Art Therapists’ Assessment Practices in the Inpatient Psychiatric Facility:

A Descriptive Survey

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DEDICATION

This work is dedicated to my parents,

Dianne and Martin Knoblauch.

I could not have done this without you.
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# TABLE OF CONTENTS

DEDICATION ............................................................................................................. ii

ACKNOWLEDGMENTS .............................................................................................. iii

ABSTRACT .................................................................................................................. viii

INTRODUCTION ........................................................................................................ 1

LITERATURE REVIEW ............................................................................................... 7
  Overview .................................................................................................................. 7
  The Inpatient Psychiatric Facility .......................................................................... 7
    Mental Healthcare in the U.S. ................................................................................ 7
    Role of the Inpatient Psychiatric Facility ............................................................. 13
    Role of the Therapist in the Inpatient Setting ...................................................... 15
  Summary .................................................................................................................. 18

Assessment in the Inpatient Psychiatric Facility ..................................................... 20
  Primary Goals of Inpatient Psychiatric Assessment ............................................. 20
  Types and Methods of Inpatient Psychiatric Assessment .................................... 21
  Challenges of Inpatient Psychiatric Assessment .................................................. 30
  Summary .................................................................................................................. 32

Art Therapy in the Inpatient Psychiatric Facility .................................................. 34
  History of Art Therapy in the Inpatient Hospital ................................................ 34
  A Platform for the Development of Art Therapy Assessment ............................ 38
  Summary .................................................................................................................. 41

Art Therapy Assessment ......................................................................................... 42
  As a Problem of Definition .................................................................................... 42
METHODS .............................................................................................................. 64

Research Design ................................................................................................. 64
Location ................................................................................................................ 64
Time Period .......................................................................................................... 65
Participants .......................................................................................................... 65
Inclusion/Exclusion Criteria .................................................................................. 65
Recruitment .......................................................................................................... 66
Instrumentation ................................................................................................... 67
Informed Consent ................................................................................................ 67
Data Collection .................................................................................................... 67
Data Analysis ........................................................................................................ 69
Operational Definitions.................................................................................................................. 69
Potential Risks to Participants .................................................................................................... 70
Special Precautions...................................................................................................................... 71
RESULTS ...................................................................................................................................... 72
Overview..................................................................................................................................... 72
Description of Responses........................................................................................................... 72
Demographic Narratives............................................................................................................. 72
Itemized Responses...................................................................................................................... 73
Common Themes.......................................................................................................................... 80
Variant themes ............................................................................................................................ 81
Summary...................................................................................................................................... 81
DISCUSSION ............................................................................................................................... 82
Overview..................................................................................................................................... 82
Common Themes Consistent with Available Literature............................................................ 83
    General Assessment Goals and Process.................................................................................. 83
    General Treatment Goals ...................................................................................................... 85
    Merger of Assessment and Treatment .................................................................................. 86
    Work Related Experience of Art Therapists ........................................................................ 87
Common Themes Unique Relative to Available Literature ....................................................... 89
    The Practice of Assessment .................................................................................................. 89
    The Assessment of Insight: Patient as Co-assessor ............................................................ 91
    Role of the Art Therapist ...................................................................................................... 92
Variant Themes............................................................................................................................ 93
Limitations .................................................................................................................. 94
Clinical Implications ................................................................................................. 95
Questions for Future Research ................................................................................. 95
Recommendations ...................................................................................................... 96
SUMMARY .................................................................................................................. 99
REFERENCES ............................................................................................................. 103
APPENDIX A: Survey .................................................................................................. 125
APPENDIX B: Email Invitation ..................................................................................... 126
APPENDIX C: Participant Self-Reflection Guide ......................................................... 127
APPENDIX D: Participant Information Sheet ............................................................. 129
APPENDIX E: Exemplar Quotes .................................................................................. 130
ABSTRACT

Art Therapists’ Assessment Practices in the Inpatient Psychiatric Facility:
A Descriptive Survey
By Kirsten Knoblauch

Betty Hartzell, PhD, ART-BC, LPC

This study explores the assessment practice of art therapists working in inpatient psychiatric facilities. This investigation is significant because while inpatient psychiatry emphasizes assessment, and continues to be a common employment setting for art therapists, little is known about their current assessment practice in this setting. State-of-the-field information is necessary if professions are to support clinicians, adapt to the changing role of treatment settings, and thereby uphold their responsibility to clients. A descriptive survey in the form of an interview was created. Five art therapists, all credentialed professionals representing a range of 13 to 40 years of practice were interviewed. Interviews were coded then synthesized into themes. Participants’ assessment practices were found to be influenced by both changes in the treatment setting, and the values of their profession. Participants described clinical evaluation as one of their primary responsibilities. While this makes their self-perceived role consistent with the function of the treatment setting, conflict was noted between the impositions of the setting and participants’ professional identities. Participants use multiple assessment formats with separate goals and purposes, and consider their use of art-based assessment to be more genuine than other assessments required by the facility. Participants described using primarily informal assessments. This was found to be the case despite knowledge of available standardized tools, and the emphasis of current mental health care on evidence-based practice. The need for a structured, if not standardized tool/process was suggested by participants’ current assessment
practice, which must meet the documentation requirements of the setting while upholding the values of clinicians. The findings of this study, though not generalizable, suggest a number of questions for future research including: What qualities would be most valued in an art-based assessment tool designed for use in inpatient psychiatry? What type of clinical information would be most relevant to art therapists’ practice in this specific setting? How can the profession of art therapy support practitioners in developing and adapting their practice to specific settings? Answering these questions may support the profession of art therapy, and its practitioners, by developing processes that broaden the field’s relevance and efficacy across mental health contexts, thereby improving client care.
Chapter 1: Introduction

The purpose of this study is to increase the knowledge base of the field of art therapy regarding the assessment practices of clinicians working with adults in inpatient psychiatric facilities. The study explores both the assessment practices and experiences of clinicians in the field to help the profession of art therapy better understand what, how, and why we do what we currently do. Additionally, this study seeks to understand the ways that the inpatient setting influences assessment practice, as well as the work related experience of art therapists. The study takes the form of a descriptive survey interview of art therapists currently working in inpatient psychiatric facilities.

Art therapy has a long history of providing both assessment and treatment in inpatient psychiatry. As early as the 1940’s, pioneers of the field were providing patients with relatively long-term care, integrating a variety of approaches to psychotherapy with the organizing, containing, and communicating features of creative expression (Kramer, 1982). As they provided care, these clinicians began to note a correlation between imagery in patient artwork, with both the individual’s clinical presentation and psychological state (Naumburg, 1950; Naumberg, 1966/1987). Combined with psychiatry’s previous interest in art made by the severely mentally ill, and new observations regarding the seeming influence of latent psychic content on the mode and manifest imagery in client art work, these early clinicians began what might arguably be seen as the birth of art therapy assessment. A number of “evaluative art procedures” (Kramer & Iager, 1984, p. 83) grew out of this process (Dewdney, Dewdney, & Metcalfe, 1967/2001; Ulman, 1965/1992; Ulman & Levy, 1968/1992), and art therapists continue to develop assessment procedures to this day. Art therapy assessment methods generally share the common feature of providing a more dynamic understanding of the client
than offered by early projective measures and diagnostic screenings (Gantt, 1992; Naumburg, 1958), differentiating the “art therapy assessment” from “art based” assessments and measures used within the psychiatric profession. Art therapists continue to provide assessment in a variety of work settings, and with a range of goals and formats (Rubin, 1999). In a recent study, 85% of art therapists surveyed indicated that they assess their clients, with a wide range of assessment approaches and formats represented within that number (Peterson, 2012).

The presence of art therapy clinicians in inpatient psychiatry continues to grow. According to the American Art Therapy Association’s 2009 membership survey report, between 2007 and 2009 alone, the number of art therapists working in inpatient psychiatric settings nearly doubled, with the adult inpatient psychiatric hospital one of the second highest employment settings for the discipline (Elkins & Deaver, 2010). The inpatient setting continues to be one of the most common work settings for art therapists today (Elkins & Deaver, 2013). Despite the high proportion of art therapists working in adult inpatient psychiatric facilities, little is known as to their current assessment practices. In a journal search of three major art therapy trade publications encompassing nearly six decades executed by this researcher between December 2011 and July 2012, no survey was found that specifically investigated the overall assessment practices of art therapists working in adult inpatient psychiatry. This is particularly noteworthy considering that changes in mental health care policy and practice over the past 50 years led multidisciplinary assessment, geared toward the identification of appropriate outpatient services, to be a primary function of inpatient psychiatric facilities (Frank & Glied, 2006; Horsfall, Cleary, & Hunt, 2010; Sharfstein, 2009). Clinicians working in this setting then, use assessment as a springboard for what is ideally a long-term community based treatment plan, despite the short-
term nature of the facility itself (Horsfall, Cleary, & Hunt, 2010). This is a feature with not only professional but ethical considerations.

The lack of knowledge within the field of art therapy regarding inpatient assessment practice is also significant considering that assessment is thought of as a necessary, though debated feature of effective, quality care within the art therapy community (Betts, 2006; Gantt, 2004; Williams, Agell, Gantt, & Goodman, 1996). Although through the late 1980’s and early 2000’s a number of art therapy researchers published normative studies of art-based assessment procedures for potential use with acute populations (e.g. Gantt, 2001; Hacking, Foreman, & Belcher, 1996), little literature exists in art therapy publications exploring their practical application into current inpatient treatment. Further, while the field has broadly addressed the influence of an evolving treatment setting on the development of professional identity and role clarity (e.g. Cashell & Miner, 1983; Gussak & Orr, 2005; Lusebrink, 1989), literature within the field has only minimally addressed clinicians’ perception of how the structure of current inpatient services impacts assessment practice specifically. This lack of knowledge regarding assessment practices of art therapists working in inpatient psychiatry, and resulting implications for both the field of art therapy and the client population is the problem I wish to address.

Participants for the study were recruited by convenience sampling via the American Art Therapy Association (AATA) Membership Directory. Eligible respondents were interviewed via telephone. The researcher first gathered demographic and background data, including professional experience and education. This information is used to create a brief, narrative description of each participant. The interview first investigates the participants’ current assessment practices, and how assessment is integrated in daily practice. The interview then examines the participants’ familiarity and experience with assessments and assessment formats.
Finally the interview explores the rationale behind the participants’ assessment practices, via how they perceive their role(s) in the inpatient setting, and the ways in which the structure of their specific work setting interacts with assessment practice. Responses were coded and analyzed for both common and variant themes, and results reported.

This study has a number of potential implications. As part of the current mental health care system, clinicians and facilities are charged with fulfilling more limited and specifically defined roles, often within equally limited and defined time constraints (Frank & Glied, 2006). As managed care took hold in the late 1980’s and through the 1990’s, the field of art therapy began to broadly consider the potential impact these system changes may have on practice. Authors began to suggest a need to adapt our skills in order to remain responsible to both clients and the profession, as well as consider the potential impact of those decisions on both profession and practice (e.g. Allen, 1992; Riley, 2009; Wadeson, 2000). This study is designed to explore the current assessment practices of art therapists working with adults in inpatient psychiatric facilities in light of these changes and questions. The findings of this study might be used to suggest further research into assessment practices that might best suit the complex needs of art therapy clinicians working in this setting, enabling them to more fully take part in a shared responsibility of guiding the trajectory of an individual’s treatment.

In a broad sense, improved “state of the field” knowledge will better able the field of art therapy to meet the responsibilities of a profession, since within a profession, knowledge is key to communication, education, identity, and ultimately practice (Elliot, 1972). As a profession, we are charged with providing knowledge and training that will enable students to become informed and effective clinicians with the capacity to engage in the “pragmatics of providing treatment, as well as the aesthetics of conducting therapy” (Riley, 2009, p. 137). This includes
developing a knowledge base that supports specialization while providing students with realistic expectations (Gonzalez-Dolginko, 2000; Riley, 2009). We must promote communication both within our field and among partner disciplines such that we are able to respond and adapt to the changing demands of mental health care (Gonzalez-Dolginko, 2000; Riley, 2009). We must support role clarity among clinicians, as lack of role clarity has been shown to decrease job satisfaction, increase anxiety, and negatively impact practice (Cashell & Miner, 1983; Gussak & Orr, 2005; Lusebrink, 1989). Finally, we are responsible to our clients. Because the above mentioned factors ultimately impact practice, we must constantly make efforts to increase knowledge of what we do, merging the pragmatics of evolving, specialized practice with sensitivity toward client needs.

The primary research questions for this study were: What are the assessment practices of art therapists working with adults in inpatient psychiatric settings? What are the experiences and attitudes of art therapists working with adults in inpatient psychiatry regarding the practice of assessment? In what way does the inpatient psychiatric facility contribute to art therapists’ chosen assessment practices? The objective was to create a comprehensive picture of what types of assessment practices are actually occurring in this specific treatment setting, the rationale behind those practices, and a meaningful understanding of the factors that contribute to said phenomena.

The study had a number of limitations. The use of a convenience sample (participants recruited through invitational e-mail via AATA) may have skewed results in that the sample may not fully represent the population of art therapists working in inpatient psychiatric settings. Clinicians who are not members of AATA may be defined by some characteristic, and that characteristic may not be understood. The ongoing challenge to define “art therapy assessment”
may pose a limitation to the study. There is a lack of clarity often presented in the literature, where the terms can hold implicitly different meanings. Clinicians may hold equally ambiguous beliefs when presented with the terms which may complicate results. A primary delimitation of the study is the small participant number, which impacts generalizability. Generalizability is not the intent of this study. Rather, the study seeks an in-depth, qualitative understanding of assessment practices with this select group of individuals.
Chapter 2: Literature Review

Overview

This literature review presents key information that was gathered to form the background of the present study. The chapter starts with a review of inpatient psychiatric services, as they evolved through the context of changes brought on by deinstitutionalization and managed care. This includes the ways in which changes in mental healthcare impacted the role of the inpatient psychiatric setting, as well as the role of the inpatient therapist. The role of the therapist is explored via literature on the evolving role of inpatient group therapies as well as the therapist as a member of the treatment team. This information is presented in order to understand the background behind current practice. The chapter continues with a review of current inpatient assessment practices, including goals and types of assessments used. Following this is a review of the history of art therapy in the inpatient setting. This information is used to develop an understanding of the way that the art therapy discipline has evolved in this specific treatment setting. The various goals, purposes, and formats of art based assessment are then reviewed. Following this is a presentation of the ongoing debate regarding the utility and appropriateness of art based assessments within the field of art therapy. This literature review concludes by presenting examples of specific art therapy assessments, followed by a gap analysis.

The Inpatient Psychiatric Facility

Mental Health Care in the U.S.

Beginning in the mid 1960’s demands for better quality, more accessible mental health services, coupled with changes in healthcare financing in the late 1980s through the 90s, led to a drastic change in the structure of mental healthcare. First, increased public awareness of the deplorable conditions of large, state run psychiatric hospitals led to a federal push toward
deinstitutionalization – the release of long-stay hospital residents into community care (Frank & Glied, 2006; Goldman, Foley, & Sharfstein, 1985; Whitaker, 2010). Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (CMHC; P.L. 88-164, 77 STAT 282) as part of this move. This act gave states the mandate – along with federal dollars – to transition long-stay hospital residents into a system of community based treatment programs (Frank & Glied, 2006; Goldman, Foley, & Sharfstein, 1985). As an alternative to long-term confinement in institutions, community based mental healthcare was believed to be both more humane, effective, and cost efficient (Brown, 1988; Frank & Glied, 2006).

The aim of the community care movement was to provide least restrictive services, believing that an individual’s integration into the community would better support the development of life skills and promote independent living (Frank & Glied, 2006; Goldman et al., 1985). This model was further supported by the New Freedom Commission on Mental Health (2003), which emphasized an orientation to mental healthcare sometimes referred to as the ‘recovery model’ (Thornton & Lucas, 2011). Recovery models involve moving an individual though a system of coordinated outpatient services, often facilitated by a team of professionals. Programs are designed to provide services that support independent living through skill building in the areas such as self-care, interpersonal relationships, and employment, while providing psychiatric, medical and social work services (New Freedom Commission on Mental Health, 2003; Schreter, Sharfstein, & Schreter, 1997; Simmonds, Coid, Joseph, Marriott & Tyrer, 2001; Trawver, 2011).

