making in therapy until later in her career, when a personal experience pushed her to make art in order to understand a profound emotional experience. Dolly did not make her own artwork until after she had experienced a painful time in her own life. She said, “I had all that book learning, but I really did not get it until I was deep into my own process.” She said that she did not consider herself as an artist then but does now, and has a better understanding of art therapy because of it.

**Uses of theory in practice.** Participants all recounted learning basic psychological theories and how they could apply them to real life clinical situations. Participants indicated that theory generally included psychoanalysis as a foundational method of working. Art making itself was incorporated into course work, but none of the participants described fine arts theory as part of their training to be an art therapist.

The survey results from this study regarding applications of psychological theory in clinical practice drove this line of questioning, to better understand how the interview participants applied graduate educational theories, if they used outside theories, or if they developed their own. The flow of discussion led to theoretical foundations the participants learned about during their graduate education. All four took theory course work independently of counseling and other similar disciplines. One participant noted that other expressive arts therapist students (e.g., music, dance/movement) took counseling or theory-based courses with the art therapy students.

All four interview participants had taken fundamental course work that included psychoanalysis, Gestalt psychology, and Jungian concepts of learning. The way their
educational programs offered these foundations differed among these four participants. Some courses were specific to a theorist and were one semester long (e.g., one semester of Jungian art therapy), whereas other programs offered “exposure” to several theories in a semester. Brenda stated, “One week it was all neuroscience. Another week it was psychodynamics and psychoanalysis . . . and then it was expressive therapy.” Brenda added that her program offered course work in postmodern philosophy in art therapy, which included introductions to feminist philosophy, studio art, and humanistic therapy orientations. Brenda’s program was a post-master’s certification accredited through CATA.

Of these four participants, those who attended well-established, larger programs had more theoretical exposure than did those from smaller programs. It is important to note that some programs introduced key concepts in the various therapeutic modalities, but in-depth knowledge of theories may not have been discussed. Relying on memory, two participants had difficulty remembering specific details and the depth of what was learned. One participant referred to this as “the basics.” Carmen went to one of the larger, more established programs on the east coast of the United States. She recounted that the program was “predominantly psychoanalytic, because I remember not liking it very much. I understood the rationale for it . . . and we just had to go through it.”

Asking how those theories were applicable to daily practice, all four participants indicated that they needed to seek additional outside sources to make art therapy more applicable to “real life” practice. Each reported different timelines and factors that caused them to look outside their education. Dolly did not practice art therapy when her program was completed because of family responsibilities. She said, “I honestly did not
get it until much later in life and had to look to see who was doing what I needed.” Art therapy was a second career for Brenda and she continues to blend her former career with that of art therapy.

Ava described her frustration with the theoretical models of learning, calling them less and less applicable to the modern healthcare systems and the types of clients who go to therapy compared to the time frame when art therapy was born. Despite in-depth training in psychoanalytic, Jungian, and Gestalt theories, Ava called them “limited,” saying, “I have to say that there [were] a lot of questions in regard to it and particularly the last 12–13 years I’ve really questioned the Eurocentric, myopic view of therapy.” She discussed the need to create accessibility or a system outside the traditional therapy models, saying, “These periods of therapy feel very limited. They don’t explain all the phenomena nor do they make sense to real people’s lives, I’ve found a lot of the time.” She reported that applying theory was not scripted in her clinical practice but that the Expressive Therapies Continuum (Hinz, 2009) may be an application she consciously uses at times. Ava looked outside her educational foundations, adapting social action and later feminist concepts to broaden her practice so that it was accessible to each client in a unique way.

Similarly, Carmen also felt the need to make art therapy more accessible to the urban populations she sought to bring art therapy to after she finished graduate school. She was taught in a traditional manner with exposure to psychoanalysis and Jungian theory but had no exposure to art therapy within the cultural context she sought out. Carmen stated:
We had exposure to some theorists, some ways of incorporating theories into our art therapy practice. But for me it was a question—some of it I found on my own. I felt like psychoanalytic therapy was not relevant to my internship where I was, nor the community that I came from. And I think that had to do with why I was more eclectic, because part of my intention was to intern using art therapy in another way as problem solving for my inner-city population.

Specifically, Carmen mentioned Lucile Venture, an art therapist of African American heritage who worked outside the traditional medical model in urban community-based settings, as an important influence who was not covered in her formal art therapy course work. Carmen stated that she had not known about Venture until after she had been working, despite Venture working in a similar geographic location. Carmen reported searching for art therapists that were people of color like herself, working within an urban, majority African American clientele. Understanding cultural diversity of this type and how to infuse these different applications of art therapy into local and national organizations were important to this participant.

In her clinical work, Carmen indicated that she does not use basic art therapy theories such as analysis because the acute care setting does not lend itself to the process of analysis. Carmen spoke about the frustrations of working in a large acute care facility providing art therapy to very large groups. Supplies are often limited; for example, Carmen recounted that she had 10 watercolor palettes on her cart and often had 15 or more clients in a group. When asked to recount the challenges, she stated:

You can’t even call it therapy. It’s behavior management and it’s frustrating. But this is what we’ve been asked to do. And four groups per day to me seems like
too much because if we’re supposed to be operating to the best of our ability, we really need time to think through the best practices. Have time to look up things and prepare for groups. As it is, you go in with two or three options or themes to work from, because we don’t even have time to figure out what might be relevant for them until we get on the floor.

Carmen continues to look outside her scope of training to develop skills based on other theoretical models, such as Cognitive Behavioral Therapy and Brief Solution Focused Therapies in order to maximize client contact and meet short-term goals.

A profound personal experience changed Dolly’s perception of what therapy was and how art therapy worked. Dolly took what she learned about theory and said that while she had course work studying therapists such as Jung, her outlook on how art therapy works changed. Dolly reported that she focused more on the process of art therapy and what she called, “… the creative path back to the actual healing…” She looked outside the theory she learned, studying loss and bereavement and how it affects families. Dolly created a welcoming atmosphere when meeting both individuals and groups, inviting them to her home studio rather than an office. She does not label clients, does not take insurance, and works within her clients’ emotional and financial means. They come to her based on a common experience and she sees clients in groups and individually and they stay with her until a resolution is met. Of her clients, Dolly said:

They are so traumatized with loss, so [I’m] really trying to give them a tool that they can use on an ongoing basis to ground themselves in the present. . . . What’s here or what are you feeling—let it move through you onto the page.
Her approach also uses feminist principles of engagement in that she has flipped the typical therapy experience, creating an atmosphere of reciprocal learning and expression. Dolly’s own experiences with profound loss caused her to seek out education on the topic, and study of theoretical work outside of art therapy actively and rigorously informs her methods.