More broadly, the recovery orientation promotes more individualized services. The client is viewed as an active participant in determining their needs. Health is viewed as an individual
journey where providers refrain from imposing predetermined, expected outcomes. In theory, services are provided from the point of view that all individuals, regardless of healthcare providers’ perception of wellness, can “take on meaningful and satisfying roles within local communities” (Thornton & Lucas 2011, p. 24).

A primary emphasis of community based care is continuity, leading these programs to sometimes be referred to as ‘continuum of care’ models (Glick, Sharfstein, & Schwartz, 2011). As part of the continuum, most inpatient psychiatric facilities now serve as short-term acute care settings, where individuals in crisis may be assessed, stabilized, then transitioned into an appropriate level of continuing care (Schreter et al., 1997). Outpatient programming may include assisted living, partial hospitalization, community counseling, psychoeducation, and family support services (Frank & Glied, 2006; Horsfall, Cleary, & Hunt, 2010; Schreter et al., 1997; Trawver, 2011). Research suggests that community treatment models reduce hospital readmissions, incidences of suicide, incarceration, and increase likelihood of employment for service users (Becker, Meisler, Stormer, & Brondino, 1999; Jones, 2002; Swartz et al. 2001; Simmonds et al., 2001).

Despite having supporters, the community mental health care movement has been critiqued as a system in an imperfect state of transition (The National Alliance on Mental Illness; NAMI, 2009; Sharfstein, 2009). Research suggests that many patients released to the community have not been consistently able to access outpatient services, with some researchers linking deinstitutionalization to increased homelessness and incarceration (Barros, de Azevedo Marques, Carlotti, Zuardi, & Del-Ben, 2010; Brown, 1988; Goldman et al., 1985; Hynes, 1987; NAMI, 2009; Olfson, Marcus, & Doshi, 2010). This may be partially due to the fact that not all states were able to fully comply with the new model, despite increased federal funding (Goldman...
et al., 1985). More recently, in some states the model is crashing, with funding cuts at the state level and hospital closures occurring before sufficient community based services are in place (NAMI, 2009). Research also suggests that changes in healthcare financing policy that apply restrictions on service utilization disrupt the continuity of care (Olfson et al., 2010).

Another criticism of the community based treatment model is that recovery oriented programs remain inadequately integrated and inconsistent in practice (The National Alliance on Mental Illness, 2009). For example, Assertive Community Treatment (ACT), a team based community care program, has been critiqued due to variations in practice among teams and inconsistent results (Burns, 2010; Rice 2011). Burns (2010) conducted a meta-analysis of 64 ACT trials correlating these factors. First, the author found that earlier outcome studies suggesting that ACT reduced rehospitalization have not been consistently replicated. Second, the author found that not all teams fully integrate ACT principles. The study suggests that the variability in adherence to the ACT program model may translate into the reduced success rate.

Broadly, in terms of both services and theory, the idea of recovery has been critiqued as a yet ill-defined concept. Literature suggests that as a model, recovery oriented care struggles to function alongside the biomedical view of mental illness, which continues to dominate psychiatry. This view suggests that mental health has been reached when an individual is able to maintain biologically determined, statistically ‘normal’ behaviors (Davidson & Roe, 2007; Hoy, 2008; Smith, 2014; Thornton & Lucas, 2011). Thornton and Lucas (2007) propose that recovery be defined not as a “descriptive matter… but rather on reaching a normatively or evaluatively characterized state… determined through the conception of a life to be valued and hoped for by the subject… or is appropriate to or correct for the individual’s self-identity” (p.26-27). The authors state that a recovery model might contrast with the current biomedical view of mental
illness, and question the values with which healthcare providers evaluate individual cases, set goals, and define health.

Another feature of the current mental health system increasingly debated is the shortened length of inpatient stay. Inpatient length-of-stay (LOS) has been drastically reduced (Glick et al., 2011; Sharfstein, 2009). The decrease has been partially driven by financial concerns and partly by the federal push toward the recovery model, where the inpatient unit provides short term stabilization and assessment instead of long-term treatment (Frank & Glied, 2006; New Freedom Commission on Mental Health, 2003). A lack of evidence base regarding the effectiveness of a shortened LOS, has led to a number of recent critical reviews. Machado, Leonidas, Santos and Souza (2012) conducted a review of international literature integrating research on psychiatric inpatient readmission and LOS. The authors found that across the majority of studies, a shorter LOS resulted in a higher likelihood of readmission, and in some cases negated the impact of outpatient services (Machado, Leonidas, Santos & Souza, 2012). For example, Grinshapoon et al. (2007, as cited in Machado, et al., 2012) showed that although community based programs lowered readmission rates for persons hospitalized for more than six months, community services had no significant impact on readmission for individuals who had a shorter LOS. This suggests that the effectiveness of community programs may be dependent on the nature of inpatient services, and that a shortened length-of-stay may not be appropriate for all individuals.

As deinstitutionalization progressed there was a broad push in the U.S. toward health care finance reform. In response, the Health Maintenance Organization Act of 1973 (42 U.S.C. § 300e) helped establish the managed care model of health financing on a national level. Managed care was developed to provide comprehensive, affordable health care to a wider range of people, while controlling costs through oversight (Fox, 2001; Tufts Managed Care Institute, 1998).
Under this model privately operated insurers offered groups of individuals access to a network of providers, with an emphasis on outpatient and preventative care (Fox, 2001; Frank & Glied, 2006; Tufts Managed Care Institute, 1998). Privatization led to greater cost sharing among public and private sources, as well as increased federal funds. Although cost sharing has had some negative impacts stemming from increased out-of-pocket costs for some members, it provided funds that increased the supply of services. For mental healthcare, greater funding supported the development of outpatient services, in keeping with the evolving community based treatment model. This in turn led to greater availability of mental healthcare for a greater number of people (Fox, 2001; Frank & Glied, 2006).

Despite providing benefits, the managed care movement resulted in a treatment system with inconsistent results (Frank & Glied, 2006; Horsfall et al., 2010; Sharfstein, 2009; NAMI, 2009). Research suggests that this is partially due to limitations designed to control costs such as proscribed length-of-stays, and stringent preauthorization parameters (Olfson et al., 2010). For example, Olfson, Marcus, & Doshi (2010), in a longitudinal analysis of service utilization in the U.S., found that 4 in 10 adults with severe mental illness using managed care services do not receive needed outpatient treatments in the first month post inpatient hospitalization, while patients using fee-for-service – a financing option allowing for unbundled service provision – were more likely to receive follow-up care. The study suggested multiple influences – among them, a managed care preauthorization policy which seemed to prevent participants from accessing outpatient services (Olfson et al., 2010). Broadly, the mental healthcare system is hindered by states continuing to cut spending and staffing, lagging in modernization, and failing to produce outcome measures. This not only contributes to the insufficient supply of services, but brings up questions of evidence-based practice (NAMI, 2009).
Role of the Inpatient Psychiatric Facility

Managed care, in collaboration with the community care model, demands that each treatment provider deliver a specific, limited, measurable service within a broader continuum of care. For the mental health system, inpatient services are viewed as the first step along that continuum (Corcoran & Vandiver, 1996; Frank & Glied, 2006; Horsfall et al., 2010; Sharfstein, 2009). As part of the community based model, the inpatient unit has been transformed into a short-term facility, focused on stabilization, assessment, and transitioning the individual to an appropriate level of outpatient services (Horsfall et al., 2010; Sharfstein, 2009).

Inpatient stays are as low as 3 to 7 days by some estimates for the majority of people admitted (Drager, 2007; Sharfstein, 2009). Individuals present in acute distress, experiencing exacerbated symptoms and may be at a high risk of suicide (Frank & Glied, 2006; World Health Organization, 2012). Symptoms may include extreme decrease or elevations in mood, psychosis, anxiety, and destructive or disorganized behaviors, in addition to self-care deficits and comorbid medical conditions (Horsfall et al., 2010; Lyketsos, Dunn, Kaminsky, & Breakey, 2002; Yalom, 1983). Many people who utilize inpatient psychiatric services experience chronic, severe mental illness and require rehospitalization (Drager, 2007; Frank & Glied, 2006; Zeiss, 1997). For these individuals, the inpatient unit is an opportunity to review prior diagnostic impressions, make pharmacological adjustments, and redirect outpatient treatment plans (Sharfstein, 2009).

A key feature of current inpatient psychiatric facilities is the interdisciplinary treatment team. Interdisciplinary teams may be composed of psychiatrists, social workers, medical staff, and therapists of various modalities including but not limited to art, music, occupational and recreational therapies (Rodenhauser, 1996; Zeiss, 1997). While the values of each discipline
may be distinct, each member of a psychiatric treatment team must contribute to the goals of stabilization and discharge, which include the following as defined by Sharfstein (2009):

- Make the most accurate assessment and diagnosis as possible within a short amount of time
- Gather assessment data as close to admission as possible
- Formulate goals together with the patient
- Work with family and other external support systems
- Determine level and type of out-patient care needed
- Revise and refocus treatment if applicable

Given the shortened length-of-stay, the achievement of inpatient goals must be both efficient and effective, and the treatment team must engage in the most collaborative way possible, if they are to appropriately guide the trajectory of an individual’s long-term care (Rodenhauser, 1996; Sharfstein, 2009; Zeiss, 1997).

Despite the community care model’s goal of facilitating long term recovery, the literature reveals that the inpatient psychiatric facility is a ‘revolving door’, with many of the individual’s discharged experiencing chronic, severe symptoms and multiple readmissions (Barros et al., 2010; Drager, 2007; Frank & Glied, 2006). Researchers and critics suggest this represents a new form of institutionalization, and question the efficacy of the current mental healthcare system as a whole (Barros, et al., 2010; Frank & Glied, 2006; New Freedom Commission on Mental Health, 2003; Whitaker, 2010). Authors suggest that chronic rehospitalizations may be due to a number of factors including unreasonable restrictions of insurance policies, difficulty accessing community based services, lack of continuity, and programs that do not fully meet the needs of the severely ill (Barros et al., 2010; Frank & Glied, 2006; Glick et al., 2011; New Freedom Commission on Mental Health, 2003; Whitaker, 2010).
Commission on Mental Health, 2003; Olfson, et al., 2010). Glick et al. (2003) suggest that short stay alone is a major contributing factor. The authors recommend moving away from the linear, pre-prescribed algorithms of managed care, and advocate for a more person centered evaluation of length-of-stay needs. Further, the authors suggest that short stays may limit the effectiveness of psychosocial assessments, and negatively impact the inpatient milieu by preventing the development of interpersonal understandings. Short stays may actually inhibit recovery as well as present an ethical dilemma (Glick et al., 2003).

**Role of the Therapist in the Inpatient Setting**

Another important function of the inpatient psychiatric facility is to provide group psychotherapy, though the role of therapy – and therefore the role of the therapist – has gone through considerable change (Emond & Rasmussen, 2012; Sadock & Sadock, 2007). Inpatient psychotherapy was originally informed by a depth psychology orientation, with mental illness viewed as the result of early trauma, or some other insult to the developing self (Cory & Page, 1978; Kibel, 1992). Goals of therapy involved the analysis, verbalization, and re-processing of these traumas at the individual level, with the group serving as a recapitulation of the trauma experience. Therapists using this approach took a passive stance, allowing insights regarding the patients’ psychic conflicts to arise (Cory & Page, 1978; Kibel, 1992). Insight was thought to be a platform on which to reorganize the psyche. Reorganization was believed to reduce symptoms, correct maladaptive relational skills, and ultimately produce a cure (Cory & Page, 1978; Leopold, 1976).

According to Emond and Rasmussen’s (2012) review of the literature, beginning in the 1970s, increasing amounts of literature questioning the benefit of depth oriented approaches to therapy resulted in the decline in popularity of such methods. In fact, some authors noted that
some individuals worsened with insight oriented therapies, while supportive, skill building approaches seemed to have positive effects (Kanas & Barr, 1982; Barr, 1986; Kanas, 1985 as cited in Emond & Rasmussen, 2012). At the same time, an increasing understanding of the biological aspect of mental illness and improvements in psychopharmacology led to the rise of the medical model of psychiatry (Frank & Glied, 2006; Leopold, 1976).

Kibel’s (1992) review found that as early as the 1960s, some inpatient therapists had deemphasized verbal depth oriented therapies altogether in favor of more directive, task oriented and experiential processes (Frank, 1963, as cited in Kibel, 1992). In this approach, therapists began to function more as active facilitators than analysts, providing therapeutic supports and structures in which the participants might engage in healthful interpersonal experiences within the ‘here and now’ of the group (Hales, Yudofsky & Gabbard, 2008; Yalom, 1983). Therapy focused on helping the patients’ become aware of their own behaviors, derive support from others, learn that talking is helpful, and discover ways in which improved interpersonal skills might bring improved experience to daily life (Yalom, 1983). Therapists also focused on the reduction of hospital related anxiety and the building of peer to peer rapport.

The move from curative to therapeutic aims expanded though the 1970s and 1980s, as literature increasingly suggested that therapeutic experiences were the most valued features of inpatient groups (Maxmen; 1973; Yalom, 1983). For example Maxmen’s (1973) research looking at perceived helpfulness of group therapy by hospitalized patients showed that not only was insight not viewed as helpful by participants, other specific factors of the groups such as hope, universality, and expressing feelings, were most highly valued. Kibel (1981) and Yalom (1983) expanded the idea of therapeutic factors to include altruism, catharsis, learning, and clarifying experience. Texts continue to promote a supportive approach to inpatient therapy.
Insight oriented approaches are contraindicated for the acutely ill, whose egos are too fragile to manage the anxiety created by insight (Hales et al., 2008; Sadock & Sadock, 2007).

Through the 1990s, further changes brought on by managed care required inpatient therapists to further adapt their practice (Deco, 1998; Wood, Rogers, McCarthy, & Lewine, 1994). Shortened length-of-stay and pressures to produce targeted, recovery oriented interventions led to the rise of brief, pragmatic group therapies (Brabender & Fallon, 1993; Hales, et al., 2008; McCann & Bowers, 2005). Therapists not only serve as a facilitator, but may now take on an educative role, targeting goals intended to produce immediate psychosocial and functional improvements that will enhance the individual’s ability to live successfully in the community (Brabender & Fallon, 1993). Group content may include developing improved social skills, illness management, problem solving, and assertiveness. Therapists may teach coping skills intended to reduce stress, address issues of self-esteem, and help patients develop alternatives to self-injurious behaviors (Brabender & Fallon, 1993; Emond & Rasmussen, 2012; O’Donovan & O’Mahony, 2009; Wood et al., 1994).

In addition to changes in therapeutic focus, the broader environment of current inpatient psychiatric services poses distinct challenges. Although managed care and the recovery model demand a focus on rehabilitative goals, high acuity and short stays may prevent therapists from being able to address such aims (Boronow, 2009). Patients are often experiencing acutely distracting symptoms, making them unable to process group content. There may be little opportunity to build a therapeutic alliance, and little control over group composition, in what is often a complex, heterogeneous milieu. As a result, the therapist may serve primarily a supportive and behavior management function, and also may serve primarily as a source of ongoing clinical observation for the treatment team (Boronow, 2009; Hales et al., 2008).
As discussed, the inpatient facility serves as a springboard for outpatient mental health services. As members of the treatment team charged with this responsibility, many inpatient therapists now focus on assessment and diagnosis to a greater degree, take on increased administrative duties and spend less time in direct patient care (Glenn, 2010; Wood et al., 1994). Although participating in a treatment team enables the therapist to contribute directly to a patient’s long-term care, the additional role may have unintended consequences, including added stress due to increased administrative duties, and a blurring of professional identity, job dissatisfaction, isolation, and burnout (Cashell & Miner, 1983; Wood et al., 1994). Cashell and Miner (1983) conducted a telephone survey of creative arts therapists on this topic. The participants, who were employed in 12 different inpatient psychiatric units, reported great ambiguity and conflict regarding their role on the unit. They identified a number of contributing factors including unclear and unrealistic job expectations, job titles that do not fully represent the variety of functions they serve, and a distinct lack of communication with employers and staff (Cashell & Miner, 1983). Although “role overload” (Glenn, 2010, p.77) has been the general theme in the literature, it is also suggests that in some cases, strong leadership, advocacy, and peer support can reduce work related stress and support the development of clear professional identity for art therapists (Glenn, 2010).