**Reciprocal learning in the client–therapist relationship.** All four interview participants have worked hard to build alliances or trust with their clients in order to understand their needs. Understanding how to help in the simplest of terms involved a flexible reciprocal relationship of trust. Transcript data were analyzed several times to extract the meaning of reciprocity and how the participants created this trust. As reported previously, changing or altering orientations to meet the needs of the client was seen as an essential element. Participants letting their clients know that they had no judgment and wanted to understand their perspective on what they needed in therapy was also important. Clinical practices discussed here are the result of a considerable amount of solid experience in the field. Therapists letting clients know that they understand the acuity of the clients’ problems and are open to their cultural, cognitive, and emotional challenges added to the relationship between client and therapist in this inquiry. It is unknown how new graduates would approach clients since none participated in the interview process.

Themes that emerged helped develop other categories or themes. Altering the environment to create a culturally sensitive, egalitarian, and welcoming space was seen as an important component to build feelings of mutuality. Some participants had materials and furnishings in place to meet the specific needs of young children, teenagers,
medically ill clients, and older adults. The space was flexible. This result became an imperative component in the analysis process, such that the living studio space and environmental considerations will be discussed separately.

All participants were conflicted about diagnostic criteria and labeling of clients and did not focus on medically oriented goal setting to base their decisions. Diagnostic criteria and other measures were used to satisfy insurance and/or facility reimbursement needs, but were not necessarily used in terms of how daily goals were met. In some cases art making was reported as secondary to the clients’ immediate needs, particularly in acute care settings (both inpatient and outpatient). Carmen reported needing to sit and wait, providing clients with information and a calm space so that she could build the mutual trust needed to begin therapy. Dolly reflected on this as well, reporting that not all clients are ready to expose their vulnerabilities. Taking away labels, developing a relationship of trust, and being able to adapt to clients’ emotional and cultural acuity were reported as essential.

Brenda, who often works with an Indigenous population, reported that it was imperative to change the pace of activity and conversation to meet the needs of her clients. Brenda explained that fast-paced medical environments are culturally opposed to some Native people and may cause a miscommunication or increase client drop-out rates. She explained:

I would say I really adapt and follow the individual client, so a lot of the time it’s not an issue for me. I am Aboriginal, so I don’t give anything special with my Aboriginal clients other than what I already know and I can just leave it that way. With every client I am very, very slow; I work very, very slowly. So for
Aboriginal people that’s very helpful to them because they are slow to build relationships.

In this case reciprocity is critical to the trust and building of the therapeutic relationship. Similarly, Ava and Carmen reported the need for adaptations based on the needs of the ethnically marginalized populations they work with.

Understanding and adapting to the total circumstance of clients seen in hospitals, clinics, and in private practice was reported as key to being a success as an art therapist. In some cases, in order to understand the economy of means that would best be suited for their clients, these participants sought out theories that informed the ethnic diversity, socioeconomic standing, and specific cultural identities of the people they saw clinically. Participants reported that clients had an array of cultural variance from immigrants to Indigenous populations to upper-middle-class adults and children. Clients varied from racially marginalized urban and rural poor to people with considerable means.

Dolly was the only participant who offered a specific specialty that prompted clients to seek her out. Her own personal experience acted as a welcome to potential clients; she identifies and understands a piece of what they are experiencing. Mutual understanding and a shared trust is the basis of her practice. Clients also have a shared understanding with each other because for the most part they all experienced a similar painful experience.

**Relationship to self and understanding experiences over time.** Personal experience over a span of time impacted all four participants. In three cases, participants referred to experience as exposure to different cultural or ethnic challenges faced by clients; arts experiences they had at community events, workshops, or conferences that
provided education about specific clinical, cultural, or familial issues that they have not personally experienced; and the experience of having a personal connection with a group of people, such as Indigenous peoples or other specific populations.

Dolly was the only participant who disclosed that she had similar personal experiences surrounding loss as did her clients. This past experience guides her work with clients and has informed her work in many ways. Dolly did not always “get” how art therapy worked and used it from the perspective of what she learned in books from graduate training. When asked about the importance of life experiences influencing the way she works, Dolly stated:

Yes, definitely because I didn’t start doing my own artwork until my daughter died . . . and that’s what really informed me. I mean, really, that was my education. I had all that book learning. I really did not get what that was until I was deep into my own process. And then I really understood what art therapy was.

She described how things changed after experiencing a personal trauma and using art, specifically collage, as a way to cope with loss, a method she uses with her clients and when presenting grief workshops to groups.

In a few cases, participants became art therapists to “give back” to a community or group of people. Ava found herself learning about the cultural aspects of the community she is in. Understanding how privilege impacted the community and where she fits into the community were important experiences she strove to be aware of. Environmental immersion and taking the time to understand the unique perspectives of a group over time informed multiple aspects of her various roles in art therapy.
Experience over time became a common theme of each of these participants, with careers spanning more than 30 years. Each of them indicated that how they practice art therapy now is very different than how they practiced at the beginning of their careers. All felt that the importance of making a meaningful connection to clients was imperative, even if they only saw a client for one or two sessions. The space they were in was a component of this connection, as were the materials available. Time and skill development through continuing education, both within the art therapy community as well as learning from outside resources, added to the life experiences of these participants.

Personal art making as an aspect of art therapist identity. All of the participants in the interview portion of this study stated that art making or creative activity was very important to them personally and professionally. The definition of artist and who fills that role came up in conversation with Ava when a question about artist training was asked. Ava identified as a self-taught artist and was involved in art prior to her graduate education. She referred to one’s innate rite or passion to create, saying:

Well, the artists outside of the academy were the ones that brought me into art therapy, partly because I identify heavily with them. I did not go to art school, I did not feel particularly “gifted,” but what I do feel is a kinship and . . . I felt it’s sort of a born rite for everybody to create, to express, to combine, and to make right.
She reported that she currently has a stronger sense of identity as an artist, relating with artists who have an unconventional training, self-taught artists who are outside the hierarchy and privilege of artist training.

Brenda and Carmen both said that making things, creating art, or otherwise participating in expressive arts were very important to them before and after becoming an art therapist. Brenda makes art regularly but her artwork is not necessarily done for the purpose of processing clinical situations. Artwork is done because of the drive she has as an artist and it is how she expresses herself.