**Summary**

As revealed in the literature, mental healthcare in the U.S. has changed considerably since deinstitutionalization, the advent of managed care, and the push toward community based treatment models. Specifically, the inpatient facility has evolved away from long-term treatment, toward short-term acute care focused on stabilization, assessment, and transiting individuals into long-term outpatient care (Frank & Glied, 2006; Sharfstein, 2009; Whitaker,
Although the community care movement has improved the quality of mental healthcare overall for many people, new challenges such as drastically shortened inpatient length-of-stays, combined with inconsistencies in the outpatient service delivery contribute to varying levels of success (Frank & Glied, 2006; Glick et al., 2011; Sharfstein, 2009; Whitaker, 2010).

The literature reveals that a key feature of the inpatient facility is the multidisciplinary treatment team. The goal of the treatment team is to identify and initiate the most sensitive long-term care possible. To do this they must share assessment data, formulate a diagnosis, develop treatment goals, identify environmental challenges and supports, and possibly refocus existing treatment. Given the extreme needs of individuals in acute distress, and the brief nature of the inpatient setting, an assessment that is both accurate and efficient is necessary (Rodenhauser, 1996; Sharfstein, 2009).

As the mental healthcare system has evolved, so has the role of the inpatient therapist. This has fundamentally changed the role the inpatient therapist plays in the lives of patients. The treatment goals of inpatient programming have gone from attempting to facilitate cure to a variety of therapeutic and practical aims (Edmond & Rasmussen, 2012). Therapists in the inpatient setting may now take on a less clinical, more supportive and educative role (Brabender & Fallon, 1993; Edmond & Rasmussen, 2012; Hales et al., 2008; Yalom, 1983). The literature suggests that certain features of the inpatient setting may in fact make it difficult for therapists to achieve therapeutic aims (Boronow, 2009). In addition, inpatient therapists may take on increased responsibilities which further expand their role (Glenn, 2010; Wood et al., 1994). As a member of the treatment team, the therapist shares the primary goal of sensitive assessment of patients. They may also contribute to a diagnosis, discharge planning and the coordination of out-patient care. For some therapists straddling multiple roles may increase stress, reduce job
satisfaction, and create conflict within the professional identity (Cashell & Miner, 1983; Glenn, 2010).

**Assessment in the Inpatient Psychiatric Facility**

**Primary Goals of Assessment in Inpatient Psychiatry**

Categorical diagnosis is currently the dominant paradigm through which mental illness is identified and treated. That is at least in terms of the larger mental healthcare system, whose facilities must produce a clinical diagnosis in order to be funded under managed care (Frank & Glied, 2006; Hales et al., 2008; Kielbasa, Pomerantz, Krohn, & Sullivan, 2004). This makes identifying the most accurate diagnosis possible a primary goal of assessment in psychiatric emergencies (Hales et al., 2008; Horsfall et al., 2010; Sharfstein, 2009). Clinical assessment aims to produce as clear a picture as possible of an individual’s symptoms in the areas of cognition, emotion, perception, and behavior. Both clinician observations and client self-report are used, generally within an interview format. Clinical assessment may also include medical and neurological tests to rule out organic conditions that may be responsible for psychiatric symptoms (Hales et al., 2008).

Assessment of risk to self or other is a primary goal in inpatient psychiatry. Individuals with severe mental illness are at a high risk for suicide and in some cases violence, therefore risk is part of discharge criteria (World Health Organization, 2005; World Health Organization, 2012). Risk is assessed both at triage and throughout the hospital stay (Reinhardt, 2008; Roca & Hurston, 2009). A number of factors are considered including intent and motivation, lethality, history of suicidality or aggressive behavior, psychological and affective state, presence of drugs or alcohol, and available coping skills (Reinhardt, 2008).
Another important role of inpatient psychiatric services is functional assessment (Bedell, Hunter, & Corrigan, 1997; Patterson and Mausbach, 2010). Functional assessment is “the degree to which the individual’s abilities and performances match the demands of his or her home, work, school, family, and social situations” (Bedell et al., 1997; p. 219). Functional abilities include coping skills, communication skills, social skills, as well as attention and other capacities that enable a person to successfully participate in a variety of life situations. Assessment focuses on identifying target treatment areas, including an understanding of the interrelationship between social context, symptoms, strengths and deficits (Bedell et al., 1997; Patterson and Mausbach, 2010).

Given the complex needs of individuals who present in acute psychiatric crisis, assessment should encompass an inclusive biopsychosocial understanding of the individual (National Collaborating Center for Mental Health, 2010; Sadock & Sadock, 2007). Psychosocial assessment is a third goal of assessment in the inpatient psychiatric facility. The psychosocial assessment explores the social environments of the individual. This may include development, education, finances, relationships, culture and identity (Congress, 2013; Farley, 1994). The psychosocial information contributes an individual’s treatment plan by determining additional services needed and supports already available (Horsfall et al., 2010; Mattaini & Kirk, 1991).

**Types and Methods of Inpatient Psychiatric Assessment**

**Clinical interviewing.** To facilitate diagnosis, clinicians in the United States use the Diagnostic and Statistical Manual of Mental Disorders, (DSM; 5th ed., DSM-V; American Psychiatric Association, 2013) as a point of reference. The DSM is an atheoretical approach to the organization and description of psychological disorders, where illness is defined by specific symptom clusters. The manual is not intended to assert cause, but to aid communication among
professionals by providing a common language. The DSM is designed to provide a comprehensive evaluation by including an assessment of personality, psychosocial stressors, and functional capacity (Sadock & Sadock, 2007).

Many assessment instruments have been developed for use in clinical diagnosis. One example is the Structured Clinical Interview for DSM-IV Axis I disorders, Clinician Version (SCID-CV; First, Spitzer, Gibbon, & Williams, 1997). Such instruments take the form of structured interviews and rating scales that use standardized questions to probe for symptoms. Despite the availability of standardized measures, and some indication that they are the most valid and reliable form of clinical assessment, the most common form of psychiatric assessment is an informal clinical interview (Andreas, Theisen, Mestel, Koch, & Schulz, 2009; Hales et al., 2008; Miller, Dasher, Collins, Griffiths, & Brown, 2001). An informal clinical interview is a non-standardized, one to one interview where the assessor relies primarily on observation skills, and informed, intuitive judgment (Hales et al., 2008; Sadock & Sadock, 2007). Psychiatric interviews generally explore the following information (Hales et al., 2008, p.8):

- Chief complaint
- History of present illness
- Past psychiatric history
- Past medical history
- Social history
- Developmental history
- Family psychiatric history
- Review of systems
Developmental history may explore developmental milestones, and the presence of abuse or neglect. Either the social or developmental history may explore the client’s sexual development, orientation and identity (Hales et al., 2008).

Included in the psychiatric interview is the mental status exam. The goal of the mental status exam is to develop a clear picture of an individual’s functioning in specific areas of cognition, perception and emotion (Hales et al., 2008). A key aspect of the mental status exam is the assessment of insight – the degree to which an individual can objectively reflect on their current state, symptoms, and/or situation. The clinician may use a standardized tool such as the Mini Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975). Both the clinical interview and the mental status exam serve as a means of establishing a provisional diagnosis, enabling the facility to initiate care, procure funding, and begin treatment planning (Hales et al., 2008; Kessler, 2002; Sadock & Sadock, 2007).

Art therapists have developed art-based assessments designed to capture clinical symptoms as they manifest in visual form. The use and utility of such methods, as relates to the topic of the thesis, will be explored later in the review.

Despite the fact that the DSM has long been endemic in the U.S., leaders in the field of psychiatry have questioned the clinical utility of the system (Mullins-Sweatt & Widiger, 2009). Scientific research has traditionally required a system that identifies syndromes under an assumption that they are discrete, measurable phenomena (Kendell & Jablensky, 2003; Kendler, 1990). These factors resulted in cumbersome criterion sets, and time prohibitive assessments (Mullins-Sweatt & Widiger, 2009). As a result clinicians sometimes have not consistently adhered to the DSM. This may negatively impact validity as clinicians may rely on overly subjective judgments (Garb, 2005).
Another possible limitation of clinical assessment is the relationship of current diagnostic systems to the medical model. The DSM has been largely influenced by the medical model which emphasizes a genetic etiology capable of producing biologically distinct syndromes (Cooksey & Brown, 1998; Mullins-Sweatt & Widiger, 2009). Research has found questionable evidence that disorders identified in the DSM are actually discrete entities and suggests that pathology exists on a continuum (American Psychiatric Association, 2013; National Collaborating Center for Mental Health, 2010). The literature suggests that dominance of the medical model may bias assessment (Hamilton, Manias, Maude, Marjoribanks, & Cook, 2004).

To improve utility and validity, some diagnostic criteria were shortened in recent revisions of the DSM, the DSM-V, and measures of severity and dimension were introduced (American Psychiatric association, 2013). These changes are in the early stages of use. The authors of the DSM-V recommend continued investigation into the dimensional nature of mental illness (American Psychiatric association, 2013).

**Risk assessment.** A number of standardized risk assessment instruments have been developed (Cutcliff & Barker, 2004; Osman et al., 2002). Despite the availability of these instruments psychiatric facilities often develop their own risk assessment forms. One example is the Sheppard Pratt Suicide Risk Assessment Instrument (SPSRAI; Sheppard Pratt Health System, 2006; Simon, 2009). The SPSRAI includes items such as past suicidal and self-injurious behaviors, intent, motivation, and the degree of such feelings as hopelessness, guilt, and self-hatred. Psychosis or substance abuse is noted, as well as psychosocial stressors and resources. Forms such as the SPSRAI are not intended to be the sole basis of clinical decisions. Rather they are intended to promote efficiency, and prompt staff to incorporate certain factors into their clinical judgment (Roca & Hurston, 2009).
Though risk assessment forms are highly common in fast-paced, high turn-over clinical settings, they may be over relied on (Simon, 2009). Due to the pressures of such settings, brevity may become more highly valued than patient care. Broadly, risk assessment tools are considered unreliable as a stand-alone indicator; if used they must be integrated into a thorough clinical evaluation (The American Psychiatric Association, 2003; Simon, 2009).

**Nursing assessment.** As the discipline with arguably the most patient contact, nursing staff are a primary source of assessment information in inpatient psychiatry (Reinhardt, 2008). Nurses take part in clinical assessment with a focus on problem identification, risk, monitoring for inconsistencies and new clinical information (Coombs, Curtis, & Crookes, 2012; Reinhardt, 2008). Psychiatric facilities often develop their own forms and procedures to guide psychiatric nurses in a variety of assessment areas, and standardized measures have also been developed (Reinhardt, 2008).

Despite the availability of such tools, the literature indicates that psychiatric nurses use primarily informal methods of assessment (Coombs et al., 2012; Hamilton, Manias, Maude, Marjoribanks, & Cook, 2004; MacNeela, Scott, Treacy, & Hyde, 2010). In a number of recent studies, psychiatric nurses reported that they do not utilize checklists or other formal inventories but instead use their own knowledge to make intuitive judgments. Participants stated that assessment is an implicit, ongoing process, as they observe and interact with patients (Delaney, Cleary, Jordan, & Horsfall, 2001; Hamilton et al., 2004; MacNeela et al., 2010). Further, nurses emphasize the importance of building rapport with the patient as a primary component of assessment (Coombs et al., 2012).
The field of mental health nursing is beginning to address the content and process of assessment, since an ad hoc approach may result in a perpetuation of anecdotal information not consistent with evidenced-based practice (Delaney, 2006).

**Functional assessment.** Although removed from the most recent revision of the DSM (DSM-V; American Psychiatric Association, 2013), the Global Assessment of Function (GAF), originally designed by Endicott, Spitzer, Fleiss and Cohen (1976), has been one of the most commonly used functional assessments in psychiatry (Smith et al., 2011). The GAF, which is a clinician rated too, consists of scales measuring symptom severity and functional impairment combined into a single score (American Psychiatric Association, 2000). Although still in use, psychiatry is currently transitioning away from the GAF. Critics of the GAF questioned the measure’s utility, stating that the combined score may not fully represent an individual’s capacities because it does not indicate an individual’s ability to perform specific life tasks (Skodol, Link, Shrout, & Horwath, 1988; Smith et al., 2011). Additionally, the GAF score reflects the most severe area of impairment, meaning that the inclusion of psychiatric symptoms into the rating may skew results (Skodol et al., 1988; Smith et al., 2011). The DSM now contains a set of diagnosis specific measures of severity, accompanied by the World Health Organization Disability Assessment Schedule (WHODAS 2.0; World Health Organization, 2010). The developers of the DSM-V believe that an independent evaluation of symptoms, severity, and functioning will result in more sensitive treatment planning, as clinicians will be able to observe the complex fluctuations and interrelationships of those factors (American Psychiatric Association; 2013b).

A second form of functional assessment is that performed by occupational therapists, a discipline represented in some inpatient psychiatric facilities (Lim, Morris, & Craik, 2007).
Although there is a plethora of standardized assessments published, occupational therapists primarily rely on informal clinical judgment (Page, 2008). As in psychiatric interviewing, the occupational therapist engages the client in an informal or semi-structured interview, and may incorporate observations made as the client completes a task or interacts with others (Dickerson, Parente, & Ringel, 2000; Smith, 1992). The goal of the interview is to engage the client in discourse where the therapist and client together discover life activities that are meaningful to the individual. The therapist may evaluate the individual’s ability to perform basic skills such as self-care, in addition to discrete cognitive skills that are needed to support meaningful activity (Page, 2008; Smith, 1992).

As is the case with risk assessment, inpatient psychiatric facilities may design their own occupational therapy assessment forms, such as the Occupational Therapy Task Observation Scale (OTTOS; Margolis, Harrison, Robinson, & Jayaram, 1996) developed by Johns Hopkins Hospital, Baltimore. Tools such as the OTTOS provide the clinician with a brief guide for rating the individual on specific functional skills. Developers recognize that these tools have not been validated. They state however that the form enables the therapist to better communicate with the treatment team and monitor change. Additionally, the OTTOS focuses assessment interviews, while meeting the documentation requirements of third party payers (Margolis et al., 1996).

Another type of functional assessment, performance-based assessments, are increasingly used in mental healthcare settings (Mausbach, Moore, Bowie, Cardenas, & Patterson, 2009; Patterson & Mausbach, 2010). Performance-based assessments measure the ability of an individual to perform specific skills of everyday life. Assessments are standardized, and take place in a controlled setting where the clinician can observe the upper limit of an individual’s capacities under ideal circumstances. Assessment may use props or role play as the clinician
observes the individual engaging in a series of everyday tasks (Patterson & Mausbach, 2010). Research suggests that a number of performance-based assessments are a valid and reliable measure of functional capacity (Patterson & Mausbach, 2010).

It has been noted that performance-based assessments may pose a burden to clinicians, since they tend to be long and require props. This is particularly noteworthy given the time and resource constraints of acute care settings. As a result, developers are beginning to adapt performance-based measures into briefer versions (Patterson & Mausbach, 2010). The developers accomplished this by reducing the number of props and measurement scales. The reliability and validity of briefer measure has not been fully established (Mausbach, Harvey, Goldman, Jests, & Patterson; 2007).