**The studio as an authentic living space.** Each participant strove to create a space that lent itself to the emotional and cultural needs of their clients. The participants nurtured the spaces, and in turn the spaces nurtured the clientele, the clinician, and everyone who entered the space. Participants did this in several ways; adapting the environment to alter the perception of an office or changing the lens and orientation of “therapy” based on the environment they had to work in. Carmen’s acute care environment was different than the other participants’ in that she had a cart, not a space or a room to work with. The need to maintain safety superseded the types of materials she had with her. Carmen provided art therapy mainly in a group setting that experienced short lengths of stay, large groups, and a shortage of space.

Ava and Dolly both referred to their space as a sanctuary. When asked if she called her space an office or a studio, Ava was adamant: “It is a studio!” Ava described in detail the variety of supplies she had collected and how they were organized and presented to clients, and described the ritual of cleaning and maintaining the space as a sacred place. She went on to describe the studio space as a spiritual living being; earlier
in the interview she referred to the “third hand” as important to theory and to the environment of the therapeutic art-making experience, stating:

   The sanctuary of the third hand—I feel like it’s a principle I get, very strongly. You know, cell phone off, door locked, no interruptions, and you know the time is predictable. But the idea of the third hand, that there’s sort of an entity in the room with us all, and whatever that needs to be, is very strong as a theory.

   Dolly created a home-based studio for clients who need an intimate, welcoming setting. She only sees clients who are experiencing grief or loss. Dolly described her studio as “magical and calming,” describing the placement of supplies as accessible and readily available to clients. She described quiet spaces for meditation, a large work table, baskets of magazines, and couches to sit on while working. She described the home environment as nurturing and safe, stating, “It is like a scared space. It’s beautiful. I mean people start crying when they come down and see it.” She also takes “everything” on the road with her when she does workshops, sometimes packing 10 boxes of materials depending on the size of the workshop.

   Brenda has a tiny office-like space that she converted to a studio in a room at a community center. Brenda also has developed a ritual of cleaning and maintaining the space so that it is different than other rooms in the facility. She has covered the facility lighting with batik cloth to alter the atmosphere, and plays soft music or nature sounds. Often she involves clients in pre-session stretching or movement as a warm up, so that they can adapt to the space. She indicated that the environment must be welcoming, calm, and have a different pace than the other areas of the facility. In her work with
Indigenous populations, Brenda noted that it was important that the space be relaxed and not medically oriented.

**Summary of Results**

In summary, it is important to acknowledge the data trends that emerged from the survey responses, particularly the text answers, were used as a point of interest when interviewing participants and when establishing trends within the data. Themes that surfaced included education and training, identity, theoretical approaches to practice from within the profession or outside the profession, experience over time, the importance of personal art making, reciprocal or mutual learning, and the living studio. The number of supposed theories listed might indicate the need to be flexible and approach a broad range of clients in clinical practice. It is important to mention the flaws in the electronic survey. Some of these design flaws did not impact the survey or its results. The most notable issue that may have affected the study was the question in which participants had to choose how they identify: as an art therapist only, equally as art therapist and artist, or “I identify differently than the above statements.” A flaw in the survey’s logic meant that answering “I identify differently” did not generate a text box in which participants could elaborate. Half of the participants ($n = 62$) selected this response but could not complete their answers.

Cross tabulations were mostly insignificant, with the exception of answers to the question of whether participants incorporate therapeutic constructs from other disciplines into their daily clinical art therapy practice. Participants who reported incorporating art therapy theory “most of the time” also reported incorporating other theories or constructs. Similarly, interview participants also incorporated outside theories in their clinical
practice. Other theories from outside disciplines that were reported as been used most frequently included mindfulness, DBT, and CBT. Responses regarding what art therapy theory participants used in clinical practice were intriguing. In the text box provided, participants reported “theories” that are not theories at all but rather materials, techniques, concepts that can help guide clinical work such as the ETC were most frequently reported, or ideas that represent core values in art therapy based on foundational material, such as “art as therapy” or “the third hand” (Kramer, 1986). Theories, such as psychoanalysis were only provided by three participants.

Theory was also a topic in the four personal interviews. Participants reported that they needed to reach outside their graduate education to understand other ideas, theories, and constructs that were more applicable to the clients they were helping. Participants also noted that cultural issues surrounding the often marginalized populations that came to therapy or were admitted to the hospital did not fit with foundational theories taught in graduate or postgraduate art therapy programs. Although she did not always work with marginalized people, Dolly sought outside sources in order to understand the grief process for herself and thereafter was able to meet her clients from a different point of view. Ava identified that later in her career she had based much of her practice on feminist principles. Although this was not significant to the other participants, much of what they reported appears to fall within the realm of feminist philosophy.

All participants viewed the environmental necessity of the living studio as vital to their practice and altered their spaces from the typical “office” environment. Dolly had her studio space and provided therapy in her home, which changes the boundaries of the client and therapist. Brenda altered or changed her space from an office to that of a
welcoming, softer space to ensure the comfort of clients. Ava spoke of her studio as a scared space that needed to be nurtured and cared for as if it were a third entity. In her interview she reported that clients do not call the space an office.

Personal experience over time provided pushed each interviewee to search for models or theories of practice that applied to their particular clients. Awareness of experience or an understanding based on events or relationships over a period of time were significant for each of these participants. The interview process created an opportunity for them to reflect and review past experiences. Realization of the vitality of learning their own art processes and how expression works through art making was valuable to the participants.
Chapter 5

Discussion

Summary of Results

This investigation sought to have a better understanding of the relationship that art therapists have with art making both personally and professionally. Art making is a common ground, no matter what viewpoint or how is it used in balance with basic therapeutic principles that guide choices. How art therapists view the mechanism of art in art therapy is important to the future of the field.

Professional art therapists were recruited through personal contacts, flyers posted at a conference and social media sites. A request by this research to ‘pass the link’ acted as snowball, gathering more and more participants. One hundred and thirty seven participants were part of an online survey that asked categorical questions about educational and work experiences, comfort level, the uses of theory in decision-making, and personal, and professional relevance of art as a vital component of vocation. Survey data consisted of descriptive numeric data and transcribed text answers. Cross tabulation of data were done to better understand the relationship between various questions and statements. Survey participants were from the United States, Canada, Europe and Asia. From the survey, forty-eight participants volunteered to be part of individual interviews lasting 50-90 minutes. Four participants were able to meet. The interview format was open-ended but did have a rubric that guided the researchers at times. Results indicate that art is valued within the profession but that art therapists have a difficult time articulating theoretical foundations specific to art therapy. The usage of outside theories
and principles of other creative arts therapies and psychodynamic philosophies of thinking were prevalent in this study.