Barry, Lambert, Vinter, & Fendy (2007) suggest an alternative solution to the challenges the acute psychiatric setting poses to functional assessment. These researchers developed the Current Evaluation of Risk and Functioning-Revised (CERF-R; Barry, Lambert, Vinter, & Fendy, 2007). The CERF-R is designed to rate the individual in 18 areas of functional skill. In contrast to performance-based measures, the items on the CERF-R are rated by consensus of the treatment team during “customary standard of care” (Barry et al., 2007, p.182). The authors contend that the CERF-R may enhance interdisciplinary communication by providing standardized language and facilitating team discourse. The authors believe the CERF-R may promote efficiency since it is integrated into the established treatment planning process (Barry et al., 2007). The authors acknowledge that the CERF-R is not consistent with some principles of the recovery model, in that it does not involve the individual in identifying their own goals. None the less, the CERF-R showed good construct validity, and was positively correlated with existing measures of functional capacity (Barry et al., 2007).
Broadly, functional assessment is a relatively new field with a number of challenges. Researchers acknowledge that validating the relationship of functional assessments to real-world outcomes is an ongoing challenge. Contextual factors that impact functional ability may not be detectable in controlled treatment settings, which may pose a challenge to treatment planning (Patterson & Mausbach, 2010).

**Psychosocial assessment.** In addition to the social history gathered during a clinical interview, there is traditionally a full psychosocial assessment done in behavioral health settings (Farley, 1994). The psychosocial assessment is a focused, one to one interview that gathers information from a variety of life contexts. The assessment tends to focus on developmental and family history, relationship patterns, and environmental stressors. The assessment may explore the person’s physical environment including home, work, school, and neighborhood. The psychosocial may examine the person’s education and employment history, and explore issues of culture and identity (Congress, 2013; Cooper & Lesser, 2002). This information is then synthesized into an appraisal of areas where the individual needs support. The psychosocial approach is particularly relevant in the recovery model as it is geared toward targeted intervention planning (Congress, 2013).

As part of the psychosocial interview, the social worker may complete institution developed forms, or use forms they develop themselves (Congress, 2013; Farley, 1994). The latter is often a result of social workers having to adapt their practice to changes in the work environment. This will be presented further below in the context of broad challenges posed to inpatient assessment practice.

**Activities/recreation assessment.** Many psychiatric hospitals require therapeutic staff to complete what is sometimes called an “activities assessment” (Feder & Feder, 1998, p. 4). This
may be carried out by the art therapist, occupational therapist or activities/recreation therapist. These assessments vary in purpose and depth, though are generally used to determine what recreation and/or creative activities are appropriate for the individual client, taking into account their functional skills, personal interests, and experiences. They may also be part of an overall treatment plan aimed at identifying the areas where improved life, social, and recreational skills will improve the individual’s ability to live in their community (Feder & Feder, 1998, p. 4). The art therapist, often subsumed under a facility’s adjunctive therapies department, may be charged with carrying out the activities assessment.

**Challenges of Inpatient Psychiatric Assessment**

Current inpatient psychiatric services pose a number of distinct challenges to assessment. As has been observed here, much of the literature is reflective of the pressures and constraints of short-term acute care. Literature from within a number of fields suggests that setting imposed limitations have resulted in a compromising of assessment principles (Farley, 1994; Smith, 1992). One example is Farley’s (1994) descriptive interview of 27 social workers employed in inpatient psychiatric facilities. Traditionally, these social workers would perform a thorough psychosocial history. As a result of changes in mental health care services – including financial constraints that they report have resulted in lay-offs and increased workload – they report that assessment has become a cursory function. They now do a brief history, often on a simplified form they develop themselves. A number of social workers reported that if they choose to do a full history, they cannot produce the assessment until after the individual has been discharged, rendering it useless to the treatment team. Smith (1992) observes that assessment in occupational therapy has become superficial, with procedures aimed at identifying specific, targeted deficits with measureable outcomes. Smith (1992) states that this is a deficits model
build in response to funding pressures that ignores the whole person. In Hamilton, Manias, Maude, Marjoribanks, and Cook’s (2004) descriptive interviews, all three interviewees – a nurse, a social worker, and a psychiatrist – stated that they had no influence over the time and location of assessment as a result of time frames imposed by the institution.

Another factor that may influence inpatient psychiatric assessment is the dominance of the medical model (Hamilton et al., 2004). Hamilton et al. (2004) found that although the three disciplines represented viewed themselves as having a distinct perspective of the patient, all participants interpreted patient verbalizations as diagnosable pathology. Participants often reframed patient feelings and perspectives in terms of symptoms. Hamilton et al. (2004) suggests that the reframing of patient feelings and concerns effectively marginalized the patient’s voice. This illustrates the concerns of both Mattaini and Kirk (1991) and Deegan (1996), who suggest that pressures to contribute to a diagnostically oriented model, fueled by categorical classification systems, may result in a loss of contextual information regarding the patient’s life situations, where the patient is seen more as a diagnosis than an individual.

Another distinct limitation imposed by the current diagnostically oriented system, is what has been criticized as an inherent “peripheral positioning of culture” (Dadlani, Overtree, & Perry-Jenkins, 2012, p. 176), and suggest that tools for multicultural assessment have been underutilized (Dadlani et al., 2012). Literature suggests that the DSM has traditionally under represented cultural contexts, which may have lead to a perception among mental health professionals that culture exerts a minimal influence on mental health (Dadlani et al., 2012).

Since culture influences the perception and interpretation of one’s mental and emotional experiences, this is a critical limitation (Dadlani et al., 2012; Hales, et al, 2008; Lim, 2006). Cultural bias may lead to the pathologizing of what are otherwise culturally appropriate
behaviors, and a failure to accurately represent the individual’s experience and needs (Dadlani et al., 2012; Eap, Gobin, Ng, & Hall, 2010). In an effort to improve cultural sensitivity, the most recent revision of the DSM, the DSM-V, emphasized culture by including an enhanced Cultural Formulation Interview (CFI; American Psychiatric Association, 2013). The DSM authors recommend continues investigation into the relationship between cultural factors and the conceptualization of mental illness (American Psychiatric Association, 2013).

**Summary**

The literature reveals that assessment in the inpatient psychiatric setting encompasses a wide variety of goals, methods and tools, and draws together a number of disciplines. The primary goals include producing a preliminary diagnosis in order to initiate care and secure funding, as well as functional and psychosocial assessments to begin long-term, community treatment planning (Hales et al., 2008; Horsfall et al., 2010; Sharfstein, 2009). Given the high risk associated with severe mental illness, and the mandate to demonstrate risk as part of admission criteria, risk is also a primary goal of assessment in inpatient psychiatry (World Health Organization, 2012; Reinhardt, 2008). There are many structured assessment tools available for use in behavioral health, including standardized measures and formal interview tools. Facilities may also develop their own assessment tools. The latter was noted in the areas of social work, occupational therapy, and activities/recreation therapy. Despite the availability of structured assessments, the literature reveals that informal processes are a common form of assessment in inpatient psychiatry (Farley, 1994; Hamilton et al., 2004; Smith, 1992). Over all, assessment in inpatient psychiatry have adapted to the role of the treatment setting and the mandate of the community-based recovery model – stabilize the individual while the treatment team identifies specific areas for outpatient intervention.
The literature reveals that current inpatient psychiatric services pose a number of distinct challenges to assessment practice. Literature from multiple disciplines reported that limitations imposed by the shortened length-of-stay, time, funding, staffing, and policy constraints led them to sacrifice sensitivity and comprehensiveness in their assessment practice (Farley, 1994; Hamilton et al., 2004; Smith, 1992). Clinicians and researchers have developed briefer measures and processes in order to adapt, though they have not been fully validated or are in early stages of development. In some cases these new assessments place a high value on standardized language and interdisciplinary communication, in addition to addressing the need for efficiency and documentation demanded by the system of care. The literature indicated that pressures imposed by the recovery model to identify targeted, measurable interventions may lead to an over emphasis on deficits. Additionally, the literature suggests that the discourse imposed by the medical model may overly influence assessment (Farley, 1994; Hamilton et al., 2004; Smith, 1992). It was seen that clinical assessment adheres to the medical model, using a diagnostically oriented classification system as a guide (American Psychiatric Association, 2013). This is despite the fact that diagnostic classifications may bias assessment, since research has yet to fully support the existence of discrete biological disorders (Charney et al., 2002; Hamilton et al., 2004; Kendell & Jablensky, 2003). Literature suggests that pressures to fit findings into the context of symptoms may lead to a misinterpretation of patient communications, dehumanizing the patient, and marginalizing their voice (Hamilton et al., 2004). A final challenge posed to inpatient psychiatric assessment may be what some authors cite as a failure of the current diagnostic system to fully integrate cultural contexts. This may cause clinicians to miss factors relevant to the presenting problem, or to inappropriately pathologize culturally appropriate behavior (Dadlani et al., 2012; Eap et al., 2010).
Art Therapy in the Inpatient Psychiatric Facility

History of Art Therapy in the Inpatient Psychiatric Facility

Art therapy has existed in inpatient psychiatric hospitals since the 1940’s, when field pioneers began experimenting with integrating art into psychotherapeutic practice (Rubin, 1986). In the late 1800s hospital superintendents and psychiatrists recognized that art works made by individuals with acute psychiatric disturbances held unique characteristics, leading them to explore the ways in which these characteristics may be related to disturbances of the psyche (MacGregor, 1989; Rubin, 1986). This resulted in a number of publications, perhaps most notably psychiatrist and art historian Hans Prinzhorn’s (1922) *The Artistry of the Mentally Ill*, which included reproductions from a vast collection of patient artwork. In this work, Prinzhorn observed in his patients what seems to be a spontaneous impulse to make art. He spent much of the text exploring the relationship between visual phenomena and psychic states. Almost simultaneously was the birth of psychoanalysis and psychoanalytic theories, which hypothesized a connection between human behavior, emotion, and the images that manifest in dreams, imagination, and art (Sadock & Sadock, 2007). Inspired by these combined developments, early pioneers in art therapy such as Naumberg (1950) began to explore potential meanings behind features observed in the spontaneous art work of individuals with mental illness, which they hypothesized might be used to reveal or resolve psychic distress. Much as psychodynamic theory hypothesized the images in dreams and fantasy to contain meaningful psychic information, the content and features of art work came to be viewed as ‘symbolic speech’ (Naumber, 1966).

These early clinicians operated in what were at the time, large, long-stay institutions. Their work with patients involved primarily free expression/non-directive approaches, with the
art therapist engaging in long-term, one-to-one psychotherapy with individuals of their choosing (Kramer, 1982; Lakovics, Becher, Goldstein, Towle, Walker-Wessells, Kruger-Weisberg, 1978; Wood, 1997). Although there were clinicians who focused on the art making itself as the primary therapeutic approach, the impulse driving the development of art therapy as a profession was akin to that of psychodynamic psychotherapy – what Wood (1997) terms “the wish to understand more in order to be helpful” (p. 151; Ulman, 1961). Art therapy theory grew though inpatient psychiatry, as the art therapists’ work allowed them to observe patterns within the form and content in psychiatric art over time (Wood, 1997).

Beginning in the 1960s through the rise of managed care in the 1990s, changes occurring in mental healthcare, in combination with the challenges of growing a profession, greatly impacted art therapy practice (Deco, 1998; Wood, 1997). In the inpatient setting, this included a number of administrative and professional challenges. First, misunderstanding and tension developed surround the difference between arts therapies and other disciplines such as occupational and recreation therapy. For example, art therapists were at times expected to fill in for other disciplines, engaging in group processes and activities that necessitated a lowering of therapeutic boundaries (Deco, 1998; Lakovics et al., 1978). Since this was inconsistent with tenants of psychodynamic psychotherapy, and viewed as disruptive of the therapeutic relationship, art therapists sometimes refused to do this. Because of this, tension sometimes arose between art therapists and allied disciplines, and between art therapists and hospital administration (Lakovics et al., 1978). Art therapists, once able to freely dictate the terms of their work, began to experience scheduling conflicts with other disciplines, and reduced control over the structure and composition of therapy groups (Deco, 1998; Lakovics et al., 1978). Additionally, due to the shortened length of stay, art therapists began to experience what Deco
(1998) describes as “abortive relationships” (p. 97) where patients are discharged before any real therapeutic relationship can be built. Deco (1998) suggests that these combined challenges at times led to feelings of helplessness and dissatisfaction, resulting in passivity, detachment, and resistance to openly engaging new patients.

In addition to navigating increasing professional challenges, the literature suggests that art therapists working in inpatient settings had to adapt their practice in response to changes in mental healthcare services. Consistent with the broader field of psychotherapy, art therapists working in inpatient settings observed that insight oriented approaches may not be appropriate (Ulman, 1966; Wood, 1997). The majority of this literature appears during the transition to community services, beginning in the 1960s and continuing through the 1990s. Wood (1997) notes that changes including decreases staffing, shorter stays, and transient treatment environments, made working from a depth oriented position not feasible. The author calls for greater clarity about work with the severely mentally ill. Ulman (1966) states that verbalizing emotionally charged material may in fact be anti-therapeutic for the most severely ill, who are already in acute distress. Rather, Ulman suggests that individuals in acute distress require support, catharsis, acceptance, and the building of emotional defenses. Ulman advocates art therapists in the inpatient setting embrace what she views as the full potential art making to facilitate “…catharsis and emotional reeducation in the broadest sense” (Ulman, 1966, p 4). Malloy (1984) suggests that art therapists move toward supporting individuals as they transition into community treatment. He suggests that art therapy is well suited to helping people address the particular problems of recovering from severe mental illness such as fear, isolation, emptiness, and feeling overwhelmed.
As a solution to the new challenges of inpatient work, art therapists who once practiced psychodynamically embraced alternative approaches where the art itself acts as a ‘bridge’ to engaging the acutely ill who otherwise may not be able to tolerate the anxiety of the therapy situation (Deco, 1998, p. 94; Killick, 1997). One example is Deco’s (1997) open studio group – a supportive, contained, yet flexible format where the composition of the group determines the level and type of therapeutic engagement. The art making process may be used to facilitate communication at the individual and/or group level, and to build cohesion. When appropriate, the art making can become a structure in which to address either the immediate intra- or interpersonal needs of the patient/group, but without an expectation of the type of engagement to occur (Deco, 1997). The therapist may use dynamic theory to inform clinical observations and develop the therapeutic relationship, but focus the work primarily on intuitive, non-verbal support and containment. In contrast to increased flexibility of open studio work, Landgarten (1991) promoted increased structure through success-oriented creative activity. In the author’s experience, support is provided through structure, distance, and clear directives from the therapist, which she believed may help build rapport, enhance self-esteem, moderate anxiety, and reduce resistance to change (Landgarten, 1991).

Inpatient psychiatry continues to be common employment setting for art therapists, and their work with the severely mentally ill has gained notable support (Elkins & Deaver, 2013; National Collaborating Center for Mental Health, 2010). A recent review of outcomes literature found that the arts therapies were the only intervention that consistently reduced negative symptoms in individuals with schizophrenia. This led the National Collaborating Center for Mental Health (2010) to include arts therapies in their clinical guideline. They noted that the studies reviewed, all published within the last two decades, emphasize supportive approaches to
therapy, focusing on enhancing communication, self-awareness, self-expression and social connectedness through interactive, experiential learning.

**A Platform for the Development of Art Therapy Assessment**

Initially, art-based assessment developed out of the fields of psychology and education, whose pioneers sought tools for investigating individual differences in temperament, development, and behavior (Frick, Kamphaus & Barry, 2010). One of these tools was the projective drawing. In a projective drawing the client is asked to make a drawing, or set of drawings, then make verbal associations to the product. Testing is based on the assumption that the individual will reveal more subconscious information by associating to the imagery than they would in an explicit interview. Data is gathered primarily from the content of a client’s drawing as interpreted by the clinician, who uses standardized guidelines to deconstruct the drawing based on a particular theory. The theory dictates an expected one-to-one correlation between a human experience or trait, and specific symbols (Dictionary of Forensic Psychology, 2008; Frick et al., 2010; Hammer, 1980). Research historically suggests that projective drawings lack solid empirical validation, with studies mired in questionable research methods and inconsistent results (Kahill, 1984; Klopfer & Taulbee, 1976; Lilienfeld, Wood, & Garb, 2000; Neale & Rosal, 1993). Additionally, art therapists began to consider projective drawing as relying too heavily on the interpretation of the clinician, resulting in a self-limiting ‘dictionary approach’ to human experience (Dewdney et al., 1967; Gantt, 2004). Despite these challenges, Gantt’s (1992) review of art therapy assessments developed between the 1960s and early 1990s revealed that art therapists adopted the tenants of projective drawings into their assessments to varying degrees (Gantt, 2004).
Independent of developments in projective testing was the continued exploration of the art work of individuals in long term mental institutions. In contrast to the content oriented approach of projective drawings, the interest in psychiatric art was primarily focused on the formal features in the art, such as line, form, and color. Additionally, there was an interest in the global characteristics, as opposed to finite details (Rubin, 1986; Gantt, 1992). Although early art therapists primarily valued art making as part of the therapeutic process, pioneers such as Naumburg (1966) noted that spontaneous pictures made by individuals in different diagnostic categories shared similar characteristics, and suggested that these features may hold value as an assessment. Since the 1960s, artists and clinicians working in inpatient treatment settings have investigated the ways that features in artwork might be used to detect pathology (Cronin, & Werblowsky, 1979; Kahn & Jones, 1965; Ulman & Levy, 1968; Wadlington, & McWhinnie, 1973), monitor change (Gantt & Tabone, 2001; Hoshino, Silbert, Knapp, & Weaver, 1998; Peres & Marcus-Ofseyer, 1978; Perkins & Wagemaker, 1977), and inform diagnosis (Amos, 1982; Cohen, Hammer, & Singer, 1988; Hacking & Foreman, 2000; Morris, 1995; Witlin & Augusthy, 1988). There is great variety within this literature, with some investigators using spontaneous/non-directed art making (1967; Ulman & Levy, 1968; Wadlington, & McWhinnie, 1973), and some using projective drawings (Kahn & Jones, 1965; Perkins & Wagemaker, 1977; Witlin & Augusthy, 1988). Regardless, each of these authors considers ways in which the formal features and global characteristics of the art may be related to psychic states. Although art therapists continue use the tenets of projective drawing in assessment, the focus on characteristics as opposed to content has became a feature on which some authors attempt to differentiate art therapy assessments within the broader, art-based category (Gantt, 1992; Peterson, 2012).
Another factor of inpatient psychiatric care that influenced the development of art therapy assessment was the changing role of the treatment setting. As the role of the setting moved toward short-term stabilization, art therapists found themselves faced with a work setting less capable of supporting psychotherapeutic work, and more focused on the identification of pathology (Deco, 1998; Ulman, 1965; Wood, 1997). Ulman (1965) who wrote extensively on the subject after nine years of inpatient work, describes increasing frustration with an institution whose function seemed cold, and offered little in the way of meaningful treatment. The author reflects on her inner conflict, desiring more involvement in the trajectory of the patients’ lives, while admittedly resisting what she perceived as an uncaring minimization of human life on the part of psychiatry. Ulman (1965) then reflects on whether choosing to remain outside the bounds of diagnostic decisions based on her frustration was warranted, stating:

“Anything the art therapist can contribute toward making the psychiatrist’s decision an enlightened one, based on all possible diagnostic evidence and prognostic clues, will at times help a patient as much as all the therapy an art therapist might offer him under other circumstances.” (p. 79).

These challenges and sentiments were echoed later by Gantt (1979), who details additional benefits of joining the psychiatric team, particularly enhanced collaboration with the psychiatrist where the art work can become a means of monitoring symptoms, gauging an individual’s response to medication, and contribute diagnostic impressions. Ulman (1965) and Ulman and Levy (1967; 1968) went on to develop one of the first structured art therapy assessments. Peterson’s (2012) Master’s thesis suggests that art therapist in inpatient settings continue to use some form of assessment in their work.
Summary

As reviewed, art therapy has a long history in the inpatient psychiatric hospital, with much of its roots derived from work in this treatment setting (Rubin, 1986). The field was greatly influenced by the historic interest in art produced by the severely mentally ill, in addition to the development of psychoanalytic theories (Rubin, 1986; Naumburg, 1950). These developments combined to suggest the therapeutic potential of incorporating art making into psychotherapy (Wood, 1997). The once long-term nature of inpatient work afforded field pioneers the ability to observe patterns in the art work of patients over time, where the art came to be viewed as a form of ‘symbolic speech’ (Naumber, 1966). Early art therapists initially provided long-term psychotherapy in the inpatient setting.

Changes resulting from the transition to managed care and community based treatment confronted art therapists with administrative and practice challenges. Misunderstanding arose regarding the nature of art therapy. Conflict sometimes occurred between art therapists and other therapeutic disciplines regarding roles and expectations. Art therapists experienced less control over the scheduling and structure of therapy groups, as well as frustration regarding the briefer relationships with patients (Deco, 1998; Lakovics et al., 1978; Wood, 1997). Consistent with the broader field of psychotherapy, some art therapists came to observe that a depth oriented approach to therapy may not be appropriate in the inpatient setting, and moved toward more supportive, cathartic, and pragmatic therapy goals (Malloy, 1984; Ulman, 1966; Wood, 1997).

The inpatient treatment setting greatly contributed to the development of art therapy assessment. Early clinicians were influenced by historic observations regarding the unique visual phenomena in psychiatric art (Naumburg, 1950; Rubin, 1986). Art therapists broadened art-based assessment by furthering the investigation into these characteristics. Although art
therapists continue to use projective drawing in their assessments, a focus on the formal characteristics in art work and their relationship to psychic states has become a key feature of assessments developed by art therapists (Gantt, 1992; Naumburg, 1966; Peterson, 2012; Ulman & Levy, 1968).

The literature reveals that changes in the inpatient treatment setting itself contributed to the development of art therapy assessment. Art therapists working in this setting were faced with a changing role, as the role of the setting became less oriented toward therapy and more focused on assessment and out-patient treatment planning (Deco, 1998; Frank & Glied, 2006; Kibel, 1992). Some art therapists, such as Ulman and Leavy (1968) and Gantt and Tabone (1998) embraced this and used years of experience with psychiatric art to develop structured assessment procedures with the potential to collect and communicate clinical information. These clinicians believed that contributing to the treatment team’s diagnostic impression allowed them to more fully participate in the long-term care of patients (Gantt & Tabone, 2001; Ulman, 1965). Art therapists continue to work in inpatient psychiatric settings (Elkins & Deaver, 2013).

**Art Therapy Assessment**

**As a Problem of Definition**

Broadly, assessment is a process or tool for eliciting information about a client with the goal of better understanding their behavior, clinical state, traits and needs (American Educational Research Association [AERA], 1995, as cited in Betts, 2006; Bruscia, 1998). The use of drawing, painting, or other creative acts in assessment is based on a broad theoretical assumption. According to the literature, art making requires an individual to organize complex sensory and perceptual phenomena, including information drawn from memory (Lusebrink, 2004). If this is true, psychic distress (e.g. psychosis, depression, anxiety) that leads to
disturbances in sensory and perceptual domains will be reflected in the individual’s creative product (Gantt, 1996; Lusebrink, 2004). For clinicians who use the arts in assessment, the creative act and/or product is seen as a tool with the potential to aid in the information gathering aspect of assessment, thereby enhancing the understanding of the individual (Bruscia, 1988; Dewdney, Dewdney, & Metcalfe, 1967; Dudley, 2004; Gantt, 1996; Peterson, 2012; Ulman, 1965).

In the profession of art therapy there is no one broadly accepted approach to assessment, nor have assessment terms been clearly and consistently defined (Chirila & Feldman, 2012; Peterson, 2012; Rubin, 1999). The term ‘art based assessment’ is a construct that has been used to include the full range of assessments utilizing art materials and/or stimulus images, including projective techniques. This can be seen in, for example, Arrington (1992) and Knapp (1992) among others. Traditionally, the term ‘art therapy assessment’ is used to refer to a specifically dynamic assessment of the individual (Naumburg, 1966). In contrast to projective techniques, the client is encouraged to interact more spontaneously with art materials. If associations are elicited, the focus is on idiosyncratic, client-driven meanings as opposed to searching for pre-defined symbols (Fink et al., 1973; Gantt, 1992; Gantt, 2004; Naumburg, 1966). In addition, the field of art therapy has broadened art-based assessment to include measures that detect the impact of pathology on form, space, line, color, etc., in contrast to the content orientation of projective tests (Bergland & Gonzalez, 1993; Cohen, Hammer, & Singer, 1988; Gantt & Tabone, 1998; Hacking & Foreman, 2000; Ulman, 1965).

Despite apparent differences, the terms ‘art based assessment’ and ‘art therapy assessment’ have also been used interchangeably, including the American Art Therapy Association’s (1990) statement “Art therapists use a variety of art-based assessments, which
include but are not limited to, free choice, and/or directed drawings, paintings, and/or sculptures. The choice of the specific art therapy assessment depends on the age of the client…” (American Art Therapy Association, 1990, as cited in Arrington, 1992; Betts 2005; Betts, 2006). In some cases the term ‘art therapy assessment’ has been used to refer to specific projective tests, such as in Smith (1983). Gantt (2004) recommend that art therapists clearly differentiate their assessments from projective techniques. The author suggests that art therapists extract the use of projective drawing from standardized assessment altogether, and focus primarily on more global, visual phenomena. This, according to the author, is consistent with the true nature of art therapy. Although Gantt (2004) also uses the terms ‘art based’ and ‘art therapy’ assessment interchangeably, she lays claim to the term ‘art based assessment’, merging the two terms as signifiers for assessments that fall within her clearly defined parameters.

A recent study found continued vagueness in the use and understanding of assessment related terms among art therapists (Peterson, 2012). Peterson’s (2012) Master’s Thesis found that a quarter of responses to a question asking respondents to elaborate on their informal assessment methods referred to formal assessment procedures. Formal assessment refers to standardized procedures designed to detect, capture, and/or measure specific clinical information (Gantt, 2004). Standardization includes the establishment of norms through empirical research, which result in a tool for systematically measuring client performance. This allows clinicians to compare observations made at a particular time, to that same dimension observed at another time, or between two or more individuals (Gantt, 2004). In contrast, informal assessment refers to unsystematic, idiosyncratic procedures occurring directly in response to a client’s immediate needs or presentation as intuited by the clinician. As such, no norms exist for such processes; subjective evaluation takes precedence over gathering comparative data (Gantt, 2004). Given the
distinction between the two terms, Peterson (2012) found the misunderstanding concerning and recommends improved clarity and education regarding assessment terms and procedures in the field of art therapy.

In addition to a lack of consistency in defining assessment terms, Chirila and Feldman’s (2012) meta-analysis found a distinct lack of consistent theory across assessment instruments used by art therapists. The purpose of the study – which included 93 pieces of literature representing nine instruments – was to discern the theory that guides therapists’ belief that art can identify pathology and facilitate change, with a particular interest in their means of collecting information and formulating a diagnosis. First, the authors found the assessments nearly impossible to classify due to an inability to identify broadly accepted theory in the studies; the researchers’ opinions seem to obscure the use of theory, and served as the predominant drive for the methodology and intentions of the measure.

Based on this review of the literature, and for the sole purpose of this study, the term ‘art-based assessment’ will be defined as: a loosely defined and broad category of assessment where clinical information regarding a client is gathered via elicited drawings, responses to graphic stimuli, or other processes where the individual interacts with art media. This may include projective drawings as well as processes and tools specifically developed within the art therapy community. The term ‘art therapy assessment’ will be defined as: a type of art-based assessment developed within the field of art therapy, intended to elicit a dynamic, idiosyncratic understanding of the client’s present psychological state or clinical symptoms; may include a standardized tool for measuring the visual phenomena in client art works, though may also take the form of informal procedures and processes.
As a Source of Debate

Although assessment is a required content area in art therapy education (American Art Therapy Association, 2007), and some prominent members of the field consider assessment the “core of good practice” (Gantt, 2004, p. 18), the appropriateness and efficacy of formal assessment has been a source of much debate in the art therapy community (Betts, 2005; Gantt, 2004; Wadeson, 2003). Proponents of formal art therapy assessment cite a number of clinical advantages. First is the added information that incorporating art making into assessment is thought to provide (Bruscia, 1998; Gantt, 2004, Gantt & Tabone, 2001). As the client is engaging in the creative act, the client’s process – a simultaneous engagement in both creative and social activity – may be observed. This allows the clinician to consider the relationship of phenomena that emerge within the imagery to real-time behavior. Clinical features may be revealed that would not be observable in a strictly verbal assessment (Bruscia, 1998; Gantt, 2004, Gantt & Tabone, 2001). Gantt and Tabone (2001) reported that their use of the Formal Elements Art Therapy Scale (FEATS; Gantt & Tabone, 1998) enabled them to successfully predict which clients would respond to various treatments. The FEATS is a likert type scale that uses 5 point intervals to rate the degree or type of certain characteristics in drawings, such as the amount of space used on the page. The presence of specific symptoms in the individual may then be inferred as they are revealed by characteristics thought to be their ‘graphic equivalent’. The authors report that using the FEATS as part of the assessment process in a psychiatric hospital resulted in more targeted, efficient treatment, by providing a greater amount of clinical information on which to base treatment decisions (Gantt & Tabone, 2001).

Proponents of formal art therapy assessment believe that the arts have a unique capacity to access clinical information that other forms of assessment do not (Bruscia, 1998; Savneet,
Art making is thought to draw together multiple levels of sensory, perceptual, intellectual and emotional functioning, in addition to memory traces of the same (Lusebrink, 2004). It is believed that stimulating multiple areas of cognition and sensation activates experiences stored in the various sensory modalities – information that verbal assessment alone may bypass (Bruscia, 1998; Lusebrink, 2004; Savneet, 2007). For example, the literature suggests that memories of traumatic events are primarily stored in non-verbal form and that art making may be uniquely suited to accessing the trauma experience (Savneet, 2007).

Additionally, supporters of art therapy assessment cite the importance of meeting current standards of practice (Gantt, 2004). Mental healthcare is managed by regulatory bodies and policy that mandate the identification of concrete, targeted, treatment goals (Corcoran & Vandiver, 1996; Kielbasa et al., 2004; President’s New Freedom Commission on Mental Health, 2003). In order to be funded, clinicians are often required to provide evidence of client progress, and to chart outcomes (Corcoran & Vandiver, 1996; Kielbasa et al., 2004). Proponents believe that standardized art therapy assessments are an imperative if art therapists are to meet the standards of accountability and quality that evidence based practice is intended to provide (Deaver, 2002; Gantt, 2004). Further advocates believe that formal art therapy assessment is necessary if art therapy is to continue to grow as a field, since any profession that intends to affect change has a responsibility to demonstrate the efficacy of its practice (Gantt, 2004).

Critics of formal art therapy assessment point out that research has been mired in methodological and philosophical concern, and that this has led to distinct deficits in reliability and validity (Betts, 2005; Bruscia, 1998; Chirila & Feldman, 2012; Dudley, 2004; Wadeson, 2002). One concern is a lack of broadly accepted theory. A recent meta-analysis of art therapy assessment research found this to be a particular concern. Chirila and Feldman (2012) reviewed
93 studies and 9 instruments in an attempt to illuminate the theory supporting the belief that art can create change and serve as a source of information. The authors found a distinct lack of consistent theory across studies which prevented them from being able to classify the studies. Many of the studies seemed to be based on idiosyncratic beliefs of the assessment’s developer. In some cases, Chirila and Feldman (2012) found that the researchers’ interpretations were discussed as if they are objectively observable phenomena. Chirila and Feldman (2012) found that 62% of the assessment procedures reviewed had been designed specifically by the researcher, for the study at hand, as opposed to using “free” art made during therapy sessions, or a previously normed assessment protocol. The authors suggest this indicates a potential researcher bias. Although a number of studies identified objectively observable visual phenomena, Chirila and Feldman (2012) found little attempt by test developers to collaborate on standardization of terminology, or to cross-norm tools intended to measure the same phenomena.