The study had some structural weaknesses that had to do with survey logic, directly impacting a question on art therapist identity (As seen in Appendix C, question 8 through 8b). Sixty-one participants answered that they identified differently than being an art therapist only, or equally an art therapist and artist. The survey was completed at 96%, eliminating non-data gathering questions or statements. Researcher bias may have played a role within the personal interviews in particular, as the researcher’s training was to become a professional artist and thus has a strong sense of identity as an artist.

**Constructing a New View of Art Therapy**

Historically art therapy came together in the United States from various parts of the country individuals from the Mid West, West Coast, and Eastern parts of the country meeting to merge their shared experience of using art to heal and help individuals and groups in hospitals (Junge, 2010; Wix, 2003, 2010). When Mary Huntoon began working with soldiers at the Menninger Clinic in the late 1940’s, helping them to use art to understand the trauma of combat fatigue, one could hardly imagine that art therapy would be what it is today (Huntoon, 1948; Wix, 2000). Art Therapy continues to hold a place in inpatient mental health care facilities. It has also moved beyond the borders of the private mental health hospital, to both short-term inpatient and outpatient behavioral health treatment and the multitude of settings this takes place in. The post-modern uses of Art therapy includes work in cancer care and other disease specific clinics, to classrooms, in prisons, homeless shelters, groups for loss and bereavement, and in private practice. These changes included the infusion of alternative theoretical applications
outside of medicine and behavioral health, such as the use of art therapy within studios, with mindfulness and meditation.

The constructivist philosophy that provided the foundation for this inquiry, investigating the subject of art making in art therapy, allowed the researcher to build ideas from the data. Research about the phenomena of art making in art therapy seems like it would be a given, in that it’s presence is the principle difference between art therapy and other helping professions. In a world that values hard science and evidence based outcomes, art making itself is hard to quantify; requires some skill level, whose process is flexible, ambiguous, at times conceptual, is created subjectively and its meaning viewed differently by each casual observer (Dewey, 1934; Eisner, 2002; Langar, 1953, 1957). Research exists about the applications of certain techniques to elicit behaviors, understand diagnostic properties of drawing elements, or the use of material processes as tools to understand content and functioning level (Gnatt & Tabone, 2012; Hinz, 2009; Lusebrink, 1992). Other research, such as appraisals of programs and their effectiveness with certain clients (Cahn, 2000; Thompson, 2009) have been done along with the use of experiential applications of the arts in studio or as activism (Allen, Block, Harris & Laing 2011; Henley, 1995; Howells & Zelnick, 2009). This certainly is a place to begin to understand how art therapy works or does not work and may add support in developing theories specific to art therapy.

Recognizing the how art therapy works has been an on going question, as have the question of what skills define who an art therapist is as an exclusive professional. Parent organizations and accrediting bodies provide educational standards and ethical principles that guide professionals, codifying the array of experiences and
certainly begin to establish a semblance of identity. Identity has always been a question for art therapists who seem struggle with weighing the artist versus the therapist in them (Allen, 1992; Deaver & Lincoln, 2005; Elkis-Abuhoff, Gaydos, Rose, & Goldblatt, 2010; Feen-Calligan, 2012; Malis, 2014). The term ‘versus’ is a contrasting preposition, as if one part of the art therapists’ identity outweighs the other. Likely, it is the equal footing of artist and therapist, whose skill and knowledge of art making, combined with an equal understanding of psychotherapeutic principles that establish the basis for such a profession. Comprehending how art making adds to the uniqueness of this profession whose foundations credits a synthesis of psychoanalysis used with art, to seek a common goal of meaningful healing would be notable if not invaluable to those who practice it. Understanding the how and why something works can help ground the future of the profession.

Survey results in regard to identity were flawed due to the failed survey logic, leaving a large questioning gap of information. Further research to clarify the meaning of these specific terms in reference to identity—artist, art therapist and ‘other’ related designations—would provide art therapists a better understanding of their role within the profession and its future in an ever changing health care environment. Polarizing language between the specific philosophies that have helped develop art therapy into contemporary practice, distract from questions that can build or solidify just who art therapists are (Feen-Calligan, 2012; Junge, 2010; Junge & Wadeson, 2006; Wadeson, 1985, 2002). In this recent study, participants were evenly split between ‘yes’ and ‘no’, indicating that ‘yes’ ($n=62$) and ‘no’ ($n=63$), they identified differently than either an art therapist, or equally as an artist and art therapist. If therapists who are art therapists
identify differently, what else is different in regards to practice methods and the theoretical philosophies that help them make decisions? Understanding how those art therapists identified and why they might have chosen to identify differently, would help the profession, governing bodies and educators be aware of the diversity of today’s art therapy membership.

The literature about art therapy indicates strong roots in psychoanalysis and the artist as a therapist, nourished by members who, as the field grew, questioned the essence of that identity (Barlow, 1987; Jones, 1983; Kramer, 1986; Langarten, 1981; Levick, 1995; McNiff, 1981; Wadeson, 1980, 1983, 1985). Members developed new ways to look at therapeutic applications of art making in the healing context, and shared these thoughts with colleagues at conferences, in journals and in books, so that art therapy would stay applicable and accessible to different types of clients (Allen, 1992, 1995, 2008; Cahn, 2000; Coholic, 2011; Franklin, 2008; Henley, 1995; Hinz, 2009; Kapitan & Newhouse, 2000; Lusebrink, 1995, 2010; Nolan, 2013; Moon, B., 2009, 2012; Moon, C., 2010; Wadeson, 2002). The results here showed that only 3 art therapists out of 125 wrote in psychoanalysis as a theory they use.

Early art therapists were often professional artists who found work providing art to patients in mental health facilities in order to add an expressive avenue adjacent to treatment, or to provide a sense of purpose and vocation to those who suffered from debilitating mental illness (Barlow, 1987; Kramer, 1986, 1993; Levick; 1995; Jones; 1983; McNiff, 1981; Robbins, 1999; Wadeson, 1983, 1985, 2003). Art therapy in the twenty-first century is a world wide, established profession, a field that has credentialing bodies with practice guidelines (Art Therapy Credentials Board, 2011), ethical standards
and guidelines for practice (American Art Therapy Association, 2013; Canadian Art Therapy Association, 2015), and educational standards for a growing number of art therapy graduate programs. To be an art therapist does not require identifying as a professional artist, nor does one need to have the skill level of a professional artist. Basic skills, specific course work and a desire to explore creative options are all that is required (American Art therapy Association, 2007).