In addition to investigating the researcher’s theoretical orientation, Chirila and Feldman (2012) looked at psychometrics of the studies, including effect size, reliability procedures, replication, and goals of the assessment. The authors found broadly inadequate statistical procedures, as well as inconsistencies between the design of studies and the researcher’s conclusions. In some cases, Chirila and Feldman (2012) report that researchers did use previously published assessments, though the previous investigations were of similarly questionable quality. These findings reflect Hacking’s (1999) review of art therapy assessment research that found notable weakness in statistical methods, inappropriate means of establishing inter-rater reliability, poor controls, and a failure to correlate new assessments with established measures.
In addition to methodological concerns, critics suggest that standardized art based assessment may be inherently invalid, even inappropriate, on philosophical grounds (Dewdney et al., 1967; McNiff, 1998; Wadeson, 2002). First, critics cite an endless variability of creative expression both across and within individuals that makes empirical certainty improbable (McNiff, 1998). Natural human differences in skill and style exist that may be impossible to control for and that are not necessarily a result of pathology (McNiff, 1998). A number of prominent members of the field state that formal art therapy assessment is reductionistic, stripping away the variability and subtlety of human experience by tying phenomena in art works to a rigid, pathology oriented classification system (Dewdney et al., 1967; Dudley, 2004; McNiff, 1998). Dewdney et al. (1967) believes that this rigidity obscures art as a therapeutic tool altogether, implying that art in assessment, and art in therapy are mutually exclusive. Additionally, critics believe that art making and art evaluation is inherently subjective. They believe art work is outside the bounds of empirical objectivity in that images will inevitably contain both therapist and client projections (McNiff, 1998). Dudley (2004) states that art therapists have inadvertently allowed themselves to be subsumed into the medical model due to a “wish to belong” (p. 16). The author criticizes the impulse within the art therapy community to participate in the dominant discourse, including what she cites as the mental health system’s tendency to pathologize as oppose to personalize distress in human experience. Yet, Dudley (2004) points out art therapists must understand and use clinical terminology to be able to communicate differences of perspective.

Linda Gantt, in her 2004 review of the state of art therapy assessment research, believes the negative attitudes toward art therapy assessment are residue from the failures of projective testing. She suggests that instead of abandoning art based assessment, art therapists must learn
from the subjectivity of projective testing and “be clear about what we actually see rather than what we hope to see in drawings” (Gantt, 2004, p.21). As a solution the author proposes the development of formal assessments that focus on form instead of content, that are descriptive rather than interpretive, and that are based on extensive norms. Gantt (2004) concurs with critics of art based assessment that cite natural variability in creative expression among individuals and across time (McNiff, 1998). This she believes further supports the need for descriptive art based assessments in that drawings naturally reflect present state as opposed to stable traits; formal art based assessment must focus on description, not interpretation (Gantt, 2004; Hacking, Foreman, & Belcher, 1996; Kaplan, 2003).

Research in art based assessment has broadened over the past two decades to include descriptive clinical assessments. A number of standardized tools have been developed that correlate the global characteristics in drawings (e.g. line quality, spatial organization) with specific symptoms (Cohen, Hammer, & Singer, 1988; Gantt & Tabone, 1998; Hacking 1999). The authors of such tools assert that these measures are a valid and reliable form of art based assessment, since they focus on objectively observable phenomena (Gantt & Tabone, 1998; Gantt, 2004). Reviews of art based assessment literature suggest that this may be the case (Betts, 2005; Betts, 2006; Hacking, 1999).

In contrast other members of the art therapy community promote a re-focusing on informal assessment (Wadeson, 2002b; Dudley, 2004). Wadeson (2002b) suggests the profession focus on training art therapists to identify their own needs as professionals, and to develop their own assessments to meet those specific needs. Similarly, Dudley (2004) suggests that art therapists avoid psychiatric labeling, focus on individualization of assessment, and draw
on intuitive unconscious process. Wadeson (2002b) believes that assessment is most appropriately an ongoing, informal practice grounded in the therapy process.

In the art therapy community, informal approaches to assessment are still utilized (Gilroy et al., 2012; Peterson, 2012). Literature suggests that some art therapists continue to consider art based assessments reductionistic and of questionable validity (Peterson, 2012). In Peterson’s (2012) survey on art therapists’ use of assessment, only 14.6% out of the 280 responders reported using formal art based assessment methods, although 33.6% use modified formal assessments (Peterson, 2012).

Art therapists on both sides of the debate agree that assessment should be tailored to the setting or purpose for which it is to be used; settings dictate what type of information is relevant, as well as the role the assessment plays in the client’s treatment (Bruscia, 1998; Gantt, 2004; Wadeson, 2002). Bruscia (1998) suggests that the solution to the art therapy assessment debate if for clinicians to be clear about the goals of assessment, taking into consideration both the needs of the client and the role of the treatment setting.

Summary

As revealed in the literature, the topic of art as assessment has presented a problem of definition, as well as a source of debate within the art therapy community. Although art is broadly seen as a source of rich clinical information, there is no one consistently applied theory or approach to assessment in art therapy (Chirila & Feldman, 2012; Rubin, 1999). Art therapists use a variety of assessment formats, including projective techniques, descriptive tools, and informal processes (Peterson, 2012). In addition to variety in approach, a recent meta-analysis found a lack of broadly accepted theory in art based assessment literature, with authors tending toward idiosyncratic rationales (Chirila & Feldman, 2012). This raises questions of validity in
that researchers’ intentions may influence results. Although there have been attempts to clarify assessment related terms – include the terms ‘art therapy’ and ‘art based’ assessment – terms continue to be used inconsistently throughout the literature. Recent research revealed a failure to collaborate on the standardization of terminology within art therapy assessment literature, in addition to continued vagueness and misunderstanding of assessment terms among art therapist (Chirila & Feldman, 2012; Peterson, 2012).

As the literature reveals, proponents of art based assessment cite a number of advantages. First is the added information that incorporating art making into assessment is thought to provide. Second is the capacity of creative processes to elicit information that verbal assessment may not access. Third is the importance of art therapists meeting standards of practice and professional responsibility (Bruscia, 1998; Deaver, 2002; Gantt, 2004; Gantt & Tabone, 2001; Savneet, 2007). Critics of formal art based assessment cite a failure of art based assessments to meet standards of reliability and validity. This includes methodological concerns such as inappropriate statistical procedures, poor inter-rater reliability, poor controls, and a failure to cross norm measurement tools (Betts, 2005; Bruscia, 1998; Chirila & Feldman, 2012). Critics also cite philosophical concerns that they believe make objective, formal, art based assessment improbable and inappropriate. This includes natural human variability in creative expression, as well as the inherent subjectivity of art making and evaluation. In addition, critics caution that formal assessment in the arts therapies may be reductionistic, rigid, and pathology oriented, particularly where assessments are designed to participate in the medical model (Dewdney et al., 1967; Dudley, 2004; McNiff, 1998; Wadeson, 2002).

A number of solutions to the art therapy assessment debate have been proposed. Some members of the field promote a move toward standardized, descriptive assessments that focus on
the detection of specific diagnostic markers as they manifests in the visual characteristics in art (Gantt, 2004). Other members of the art therapy community suggest the profession focus on informal assessment. Supporters of informal assessment promote the training of art therapists in developing individualized assessments that meet both their needs as professionals as well as the needs of clients (Dudley, 2004; Wadeson, 2002b). They support intuitive processes, where assessment is merged with the course of therapy. Recent research suggests that informal assessment continues to be utilized by art therapists, and that clinicians continue to debate the appropriateness and empirical validity of formal, art based assessment (Peterson, 2012).

Clinicians on both sides of the art therapy assessment debate agree that art therapists must be clear about the purpose of assessments, and take into consideration the needs of the client as suggested by the role assessment is to play in the client’s treatment (Gantt, 2004; Wadeson 2002b).

**Examples of Art Therapy Assessments and Measures**

The field of art therapy has incorporated art based evaluation procedures toward the assessment of a great variety of phenomena. Some assessment processes take the form of applying a broad theory of creativity to relatively un-prompted client art making (e.g. Hinz, 2009), while art therapists also continue to use projective drawing (Peterson, 2012). The following are examples of art therapy assessments. This is not intended to be a comprehensive list. It must be noted that art therapists sometimes adapt published assessments to meet their individual needs (Peterson, 2012).

**Ulman Personality Assessment Procedure**

The Ulman Personality Assessment Procedure (UPAP; Ulman, 1992/1965) is one of the first standardized art therapy assessments. The UPAP is a four drawing protocol intended to gather a range of psychic responses by simulating a variety of life experiences (Thayer-Cox, et
al., 2000; Ulman, 1992/1965). The individual is presented with 18in. x 24in. grey kraft paper, a box of 12 pastels, and asked to “please use these materials to make a picture” (Ulman, 1992/1965, p. 79). The freedom in the first drawing is intended to elicit the individual’s primary defensive style, based on the idea that an undirected drawing will mirror a person’s basic response to experience (Thayer-Cox, Agell, Cohen, & Gantt, 2000; Ulman, 1992/1965). When the first picture is complete, the individual is guided through an exercise where they draw large sweeping lines and circles in the air. They are then asked to recreate their movements on paper. In contrast to the first picture, this second picture is intended to elicit the individual’s style of responding to directed experience. Next, the individual is asked to make a scribble drawing, and to develop the marks into any images they suggest. The individual is then asked to make a fourth drawing starting with a scribble if they wish. The individual’s response to the final directive is noted, specifically regarding the way the previous drawings may have influenced the final image (Thayer-Cox, et al., 2000; Ulman, 1992/1965).

Although the UPAP is not accompanied by a rating guide, Ulman (1992/1965) suggests the assessor focus on the formal elements in the drawings, as the person’s artistic style may reflect their style of responding to life (Thayer-Cox, et al., 2000; Ulman, 1992/1965).

**Diagnostic Drawing Series**

The Diagnostic Drawing Series (DDS; Cohen, Hammer, & Singer, 1988) was the first standardized art therapy assessment designed to detect diagnostic markers of symptoms specifically outlined in the DSM (at that time, the DSM III; American Psychiatric Association, 1980). The DDS asks for three pictures which are prompted one at a time as follows: “Make a picture using these materials”, “Draw a picture of a tree”, Make a picture of how you’re feeling using lines, shapes, and colors ” (Cohen, Hammer, & Singer, 1988, p. 14). The individual is
supplied with 18in. x 24in. white drawing paper and a twelve pack spectrum of chalk pastels. 15 minutes are allotted for each picture. Like the UPAP, the first picture is intentionally unstructured. The first picture is intended to gauge the individual’s psychological defenses via their response to the test situation. The first picture is also intended to make the DDS a flexible tool in that a ‘free’ drawing allows the assessor to apply any theory of interpretation (Cohen, et al., 1988). The second picture is the most structured of the three, and is intended to link the DDS with projective testing. The tree was chosen both for its universality, and because of its presence as a symbol in a number of psychological theories. The third drawing is intended to prompt more self-reflection and self-direction based on the assumption that a directive open to interpretation may elicit a more idiosyncratic response (Cohen, et al., 1988). The third picture is also intended to provide an opportunity for the individual to organize and contain moods elicited by the previous drawings. Discussion is to be held until after all three pictures are made to allow the “channeling of psychic energy” (Cohen, et al., 1988, p. 13) into the pictures. In the inpatient setting the DDS is intended to be administered in an individual session, within three to five days of admission.

The DDS protocol is accompanied by a rating guide composed of 23 scales. The authors designed the scales to record the presence or absence of formal characteristics thought to correlate with psychiatric symptoms (Cohen, et al., 1988; Thayer-Cox, et al., 2000). The DDS scales are a combination of nominal and ordinal. For example, raters are asked to indicate the individual’s style of abstraction as “Geometric”, “Biomorphic”, or “Mix” (Cohen, et al., 1988, p. 16). The DDS also includes a Drawing Inquiry form which aids the assessor in eliciting associations to the drawing’s content (Mills, Cohen, & Meneses, 1993). Symbols may be used to
make inferences regarding the individual’s psychic life, but gathering clinical information from the formal elements is the intended focus of the DDS (Cohen, et al., 1988).

The DDS has been extensively researched both in clinical and normal populations, and there is some indication that it is a reliable and valid tool for identifying psychiatric syndromes (Mills, et al., 1993).

**Formal Elements Art Therapy Scale**

The Formal Elements Art Therapy Scale (FEATS; Gantt & Tabone, 1998) is a 14 variable, likert-type scale designed to rate the amount or quality of specific formal elements in drawings. Like the DDS, the FEATS was designed to detect the “graphic equivalent” (Gantt, 2001, p. 126) of symptoms outlined in the DSM, as they are manifest in the following phenomena: Prominence of Color, Color Fit, Implied Energy, Space, Integration, Logic, Rotation, Problem-solving, Developmental Level, Line Quality, Rotation, Perseveration, as well as the details and quality of objects and persons (Gantt & Tabone, 1998). Here, Developmental Level refers to stages of cognitive and emotional development as illustrated in Lowenfeld’s studies of children’s drawings (Lowenfeld & Brittain, 1978).

The FEATS was designed to accompany Lowenfeld’s (1939) Person Picking an Apple From a Tree (PPAT) directive. The authors of the FEATS believe that holding the content contestant within a single directive makes results more comparable across groups, and enhances the FEATS’s usefulness in monitoring clinical change (Gantt & Tabone, 1998). The individual is supplied with 12in. x 18in. white drawing paper, a spectrum of 12 felt tip markers, and asked to produce the PPAT. The FEATS rating manual includes sample drawings for each variable, which is thought to enhance reliability (Betts, 2005; Gantt & Tabone, 1998). Although gathering descriptive data is the focus of the FEATS, the authors include a Content Tally Sheet to record
the content of the drawings for use in therapy (Gantt & Tabone, 1998). In a clinical situation the FEATS is intended to be administered as close to admission as possible. The FEATS has been researched with both a variety of clinical populations, though the investigators caution that more extensive norms are needed to determine the tool’s clinical utility (Bucciarelli, 2011; Gantt, 2001).

**Sheppard Pratt Art Rating Scale**

The Sheppard Pratt Art Rating Scale (SPAR; Bergland & Gonzalez, 1993) was designed to assess the degree of “artistic integration” (p. 81) in spontaneous art works. The SPAR does not include a standardized protocol. Instead, the SPAR provides a guide for rating any two-dimensional art work on the following six variables: Space, Figures, Energy, Color, Composition, General (Bergland & Gonzalez, 1993). Each variable is rated along a seven point Likert-type scale, representing a continuum of “organization, cognitive development, and emotional maturity” (Bergland & Gonzalez, p. 82). In contrast to the FEATS, the SPAR illustrates points along the scale with detailed verbal descriptions as opposed to images. For example, a rating of seven on the Space variable is described as “intuitive awareness of space; endless space or depth can be implied without loss of personal space; elements on the surface appear to have relationships in depth as well as in length and breadth.” In contrast, a rating of one on the Space scale is detailed as “chaotic spatial sense; experimentation with art materials in random diffused way, all over media space” (Bergland & Gonzalez, 1993, Table 1). When both total and individual variable scores are correlated with some diagnostic categories, research suggests that the SPAR has promising discriminant validity (Bergland & Gonzalez, 1993). The authors of the SPAR acknowledge that further research is necessary to ascertain the diagnostic reliability of the tool.
Descriptive Assessment of Psychiatric Art

The Descriptive Assessment of Psychiatric Art (DAPA; Hacking et al., 1996; Hacking & Foreman, 2000) is another assessment designed to discriminate psychiatric diagnoses via the formal characteristics in art. The DAPA guide consists of nominal and ordinal scales for rating the following variables: Color, Color Intensity, Line, Space, Emotional Tone, and Form (Hacking et al., 1996; Hacking & Foreman, 2000). For example, nine specific colors are rated as present or absent, and their intensity is assessed as high, medium, or low (3, 2, 1, respectively). Line can be rated as thick, thin, or varied.