Countless books have been written about art therapy, it’s core philosophical basis in psychoanalysis (Langarten, 1981; McNiff, 1081; Rubin, 2011; Wadeson, 1980, 2002), historic documentation of its development (Junge, 2010; Junge & Wadeson, 2006) and postmodern dynamics of art in therapy (Kapitan & Newhouse, 2000). Books range in understanding from “how to” use techniques, to the integration of advanced applications of techniques or media applications incorporated with philosophies of art, community and social justice.

The manner in which an art therapist utilizes, values, makes decisions about and understands art making is not typically studied. The literature suggested at least two different orientations or leanings in how art therapists provide therapy. Historically those are art making in conjunction with psychotherapy and experiential uses of art making in therapy (Allen, 2013; Goebles, 1984; Junge & Wadeson, 2006; Junge, 2010; Kramer, 1986; McNiff, 1981; B. Moon, 2009, 2012; Ulman & Dachinger, 1975; Wadeson, 2001). Therapists are required to understand how to use a variety of tools or methods and understand the theoretical groundwork from which the implements came from. In graduate education counselors and therapists learn early on that being a clinician is not
based on intuition or what feels right, but rather about how one applies what one has learned to real-life clinical situations (Egan, 2014; Wedding & Orsini, 2014).

The agency or work of art therapist is not only their understanding of the psychotherapeutic means of healing; it also requires a clear understanding of art making, regardless of their orientation (experientially process-oriented or art psychotherapy). Art therapists therefore must understand what grounds these aspects of art therapy come from, in order to inform their practice. Art making within the context of art therapy needs to be more than intuitive, or based on particular skills—it must be part of a theoretical source of some type. Does this mean art therapists need to understand the philosophical usage of art or fine arts pedagogy? Fine artists learn a variety of theories that support skill development surrounding properties of color, design, and field of vision (which includes negative space), conceptual formation and symbolic representation, as well as design theory (Arnheim, 1974, 1988). The literary findings here discussed a sometimes-polarizing perspective, with art therapists continuously trying to understand who were when the profession began and where the future lies. Theoretical foundations inform role identification and are important to how the profession is viewed from within and as it is viewed by those outside the range of training and expertise. Having theories based in research driven inquiry can only establish a solid future for art therapists.

Results indicated that participants in the survey portion of this study had difficulty articulating and defining theories exclusive to art therapy, specifically what philosophical foundations they use in their clinical practice. Outside theories from counseling or psychology were reported both as art therapy theories and as “other” theories. In some ways the participants were very clear and concise when providing outside theories that
they incorporate into practice. Descriptions of art therapy theories were broad and not as clear.

Theories specific to art therapy were presented by survey participants tentatively, providing broad or non-determined methods, with participants writing more than the space would allow at times to describe how they worked, with only a few respondents adding what frameworks or constructs they work within. The topic was important yielding lots of data, but the answers were far from direct. The list was expansive and included a tangle of different ideas, techniques, methods of practice, aspects of other theories (e.g., sublimation), and speculative ideas. Fine arts theory as a way to inform practice was not reported in either the survey or the personal interviews. Some of the statements provided in the text box could be grounds for some type of theoretical work in art therapy.

Theoretical education in art therapy varies in presentation. A minimum of 24 credit hours of “art therapy content” (AATA, 2007, p. 3) is required for students to complete a graduate art therapy program in the United States. Art therapists in this study appeared to develop a framework of practice methods and skill-based techniques to elicit certain responses from their clients.

Does this mean that art therapists do not know or understand theory? Or that art therapy education is missing a key component? Indications are that participants in this study use a range of outside theories, incorporating them into practice. Often participants indicated “adding” outside theory to art making procedures or techniques. The premise of theory is to gather evidence that supports an idea or explanation of something. Art therapists need to be able to explain not only what the competencies of practice are but
also the basis that supports it. In the personal interviews reported here, participants reported going to outside theories to best meet the needs of clients because there was a disconnect with regards to what they were taught in graduate school. Marginalized populations seen by some of the participants required a change in hierarchical relationship to the client. Articulating how things are done (e.g., techniques and materials used) was not an issue for participants throughout the entire study. However, explanations of how they make decisions based on theory were significantly vague.

Psychoanalysis has historically been the principle orientation of art therapy and has had direct impact on how the role of art in art therapy developed many years ago. Analysis as looked at through the eyes of the art therapist has meant understanding how art making helps clients build ego strength, peeling back layers while using the safety of visual representation to articulate the core basis of illness. In a personal communication with Myra Levick (July 19, 2015), one of AATA’s founders and a noted author and researcher in the field, without psychoanalysis art therapy would not exist. Psychiatrists of the 1940s looked outside the scientific realm in order to treat seriously ill clients. Hospitals and doctors turned to artists and their unique skills to help patients (Huntoon, 1949; Jones, 1983; Junge, 2010; Junge and Wadeson, 2006; Kramer, 1986; M. Levick, personal communication, July 19, 2015; McNiff, 1981; Ulman & Dachinger, 1975). In the survey data, in response to participants being asked for specific theoretical applications of practice, psychoanalysis was written three times.

Interview participants in the interviews recounted learning about psychoanalysis and being introduced to its progenies (Jungian, Gestalt, Adlerian theories, as well as some modern theories of counseling, and practice methods or concepts such as the ETC and
Art As Therapy), but they all expressed that it was not necessarily used in their current practice. The participants reported that they did not necessarily apply those theoretical constructs to daily practice in order to be accessible to clients and the practice environment, or to adapt to a cultural diverse clientele. These art therapists used other types of theories or concepts to make at therapy more suitable to their clients no matter what the setting. Interview data revealed that several theoretical approaches of psychological helping were experienced in participant’s art therapy graduate education, but at differing depths and frequencies.

The way the interview participants reported working in day-to-day practice had parallels to feminist theory and principles of practice, but recognition of this was only reported by one interviewee, Ava. If the participants here, had been provided with a framework of practice that was able to reach out to a broader group of clientele, would art therapists have a better understanding of theoretical orientations? Feminist theory is not new to the creative arts therapies (Hahna, 2013; Hahna & Schwantes, 2011; Halifax & Davis, 1997). Hahna (2013) wrote about incorporating feminist theory into creative arts education in order to increase social awareness, reflexivity, and to equalize the relationship between professor and student. In this study, interview participants all were in agreement that theoretical approaches in practice needed to be altered to better meet the needs of the client. Feminist literature and models within the psychoanalysis and counseling professions is not new, but does appear to struggle at maintaining equal footage with the medical model (Wesley, 1975; Young-Bruehl, 1994).

Feminist principles hypothesize a change from the standard methods of presenting, carrying out, and providing therapy (Hahna, 2013; Halifax & Davis, 1997;
Humble, Morgaine, 2002). It means changing the balance of power in the therapy relationship, allowing the therapists and client to be on the same level. Medical models typically contain a hierarchy of care with the “expert” being the final decision maker in the wellness process. Infusing cultural competencies and understanding of their clients directly from the client’s point of view made the interview participants more accessible to a variety of people. Feminist theory looks at social relationships differently. Therapists or counselors in feminist applications step down from the “expert” role and create an increased reciprocal relationship, with special attention to the multiethnic values of prospective clientele—as three of the interview participants did. Carmen was the only participant who worked within an acute care facility and was deeply embedded within the medical model and the hierarchy of care. Her frustrations expressed her desire to alter how she presents wellness to very ill clients so that she can have more impact and practice “real” therapy.

These aspects of feminism, social action, and multicultural advances in art therapy are not new. Approaches requiring acknowledgement of social issues and employing an egalitarian understanding of the social, ethnic, and economic realities clients face provides a new framework within which to work (Talwar, Iyer, & Doby-Copeland, 2004). Clearly theories of practice art therapists use and define as essential should be considered as a topic of future research.

Art therapists continue to look at other disciplines to help develop a sense of identity, to guide and structure their education, credentialing, and appeals for state licensure. Art therapists have beseeched their peers, writing about the need to reach into the future of the field for models of philosophies and research in order to have a firm
grasp on what exactly we do and who we are as opposed to other counselors and psychotherapists. Changes to standards of education directly impact practice in art therapy, emphasizing counseling as a structure for art therapists in professional practice. Overemphasis on counseling competencies and little focus on standards for art in practice make this a lopsided situation. More study about what art therapists understand about foundational constructs of both is needed in order to make educational and professional practice recommendations.

**Researcher Bias, Disclosures, and Limitations**

Bias is a component in any research. In developing this study it became apparent that there were some obvious biases that impacted the outcome(s). I was trained as a fine artist at the Cleveland Institute of Art; completing the 5-year fine arts education program designed to train professional, working artists. A bias toward the use of a broad spectrum of materials in art therapy was strongly influenced by my artist’s education. Developing the ability to communicate using art materials was essential to the development of my work as an artist and practice as an art therapist. My visual processing of text answers within the surveys propelled the analysis; words and the meaning behind them gave the research context in the visual and conceptual worlds of art therapy and fine art.

In addition, I am an adjunct art therapy educator, and I issued invitations to participate in research to colleagues who were art therapy educators. As a result two participants in the personal interviews identified themselves as past or present art therapy educators. All four interviewees provide workshops and educational opportunities about their area of expertise in art therapy. This may have resulted in the possibility of bias in
the reporting of personal interviews with regards to theoretical knowledge and understanding of graduate education requirements.

This research study has limitations in the application of the findings. Target participation for the survey was 10% of eligible art therapists based on AATA membership. Considering that 137 participants took the survey and only 95 fully completed it, the target was not reached so the sample and the findings cannot be applied to a general population of art therapists. Interview expectations were met in that up to ten participants were expected for the personal interviews. Forty-eight responded, volunteering to participate, 5 followed up, but only 4 returned consents and were included. Other limitations include the flawed survey logic and general construction of the survey.

**Implications for the Field of Art Therapy**

The research discussed here was intended to comprehend how art therapists experience and understand art making as an exclusive mechanism that acts as an agent of change in the therapy relationship. Putting into words what depicts the essence of the field is challenging. It is the art in art therapy that gives purpose and vision to those who call themselves art therapists.

Edith Kramer (1986) referred to the art and the making of art as the “Third Hand” indicating it’s presence was more than a component in art therapy, it was is like an additional being to the client and the therapist. Indeed the interviews conducted for this research yielded similar thoughts about the place that held the relationship when discussing the studio as a living space, often describing the art and the presence of materials, in this atmosphere of art making as magical. The phrase “art as therapy” and
“ETC” (Expressive therapies Continuum), both seemingly materials based concepts, were reported here as important theoretical foundations for the art therapists who participated. It may sound mysterious to those outside the field who have different expectations or perceptions of art therapy based on it’s traditional use in psychiatric care, as an adjunct to psychotherapy, strongly rooted in psychoanalytic theory (Levick, 1995, Vick, & Sexton-Radek, 2008).

Art making is important to art therapists, helping define them as unique in a vast array of helping professionals. Why we use it appears to be difficult to articulate, as are the theoretical influences that ground art making as it is applied to art therapy. The dueling paradigms indicated in the literature were not evident here, but the numbers reported only represented 4% of art therapists of the 3,370 AATA sent surveys to (Elkins & Deaver, 2015). This does not count art therapists living outside of the United States who participated in this inquiry. If art making is what makes us unique, art therapists must work to define what they practice so that it is more than intuitive. Defining ourselves is complex; art therapists apply art therapy broadly in order to be accessible to potential clients and situations. Describing ones work as one specific method (clinically, community, studio or medically) does not demote or marginalize others in the field who may practice from a different perspective, it makes art therapy expansive. These differences should be studied and defined in an inclusive manner, strengthening that third entity in the process—the art.

While this inquiry is not generalizable to the entire population of art therapists, findings indicated that art therapists reach far beyond their education, incorporating philosophies and concept of grounded, outside theories. The application other theoretical
orientations based in psychotherapy, counseling and or other specialties allow art making to take place under new structures reaching far beyond the hierarchy of the medical model as described by Levick (personal Communication, 2015). The understanding of art making as the third entity in the therapy relationship, as described by Kramer (1986) points to a system of working rather than just imposing shared knowledge of skills to clients. Art therapy itself if viewed in a system becomes an amalgamate of three sister components (psychotherapy, art making and the therapeutic relationship) resulting in it is it’s own unique thing.