Like the SPAR, the most recent version of the DAPA uses art work made spontaneously during inpatient hospitalizations, with no control for media, paper size, subject matter, or administration (Hacking & Foreman, 2000). A grid is drawn on transparent film and laid over the image dividing it into 20 squares. The assessor rates the content of each square on each variable, resulting in 20 scores that are averaged to result in a composite score for each variable. For example, the Emotional Tone “as it [is] perceived by the rater” (Hacking et al., 1996, p. 426) is rated as negative, neutral, or positive (3, 2, 1) within each individual square. The DAPA authors emphasize a need for an objective method that controls for the variety of content possible in spontaneous art (Hacking et al., 1996). They believe that they grid accomplishes this task.

Research suggests that the DAPA shows promising discriminant validity, though some variables did not reveal significant differences across diagnostic groups (Hacking & Foreman, 2000). The DAPA authors recommend further research with better controls to establish the true diagnostic potential of the tool.
Brief Art Therapy Screening Evaluation

The Brief Art Therapy Screening Evaluation (BATSE; Gerber, 1994) is an art therapy assessment developed specifically for use in the inpatient psychiatric setting. Gerber (1994) outlines the following specific goals:

- To gather information quickly and efficiently
- To translate imagery into understandable terms
- To determine level of care needed
- To integrate information with treatment team
- To adapt principles of art therapy to current health care economy
- To identify and report personality and behavioral characteristic which may directly impact treatment
- To screen for cognitive or neurological deficits requiring further testing
- To introduce the process of art therapy early in treatment (p. 2)

Prior to administration, the clinician is to conduct a full, focused clinical interview covering illness history, current symptoms, a mental status exam, psychosocial profile, functional skills and goals of treatment (Gerber, 1994). The individual is then presented with 8 1/2in. x 11in. white paper, eight fine tip colored makers, and given the following directive:

“Draw a picture of two people doing something in a place. Work approximately for five minutes. Do not use stick figures.” When the drawing is complete the individual is asked to respond to the following prompts one at a time: “Identify every object in the drawing.” “Tell a story about the drawing.” “Identify which part of the picture you feel like right now and why.” “If you were to choose an object or non-human symbol to represent your feelings now, what would it be and why?”
In contrast to the assessments previously reviewed here, the BATSE hails the tenants of projective drawing, providing The Eight Guideposts to guide the clinician through analysis of the drawing’s content. The guideposts include identifying indicators of suicidality, violence, trauma, defenses, transference patterns, regression, fixation, and “unresolved conflict” (Gerber, 1994, p. 6). Interpretations are to be based on a number of psychodynamic principles, for example “Those characteristics most unacceptable… [to the] unconscious appear in the other identified human figure or in the non-human representations” (Gerber, 1994, p.7). The clinician is to use the evaluation form provided in the BATSE manual to communicate psychodynamic and diagnostic impressions to the treatment team.

**Bird’s Nest Drawing**

The Bird’s Nest Drawing (BND; Kaiser, 1996) is a projective assessment developed specifically to examine an individual’s attachment security. As a projective assessment, the BND is theory-based, merging the concepts of attachment theory with the expectation that attachment patterns will be projected into the drawing’s content (Kaiser, 1996). The client is provided with white 8½in. x 11in. paper, a pencil, eraser, and eight fine point colored markers. There is no time limit for the drawing. In the original directive the client is asked to “draw a bird’s nest”, though in an effort to be less restrictive, a recent version of the directive was expanded to “draw a picture with a bird’s nest” (Francis, Kaiser, & Deaver, 2003, p. 128; Kaiser, 1996). Both are directives represented in the literature.

The BND protocol is accompanied by a rating sheet. Ratings are nominal, and generally explore the qualities of the nest, as well as the relationship between the nest, its contents and the environment (Francis, et al., 2003, Kaiser, 1996). The clinician is to infer from the drawing
contents, as well as any verbal associations, the client’s internalized “expectations of how to relate to family members and intimate partners” (Kaiser, 1996, p.333).

The BND has been researched with a variety of client populations and age groups. The literature suggests that the BND has the potential to be a reliable assessment of attachment security, and may enhance treatment planning by incorporating information that supports the development of the therapeutic relationship (Kaiser & Deaver, 2009).

**The Bridge Drawing**

The Bridge Drawing, developed by Hays and Lyons (1981) is another projective assessment developed within the field of art therapy. The directive is based on the authors’ historical, cultural, and evolutionary consideration of the bridge as a symbol. For example, the authors’ reference characteristics of a bridge as a means to cross obstacles and provide linkage to one’s needs, to alternative environments, and to other individuals. According to Hays and Lyons (1981), a bridge may reflect an individual’s perception of their ability to attain goals, or contain a projection of emotional attitudes toward the future such as hope, commitment, security, and permanence.

The original Bridge Drawing protocol provides no standardized materials or time limit, simply asking the client to “Draw a picture of a bridge going from someplace to someplace” (Hays & Lyons, 1981, p. 208). When the drawing is nearly finished the client is asked to use an arrow to indicate the direction of travel, to use a dot to indicate where they are in the image, and to prove a verbal description of the picture (Hays & Lyons, 1981). As an assessment, the goal of the Bridge Drawing is to enhance communication in therapy by eliciting projections of the variables mentioned above. The Bridge Drawing does this by considering the construction and qualities of the bridge itself, the objects or environment transversed by the bridge, the nature of
bridge attachments, the perspective of the viewer, as well as the location and directionality of the client’s self representation (Hayes & Lyons, 1981). Hays and Lyons (1981) guide the clinician through interpretation by outlining 12 discrete variables, for example “Solidarity of bridge attachments” and “Matter drawn under the bridge” (p. 209).

Although the original Bridge Drawing literature does not include a standardized scoring system, a rating system adapted from certain DDS and FEATS scales was recently applied to the bridge drawings of individuals with psychosis. Teneycke, Hoshino, and Sharpe (2009) suggest that their version of the Bridge Drawing assessment may be a powerful tool, as it merges the qualitative sensitivity of projective assessment with identification of specific symptoms via the formal elements. Teneycke et al. (2009) go on to recommend continued research into art-based assessment, particularly in the area of rating visual characteristics; the authors found that seven of the 26 formal elements examined did not meet standards of inter-rater reliability when applied to the Bridge Drawing. Teneycke et al. (2009) encourage the field of art therapy to better operationalize assessment terms and their relationship to human behavior and emotion.

**Summary and Gap Analysis**

As evidenced in the literature, mental health care has changed drastically since deinstitutionalization and the advent of managed care. This has had direct impact on the system of care, including the goals of treatment facilities and the roles of clinicians. The assessment practices of clinicians working in inpatient psychiatric facilities has been notably impacted, as the inpatient unit has moved from serving as long-term care to a short-term, diagnostically oriented function. Broadly, clinicians have had to adapt their assessment practices in response to the new model. Although the literature indicates that art therapists continue to work in inpatient facilities, and continue to utilize a variety of assessment formats in general, little is known as to...
the specific assessment practices of art therapists working in inpatient psychiatric facilities. The purpose of this study is to broaden the knowledge base regarding the assessment practices of art therapists working in adult inpatient psychiatric facilities. This is particularly important given the changing nature of mental healthcare, which emphasizes multidisciplinary assessment, the targeting of specific treatment goals, and documentation. The literature suggests that this knowledge is necessary if the profession is to effectively educate students, meaningfully participate in various treatment settings, and uphold their responsibilities to clients.
Chapter 3: Methodology

Research Design

This study took the form of a descriptive survey of art therapists working with adults in inpatient psychiatry regarding their assessment practices. The survey (Appendix A) was conducted via a telephone interview. An interview format was chosen because of this method’s ability to collect in-depth, qualitative information from a number of individuals, and probe the subtle interaction of multiple variables (Mertens, 2010). The interview contained questions used to elicit themes relevant to the research questions. Interviews were transcribed. Both common and variant themes were labeled, coded and reported via qualitative analysis.

The primary objective of the survey was to enhance the knowledge base of the field of art therapy regarding current practice. Specifically, the study explored the assessment practices of clinicians working with adults in inpatient psychiatry. Secondarily, the study sought to illuminate the rationale and contributing factors behind chosen assessment practices in the inpatient mental health setting. The study explored the following research questions: What are the assessment practices of art therapists working with adults in inpatient psychiatric settings? What are the experiences and attitudes of art therapists working with adults in inpatient psychiatry regarding the practice of assessment? In what way does the inpatient psychiatric facility contribute to art therapists’ chosen assessment practices?

Location

Practicing art therapists were recruited from various locations in the United States.
Time Period

Recruitment began via chain sampling January, 2013, and post approval by the Drexel University Institutional Review Board. All clinicians sent the invitation email were asked to reply by March, 15th, 2014. Interviews were completed in May, 2014.

Participants

Participants were expected to be of a range of gender, racial/ethnic backgrounds, though due to the demographics of the art therapy profession, the sample was likely to be predominantly composed of Caucasian females. Participants were expected to be at least 25 years of age, given the time required to meet inclusion criteria. The study sought to enroll eight participants who met inclusion and exclusion criteria as follows:

Inclusion Criteria

- At least 2 years of employment practicing art therapy with adults in an inpatient psychiatric facility (can be more than one facility) within the last five years
- A minimum of half-time employment, to be defined as a least 20 hours per week on site
- Completion of coursework and internship in an AATA approved masters level degree program in art therapy or be a credentialed professional

Exclusion Criteria

- Art therapists who do not have e-mail or access to the internet
- Art therapists not currently practicing art therapy
- Art therapists who have not had 2 years employment practicing art therapy with adults in an inpatient psychiatric facility
- Individuals who have not completed coursework and internship in a master’s level degree program in art therapy or are not a credentialed professional

Inclusion criteria were designed to open the survey to practicing clinicians who may be working while completing a thesis requirement, in addition to credentialed professionals.

**Recruitment**

The study sought to recruit participants using both purposive chain-sampling and through convenience sampling. The convenience sample was contacted through e-mail via the American Art Therapy Association (AATA) Membership Directory. The researcher is a member AATA. All AATA members have access to the Membership Directory. Post approval by the Drexel University Institutional Review Board, the researcher sent the invitational e-mail (Appendix B) to AATA members, inviting those meeting inclusion criteria to participate. Emails were sent to the 5 membership categories most likely to contain the target population: “Credentialed Professional”, “Professional”, “New Professional”, “Student”, and “Student Plus”. These categories totaled 3,454 members. The invitational e-mail was sent from an e-mail account opened solely for this purpose.

Purposive chain-sampling began by the co-researcher identifying key informants – persons identified whose professional profiles suggest they hold knowledge relevant to the research questions (Mertens, 2010). Sampling continued as potential participants were referred to the researcher by key informants. All individuals referred to the study via chain sampling who expressed interest in participating were asked to provide their e-mail address, and were sent the invitational email.

The e-mail invitation introduced the purpose of the survey, inclusion criteria, expected time commitment, and invited clinicians meeting inclusion criteria to participate in the study.
The email invited clinicians to reply to the e-mail, or call the co-researcher at the provided phone number. Respondents were asked to verify inclusion criteria, and to set up a date and time for the interview. All study related phone communications were made using a cellular phone and phone number acquired solely for this purpose. Upon scheduling the interview, each participant received the Participant Self Reflection Guide (Appendix C) via email. The guide was intended to enhance participants’ self-reflection prior to the interview.

**Instrumentation**

There was no instrumentation used in this study.

**Informed Consent**

Because participants were professionals working in the field, and discussing a non-client specific area of practice, a signed formal consent was not necessary. Although for purposes of conducting the interviews personally identifying information was gathered during recruitment, no personally identifying information is associated with the data in any way. Participants were asked to choose a pseudonym and all personally identifying information was destroyed after data collection. Participants were informed of and assured of anonymity and confidentially in the invitation to participate. Participants were informed that they may cease participation in the study at any time. All data collection procedures were reviewed with the participants prior to the interviews. Transcripts were secured in a locked file in the office of Drexel University’s Creative Arts Therapy department, where they will stay for three years after completion of the study, then destroyed.

**Data Collection**

First, participants’ demographic and professional information was collected via the Participant Information Sheet (Appendix D). Information gathered included age, geographic
location, education/credentialling and professional experience. This information, along with the individuals chosen pseudonym, was used to create a brief descriptive profile of each individual. Data was collected for the study via the interview created by the co-researcher. The interview was administered via telephone. Each interview took approximately 25 minutes. The interviews were audio recorded and transcribed. Audio recordings and transcripts were stored in a secure database during data analysis.

The interview was developed to elicit information regarding if and how art therapists working with adults in an inpatient psychiatric setting integrate assessment into their practice. Additionally, the interview was designed to investigate the rationale and contributing factors behind participants’ chosen assessment practices, including role perception, relationship to the treatment setting, and the clinicians’ perspectives and experiences regarding assessment in the inpatient psychiatric facility. Participants were asked each of seven survey questions (see below) and were asked to elaborate further when initial responses suggest additional topics relevant to the research question(s). The interview questions were as follows:

1. If you assess your clients what are your current assessment practices?

2. What are your primary goals in using assessments with clients at your current employment setting?

3. If you are familiar with the concepts of “formal assessment” and “informal assessment” what is your understanding of these terms?

4. What is your relationship with the treatment team at your current employment setting?

5. What do you feel is your primary role in working with clients at your current employment setting?
6. Please discuss your role(s) in working with clients in terms of the role you see your current employment setting play in your clients’ treatment.

7. In what other ways do you feel that the inpatient psychiatric setting impacts your assessment practice?

Data Analysis

Interview transcripts were reviewed and open coded. Participants were contacted to clarify responses where emergent data suggested an area of potentially meaningful elaboration. Responses were organized into a matrix where emergent themes and patterns were identified. Both shared and variant responses were reported for each survey item. Themes and trends were identified with shared responses emphasised.

Operational Definitions

1. **Assessment** – a process or tool for eliciting information about a client with the goal of better understanding their behavior, clinical state, traits and/or needs; used in tandem with a system, structure or theory, within which to interpret client responses (American Educational Research Association [AERA], 1995, as cited in Betts, 2006; Bruscia, 1998, Gantt, 2004).

2. **Art-Based Assessment** – based on a review of the literature, will be defined here as: a loosely defined and broad category of assessment where clinical information regarding a client is gathered via elicited drawings, responses to graphic stimuli, or other processes where the individual interacts with art media. This may include projective drawings as well as processes specifically developed within the art therapy community.

3. **Art Therapy Assessment** – a type of art-based assessment developed within the field of art therapy, intended to elicit a dynamic, idiosyncratic understanding of the client’s present psychological state or clinical symptoms; may include a standardized tool for
measuring the visual phenomena in client art works, though may also take the form of informal procedures and processes (Gantt, 2004; Kaplan, 2003; Naumburg, 1966).

4. **Formal Assessment** – An assessment designed to detect, capture, and/or measure specific, pre-determined features within an individual or group, using a standardized set of procedures with published norms; a descriptive assessment, enabling a client’s trait or state, observed at a particular time, to be compared to that same dimension observed at another time, or between two or more individuals (Gantt, 2004).

5. **Informal Assessment** – an unsystematic, idiosyncratic, non-standardized form of assessment developed directly in response to a client’s immediate needs or clinical presentation; an assessment process for which no norms exist, where spontaneous, subjective evaluation geared toward present therapeutic needs, takes precedence over gathering generalizable, descriptive or comparative clinical information (Gantt, 2004).

6. **Projective Drawing** – a drawing directive, or set of directives designed to elicit personality or other psychic information deemed relevant within a particular diagnostic or theoretical context; a type of projective test where data is gathered primarily from the content of a client’s drawing, where meanings are based on an expected one-to-one correlation between a human experience and a graphic symbol – the symbol having been previously observed as a pattern emerging in comparable, diagnostic situations or established norms (Dictionary of Forensic Psychology, 2008; Sattler & Hoge, 2006).

**Potential Risks to Participants**

Given that the study topic was limited to professional practice, the study posed little risk to participants. To the knowledge of the researchers, risks associated with the discussion of work related topics, such as stress, anxiety, or concern of adverse impacts on employment or
reputation did not occur. If undue stress or anxiety were to occur, participants would be advised to seek a therapist in their location. It was made clear to all participants that they may cease participation in the study at any time.