What does this mean for the profession? Is it important to understand why we need art making and how it works in art therapy? Further study is needed to clarify and define the identities of both the therapist and the artist, describing what grounds the blending of such titles to make an art therapist. In Elkins and Deaver (2015) reported that only 10.3% of the 703 AATA survey respondents surveyed, indicated they worked in what may be considered the traditional psychiatric settings. Early art therapists most often worked in these types of settings with methods based in psychoanalysis. Work setting was not asked about in the present study, however findings reported here in both the qualitative and quantitative tracts of inquiry, participants indicated that they make art therapy accessible to their clients.

A clear understanding of how art is used in art therapy is more than conceptual, more than taking classes to broaden a repertoire of skills, it involves a securing evidence that the blended theories secure a artifacts of the past, leading art therapy into the future. Blending two colors can create a swirling effect, until when well mixed when they
become one color that stand out from its parents. Art therapy needs to understand where it came from in order to understand itself.
Appendix A

RECRUITMENT FLYER
PARTICIPANTS NEEDED FOR
DOCTORAL STUDY

TOPIC: THE USE OF ART MAKING IN ART THERAPY

PLEASE USE THE FOLLOWING LINK TO PARTICIPATE

https://lesley.co1.qualtrics.com/SE/?SID=SV_cYhn2PFUSe5AtuJ

THIS STUDY HAS BEEN APPROVED BY THE LESLEY UNIVERSITY INTERNAL REVIEW BOARD

Researcher
Mary Ellen Hluska,
Doctoral Candidate,
Graduate School of Arts and Social Sciences,
Division of Expressive Therapies, Lesley University
Cambridge, MA
For more information, please contact me at,
(410) 599-5028, mhluska@lesley.edu

Faculty Supervisor
Michele Forinash
Lesley University,
Graduate School of Arts and Social Sciences
(617) 868-9600, forinism@lesley.edu
Hello friends and fellow Art Therapists,

I am emailing to you to ask if you would kindly participate in a survey I am doing as part of my doctoral studies in Expressive Therapies at Lesley University. The Lesley University Institutional Review Board (IRB) has approved this study.

My research study asks what role art making has in art therapy as it is used by art therapists both in clinical practice and personal practice.

I am recruiting art therapists who have at least a Master’s level, or equivalent, in art therapy to participate. I am trying to recruit as many art therapists as possible so I ask that you pass this email on to as many art therapists as possible. Professional art therapists from all over the world may participate.

The study has an initial online survey component and also has the opportunity for you to participate in personal, individual interviews. For more information, please access the Informed consent and instructions by following the following link,

https://lesley.co1.qualtrics.com/SE/?SID=SV_cYhn2PFUse5AtuJ

If you have any questions that I can answer please contact me and I will be happy to answer them. Please contact me at

mhluska@lesley.edu
(410) 599-5028

Thank you for your time and interest.

Sincerely

Mary Ellen Hluska, MA, ATR-BC
Licensed Clinical Professional Art Therapist
ABD, PhD Candidate, Lesley University
Maryland, USA
APPENDIX C

SURVEY QUESTIONS
The Use of Art Making in Art Therapy

1. Thank you for your interest in an online study to assist in doctoral research on the role of art making in art therapy. The purpose of the survey is to explore the role of art making both in your clinical practice/work environment and in your personal practice. The Lesley University Institutional Review Board (IRB) has approved this study. For more information or for additional information you may contact the researcher, Mary Ellen Hluska, by email mhluska@lesley.edu. You can contact the Principle Investigator’s advisor Dr. Michele Forinash at (617) 868-9600, 29 Everett St., Cambridge, MA, 02138, with any additional questions. By participating in this study you understand that: This online survey is anonymous. Your participation will take up to 25 minutes of your time. You may choose to withdraw from this study at anytime. You can withdraw by simply closing your browser window. At the end of this survey you will be given a chance to express interest in participating in the individual interview portion of this study. A link to a confidential contact form and instructions will be provided. By selecting “yes” below, you have read the above and consent to be part of this research study on the role of art making in art therapy.

☐ Yes I would like to participate (1)
☐ No I do not want to participate (2)

If No I do not to participate Is Selected, Then Skip To End of Survey

2. Please write your location. Include your state, province or territory and country.

3. Please indicate your gender.
☐ Male (1)
☐ Female (2)
☐ Other (3)

4. Please identify your ethnicity.
☐ Asian or Pacific Islander (1)
☐ Black or African American (2)
☐ Hispanic or Latino (3)
☐ Native American (4)
☐ White or Caucasian (5)
☐ Multiracial (6)
☐ Other (7) ____________________
☐ Decline to answer (8)
5. Please indicate which best describes your age.
- Under 25 (1)
- 25-40 (2)
- 41-55 (3)
- 56-70 (4)
- 71 or older (5)

6. Please indicate your highest level of education you have completed.
- BA (1)
- BFA (2)
- MA (3)
- MS (4)
- MFA (5)
- PhD (6)
- Other. Please explain (7) __________________

7. Please indicate your level of credentialing (check all that apply).
- ATR (1)
- ART-BC (2)
- HLM (Honorary Life Member) (3)
- LPC (Licensed Professional Counselor) (4)
- State Art Therapy Licensure (5)
- Other credential or Licensure. Please explain. (6) __________________

8. Please read each choice carefully and choose “yes” or “no.”

<table>
<thead>
<tr>
<th>Choice</th>
<th>Yes (5)</th>
<th>No (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I identify as an art therapist only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I identify equally as an art therapist and an artist (self taught or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>professional).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I identify differently than the above statements.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If “yes” is selected in response to “I identify equally as an art therapist and an artist (self taught or professional)” in Question 8, then:

8a. Please choose one of the following two choices that best describes your artist identity.
- I identify as a self taught artist (informal education, self exploration or some classes to develop skills and interests). (1)
- I identify as a professional artist (formal educational training in arts theory, and skill development leading to formal professional identity). (2)
If “yes” is selected in response to “I identify differently than the above statements” in Question 8, then:

8b. Please explain how you identify differently than the choices provided.

9. I am sometimes conflicted in my role as an artist.
   - Yes (1)
   - No (2)
   - Sometimes (3)

10. I am sometimes conflicted in my role as an art therapist.
    - Yes (1)
    - No (2)
    - Sometimes (3)

11. The following statements apply to your use of art making in your clinical or professional context. Please select an answer from the drop down box that best represents your experience.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never (1)</th>
<th>Rarely (2)</th>
<th>Sometimes (3)</th>
<th>Most of the Time (4)</th>
<th>Always (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I incorporate art therapy theory or concepts into daily practice.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>For example, the Expressive Therapies Continuum (ETC).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I incorporate therapeutic constructs from other disciplines into my daily clinical art therapy practice. For example, Dialectical Behavior Therapy.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use basic art supplies and simple processes with clients in my clinical practice (some examples are, chalks, pencil, crayons, water colors, clay)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>(3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use complex art materials and processes with clients in my clinical practice (some examples are, plaster, print making, found objects, sewing).</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>(4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am limited in the supplies that I can use in my practice because of population or environment.</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
12. Please name any art therapy theory or concepts that you use in practice.

13. Please name any other theoretical concepts, from other disciplines, you incorporate into art therapy.

14. The following statements apply to your use of art making in your personal life. Please select an answer from the drop down box that best represents your experience.

<table>
<thead>
<tr>
<th></th>
<th>Never (1)</th>
<th>Rarely (2)</th>
<th>Sometimes (3)</th>
<th>Most of the Time (4)</th>
<th>Always (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I engage in personal art making on a daily basis. (1)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I engage in personal art making a few times per week. (2)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I engage in personal art making several times per month. (3)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I belong to a group that meets and engages in art making (guild, art classes, etc.) (4)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I frequently exhibit my art work. (5)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I give away my art work to charitable causes. (6)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>I do not make art at this time. (7)</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

If “always” is selected in response to “I do not make art at this time,” in Question 14, then:

15. I do not make art at this time. Please explain in the box below.

16. The following statements apply to your use of art making in your personal life. Please select an answer from the drop down box that best answers your experiences.

<table>
<thead>
<tr>
<th></th>
<th>Never (1)</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most of the Time</th>
<th>Always</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>(2)</th>
<th>(3)</th>
<th>the Time</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I use basic art supplies and simple processes in my own art making practice (examples are, paints, charcoal, pencils, sketchbooks). (1)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I incorporate unconventional materials and processes, such as crafts into my art making practices (examples are beading, fabrics and/or sewing, ceramics, welding, printmaking, weaving). (2)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I incorporate other arts (writing, music, movement) into my art making practices. (3)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I am adventurous and like to explore new fine arts materials and processes in my art making. (4)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I take classes to facilitate art making. (5)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

17. Please explain the type of art making training you had. Click all that apply.

- My arts education had strong foundational coursework in design and fine arts. (1)
- My college or university was a self-structured program. I was able to design the major around my interests. (2)
- My arts education allowed me to expand my knowledge of art history and apply it to my art making philosophies. (3)
- My arts education focused strictly on the development of my skills as a fine artist. (4)
- My arts education was entirely self taught. (5)
- Other (6) ____________________
18. Indicate any other arts you engage in. Please check all that apply.
☐ Creative writing, poetry (1)
☐ Play a musical instrument (2)
☐ Singing (3)
☐ Dancing (4)
☐ Culturally specific art making (for example Pysanka or Ukrainian egg decorating) (5)
☐ Other (6) ____________________

19. You now have the option to participate in an individual interview will be conducted over the telephone or through Skype. Please check yes if you are interested in participating in an individual interview. You will be contacted via email to make arrangements for the interview. Thank you.
☐ Yes (1)
☐ No (2)

If “yes” is selected in response to Question 19, then:

20. Your contact information (optional, but necessary if you selected “Yes” above).
   First name (1)
   Last name (2)
   Email address (3)
   Re-enter email address (4)
   Area or country code and telephone number (5)

21. You have reached the end of this survey. THANK YOU FOR YOUR TIME.
APPENDIX D

INFORMED CONSENT FORM
Informed Consent Form:
The Role of Art Making in Art Therapy: In Practice and As Practice

Principal Investigator: Mary Ellen Hluska (co-researcher, Michele Forinash), PhD program in Expressive Therapies, Lesley University

You are being asked to volunteer in this study to assist in doctoral research on the role of art making in art therapy. The purpose of the study is to explore the role of art making both in your clinical practice/work environment and in your personal practice.

You will be asked basic demographic and background questions as well as general questions about your work environment, art therapy influences, and the philosophies of art therapy you espouse.

The interview may take up to 60 minutes and will include yourself and the Principle Investigator. You will be contacted about preferred times and method of contact (telephone or Skype). The Principle Investigator will contact you and you will incur no expense from this interview. Interviews will be recorded using a digital voice recorder. No identifying information will be used.

This research project is anticipated to be completed by approximately December 2015.

By consenting to participating in this study, you understand that:
- You are volunteering for an interview that will take up to 60 minutes.
- Sessions will be audiotaped by a digital voice recorder.
- Your identity will be protected.
- The interview will include a verbal discussion about your art therapy education, the role of art making in your clinical practice, and the role of art making in your personal practice.
- No emotional or other ill effects are expected because of this interview.
- You may choose to withdraw from the study at any time with no negative consequences.

This study will not necessarily provide any personal benefits to you. You may experience increased self-knowledge and insights as to the role of art making in your professional and personal life.

The audio recordings and transcripts will be kept in a locked closet in the investigator’s possession for possible future use. This information will not be used in any future study without your written consent.

Confidentiality, Privacy and Anonymity:
You have the right to remain anonymous. If you elect to remain anonymous, we will keep your records private and confidential to the extent allowed by law. We will use pseudonym identifiers rather than your name on
study records. Your name and other facts that might identify you will not appear when we present this study or publish its results.

If for some reason you do not wish to remain anonymous, you may specifically authorize the use of material that would identify you as a subject in the experiment. You can contact the Principle Investigator’s advisor Dr. Michele Forinash at (617) 868-9600, forinism@lesley.edu, 29 Everett St., Cambridge, MA, 02138, with any additional questions.

You will be given a copy of this consent form to keep.

---

a) **Investigator’s Signature:**

________________________ ____________________________

Date Investigator's Signature Print Name

b) **Subject’s Signature:**

I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as described above. I understand that I am free to discontinue participation at any time if I so choose, and that the investigator will gladly answer any questions that arise during the course of the research.

________________________

Date Subject's Signature Print Name

---

There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Co-Chairs Dr. Terry Keeney (tkeeney@lesley.edu) or Dr. Robyn Cruz (rcruz@lesley.edu) at Lesley University, 29 Everett Street, Cambridge, Massachusetts, 02138.
References


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doi:10.1080/07421656.2010.10129388