**Special Precautions**

Although personally identifying information was initially collected for the purposes of scheduling and conducting the interviews, all personally identifying information was destroyed once data was collected and analyzed. Participants are identified in the study by a pseudonym only. Participants were informed that all data collected and reported would remain anonymous and that their indentifying information would be destroyed. Every effort was made to ensure the comfort of participants. If discomfort had been detected, participants would be reminded that they may withdraw from the study at any time and to seek a therapist in their area.

There were no restrictions on participation as regards to gender, race, ethnic identity, sexual identity or religion. There was no incentive to participate in this study.
Chapter 4: Results

Overview

This chapter contains the results of the present study. The section begins with a description of responses, followed by a demographic narrative of each participant. The chapter continues with itemized responses to the seven survey question, followed by emergent themes, both common and variant. Itemized responses were derived from explicit statements made by participants, as well as latent content that emerged as the data was extracted and organized into a matrix. Similarly, themes were derived from both explicit statements, and from latent meanings that emerged as the itemized responses were coded. The transcripts were then re-reviewed and re-coded for additional latent meanings, which were then integrated into the developing themes.

Description of Responses

Fifteen individuals who were sent the invitational email through the American Art therapy Association (AATA) Membership Directory expressed interest in participating in this study. Three individuals expressed interest in participating via chain-sampling. Based on the information gathered in the Participant Information Sheets, seven respondents met inclusion criteria. Out of those seven, five individuals agreed to participate and scheduled a telephone interview with the co-researcher. Each interview was approximately 30 minutes long. All participants were individuals who had been contacted via AATA’s Membership Directory.

Demographic Narratives

The following are narrative descriptions of each participant, based on the information provided in the Participant Information Sheet. All names used in the study are pseudonyms.

- Yolanda is a Board Certified Art Therapist (ATR-BC) as well as a Licensed Psychoanalyst in a large east coast city. She has been practicing art therapy for a total of
40 years. In addition to a Master of Professional Studies in Art Therapy and Creativity Development, she also has an EdD in Administration and Policy Studies. She has been practicing art therapy in the inpatient setting for 18 years.

- Olivia is a Board Certified Art Therapist (ATR-BC) with a Master of Arts in Art Therapy. She has been practicing art therapy for a total of 13 years, and has been working in the inpatient setting for eight years. She is currently practicing in the Midwestern part of the country.

- Maggie is a Board Certified Art Therapist (ATR-BC) with a Master of Arts in Art Therapy. She has been practicing art therapy for a total of 14 years, and has been working in the inpatient setting for her entire career thus far. She is currently practicing just outside a large east coast city.

- Sam is a Board Certified Art Therapist (ATR-BC) with a Master of Arts in Art Therapy. In addition to the ATR-BC she is a Licensed Clinical Professional Counselor (LCPC). She is currently practicing in the lower Midwest. She has been practicing art therapy for a total of 14 years. Until recently she worked in the inpatient setting for seven years.

- Mary is a Registered Art Therapist (ATR) with a Master of Education in Art Therapy. She is currently practicing in a large east coast state. She has been practicing art therapy for a total of 18 years and has worked in the inpatient setting for 10 years.

**Itemized Responses**

This section contains a summary of participants’ responses to the 7 interview questions.

**Item 1** asked participants whether or not they assess their clients and if so, to elaborate on their assessment practice. The following is a summary of responses to Item 1.

- All participants do assess their clients.
• All participants described using primarily informal assessment processes.

• Two participants indicated that they use primarily information reported in treatment team meetings, and in patient charts, to make their initial assessment of patients.

• Four participants stated that they complete a non art-based assessment to comply with documentation requirements of the facility and/or the state, and
  1. The assessment is a combination of structured questions and the therapist’s clinical impressions in the form of a narrative.
  2. The assessment is a non-standardized form or format developed by the facility or the participant.
  3. The assessments focused on gathering information, including a description of the presenting problem, mental status, the individual’s perception of their condition and needs, personal interests, and a brief psychosocial evaluation.
  4. The assessments are entered into an electronic medical record.
  5. Three participants stated that they designed the non art-based assessment themselves.

• All participants indicated that they regularly use informal art-based assessment and
  1. The informal art-based assessment occurs primarily during normal patient care.
  2. The informal art-based assessment occurs primarily in a group setting.
  3. Three participants document the art-based assessment in the patients’ medical record, including a description of the art work and clinical impressions.
  4. Four participants, including the two who do not document art-based assessment information, do discuss art-based clinical impressions when in treatment team meetings if the artwork shows a clinically relevant change.
5. Three participants state that they sometimes adapt a formal, art-based assessment, intended for use with a single client, as an informal directive in the group setting.

6. All participants indicate that art-based assessment occurs ongoingly, as the artwork made in group sessions is used to monitor for changes throughout treatment.

7. Four participants referred to their art-based evaluation as intuitive.

8. One participant merged a non art-based assessment required by the facility with her informal art-based assessment.

- All participants indicate that they see their art-based evaluations as separate and more genuine than assessments the facility requires them to produce.

- All participants are familiar with a variety of formal, art-based assessments.

**Item 2** asked participants to describe their primary goals in using assessment with clients in the inpatient setting. The following is a summary of responses to Item 2.

- For all five participants, a primary goal of assessment in general is to gather information regarding the presenting problem, mental status, insight, and immediate needs.

- All five participants stated that a primary goal of assessment is to inform treatment planning.

- For three participants, building rapport with the patient is a primary function of assessment.

- Three participants stated that a primary goal of their art-based assessment is to evaluate the individual’s degree of insight into their current condition.
• Four participants stated that a primary goal of the art-based assessment is to help the individual to self-assess – to explore their self-perception, and to gain insight into their current state or situation.

• Four participants stated that the goals of their art-based assessment include providing collateral information to confirm or re-evaluated diagnosis, and to monitor for changes during treatment.

Item 3 asked participants to state their understanding of the terms “formal assessment” and “informal assessment”. The following is a summary of responses to Item 3.

• All five participants described formal assessment as a structured, standardized, protocol that comes with a tool and/or set of criteria for measuring specific, predetermined variables.

• All five participants described informal assessment as an idiosyncratic assessment procedure where the clinician relies primarily on their theoretical knowledge and professional experience to make intuitive judgments and:
  1. Is more client driven than formal assessment
  2. Is more spontaneous than formal assessment

• One participant stated that her non art-based assessment is formal, though her description of it is informal as defined in the literature and for the present study.

Item 4 asked participants to discuss their relationships with the treatment team. The following is a summary of responses to Item 4.
bullet All participants consider themselves valued, active members of an interdisciplinary treatment team.

bullet One participant attends daily interdisciplinary treatment team meetings.

bullet Four participants reported that they attend interdisciplinary treatment team meetings part-time due to the scheduling terms of their employment.

bullet Three participants state that they see themselves as an advocate for the patient, and a representative of the patient’s voice.

bullet Three participants state that they regularly refer to the artwork, and the individual’s verbal associations when in individual consult with another team member.

**Item 5** asked participants to describe their primary role(s) in working with clients in the inpatient setting? The following is a summary of responses to Item 5.

bullet All participants state that a primary role is to help the patients increase self-knowledge, and develop insight into their current condition or situation.

bullet Four participants state that a primary role is to monitor patients for change, and to report observations of patient functioning to the interdisciplinary team.

bullet All participants state that a primary role is to provide support by

  1. helping patients adjust to hospitalization, and reduce hospital related anxiety.

  2. helping patients to communicate, and to express themselves in a constructive way.

bullet Three participants stated that a primary role is to serve as an advocate for the patient’s perspective, and to represent the patient’s voice in the context of the interdisciplinary team.
Three participants stated that a primary role is to introduce patients to the experience of creativity and to educate on the use of art making as a coping skill and process for healing.

**Item 6** asked participants to discuss their role in working with clients in terms of the role that the inpatient setting plays in the patients’ treatment. The following is a summary of responses to Item 6.

- All participants state that the primary role of the inpatient setting is to provide safety and stabilization to individuals in crisis, and support the transition to community based care.
- All participants see their role as complementary to that of the facility in that they provide opportunities for stability through here-and-now goals including:
  1. Providing support and structure
  2. Providing a forum where patients can communicate and be heard
  3. Providing an opportunity for patients to use creativity to cope and adapt to hospitalization
  4. Providing an opportunity for patients to experience catharsis and healing through creative activity
- Four participants see their role as complementary to the role of the facility in that they encourage the development of insights necessary to transition back into the community.

**Item 7** asked participants to discuss other ways they feel that the inpatient psychiatric setting impacts assessment practice. The following is a summary of responses to Item 7.
• All participants emphasized the impact of time on assessment practice in that the short-term nature of the setting makes completing an individual, art-based assessment with each patient unfeasible.

• Two participants emphasized the impact of time on assessment practice in that they do not have enough time to use existing formal art-based assessments.

• Four participants emphasized the impact of time on assessment practice in that due to time constraints, assessment occurs primarily in group setting.

• Three participants emphasized the impact of staffing cuts and reduced work hours, which make them unable to meet each patient for individual assessment prior to seeing them in the group/therapeutic setting.

• One participant emphasized the impact that budget and staffing cuts have had on her professional identity in that:
  1. She has been asked to take on additional responsibilities that skew and devalue her role as a clinician.
  2. These same changes have lead her to be more a part of the treatment team in that the team has had to work together to adapt to fewer resources.

• Four participants expressed conflict and uncertainty regarding their role, in the context of changes in inpatient psychiatric services.

• One participant described feeling “lost” with regards to adapted to changes in practice and documentation, and noted that her education did not prepare her for work in the inpatient setting.
Common Themes

For the purposes of this qualitative study, which enrolled five participants, common themes will be those identified in three or more interviews. Themes will be defined by meanings derived from both explicit statements made by participants, and from latent content. Data was extracted from the transcripts, organized into a matrix, and then coded to form themes. Transcripts were then re-reviewed for latent content, which was then coded and integrated into the emerging themes. Exemplar quotes for each theme are contained in Appendix E. The following is a presentation of common themes.

- Art therapists working in the inpatient psychiatric setting do assess their clients, and use multiple assessment formats with separate goals and purposes.
- When using art-based assessment, art therapists working in inpatient psychiatric settings use primarily informal processes.
- Art therapists working in inpatient psychiatric settings merge assessment with treatment.
- Art therapists working in inpatient psychiatric settings see insight as a primary focus of both assessment and treatment.
- Art therapists working in inpatient psychiatric settings view their art-based assessment as separate and more genuine than assessments required by the facility.
- Art therapists working in inpatient psychiatric settings see providing support as a primary therapeutic goal.
- Art therapists working in inpatient psychiatric settings see themselves as active, valued members of interdisciplinary treatment teams.
- Art therapists working in inpatient psychiatric settings see themselves as an advocate for patient, by providing a forum for the patient’s voice.
Limitations of time and resources posed by current inpatient, mental health services have had a major impact on the assessment practice of art therapists working in this setting.

Art therapists experience role conflict and uncertainty as a result of changes that have occurred in the inpatient psychiatric setting.

**Variant Themes**

For the purposes of this qualitative study, variant themes will be defined by meanings that emerge in no more than two interviews. The following is a presentation of variant themes.

- Art therapists working in inpatient psychiatric settings sometimes use second hand sources of information to make their initial assessment of patients.
- Reduced resources have both challenged and supported the professional identity of art therapists working in inpatient psychiatric settings.
- Art therapists working in inpatient psychiatric settings may feel lost, and have difficulty adapting to the current demands of inpatient psychiatric work.

**Summary**

This chapter presented a summary of participants’ responses to the interview questions. All participants’ answered each of the seven questions. There is a notable prominence of shared responses, suggesting that there may be more similarity than variance in the practice and work related experience of participants. The following chapter contains a discussion of findings, with an emphasis of common themes.
Chapter 5: Discussion

Overview

Art therapists have a long history of working in inpatient psychiatric facilities. As a treatment setting, the inpatient facility had a great influence on the development of art therapy as a profession, including the field’s approach to clinical assessment (Rubin, 1986; Ulman, 1965; Wood, 1997). Although inpatient psychiatry has changed drastically over the years, and continues to be a common employment setting for art therapists, little is known about the current assessment practices of art therapists working in this treatment setting. This information is important because clinical assessment and diagnosis has emerged as a primary function of inpatient psychiatric facilities (Horsfall, Cleary & Hunt, 2010; Sharfstein, 2009). Further, although assessment in the art therapy profession continues to be a source of debate, it is broadly considered by clinicians on both sides of the debate to be an essential aspect of practice (Bruscia, 1998; Dudley, 2004; Gantt, 2004; Wadeson, 2002). Finally, the literature suggests that in order to provide quality care, it is essential for art therapy as a profession to understand the needs of clinicians and the role art therapists play in various work environments.

The purpose of this study was to shed light on the assessment practice of art therapists working in inpatient psychiatric settings, and to understand the rationale and contributing factors behind those practices. This chapter contains a discussion of findings and places results in the context of the literature reviewed. The chapter begins by identifying common themes that are consistent with the available literature. The chapter continues with a section discussing common themes identified as unique relative to the available literature. The following section discusses two notable variant themes, one of which presents an alternative perspective to the challenges
faced by art therapists working in inpatient psychiatry. The chapter concludes by exploring the limitations and implications of this study.

**Common Themes Consistent with Available Literature**

The common themes revealed by the present study are consistent with the literature review in four main areas. These areas are: general assessment goals and process, general treatment goals, merger of assessment and treatment, and the work related experience of art therapists.

**General Assessment Goals and Process**

In the present study, participants’ statements suggest that their general assessment goals and process are consistent with assessment as it is practiced by other professions working in the inpatient setting, as represented in the literature. First, the clinicians interviewed consider themselves to be active members of a multidisciplinary treatment team, with initial assessment, as well as ongoing clinical evaluation to be one of their primary roles. This is consistent with the current treatment team model (Horsfall et al., 2010; Sharfstein, 2009). They also report supporting the goal of the treatment team to identify appropriate outpatient care, by using their evaluations to either clarify or qualify the team’s initial diagnostic impressions. Notably, participants emphasized the role of providing ongoing clinical observation and reporting this information to team members, suggesting that the emphasis on assessment that is part of inpatient care, is appreciated by art therapists (Horsfall et al., 2010; Sharfstein, 2009).

The participants consider their assessment practice to be primarily an informal process. This is despite the fact that the art therapists reported being familiar with standardized assessment tools. This finding echoes a prominent theme in the literature where psychiatrists, social workers, and nurses in an inpatient setting report using informal, in some cases ad hoc,
assessment processes despite the availability of standardized tools (Coombs, Curtis, & Crookes, 2012; Delaney, Cleary, Jordan, & Horsfall, 2001; Farley, 1994; Hales et al., 2008; Hamilton et al., 2004).

Notably, the literature revealed that clinicians across disciplines experience a sense of dissatisfaction and frustration with what they see as a compromising of assessment principles (Hamilton, Manias, Maude, Marjoribanks, & Cooke, 2004). Literature suggests that an informal approach to clinical assessment may result in insufficient or biased information, which is inconsistent with both evidence-based practice and person-centered care (Hamilton et al., 2004). The present study suggests that art therapists working in inpatient psychiatry also experience such limitations and frustrations regarding their assessment practice, which will be elaborated on later in this chapter. These factors, along with participants’ requirement of a tool that meets documentation standards, suggests that a structured, if not standardized assessment tool may be valued by art therapists working in the inpatient psychiatric setting.

As seen in the literature, the terms “formal” and “informal” assessment are defined and used inconsistently in the art therapy community; non-standardized tools are sometimes referred to as formal in the empirical sense, leading to misunderstanding among clinicians as well as a limited evidence base (Peterson, 2012). Four of the five participants’ descriptions of their assessment practice were consistent with their stated definitions of “formal” and “informal” assessment. Their definitions were in turn consistent with the qualities of formal and informal assessment used in the broader mental healthcare literature, and as defined for this study (Gantt, 2004; Peterson, 2012). This finding suggests that there may be a more consistent understanding of the different forms of assessment among art therapists practicing in inpatient psychiatric
settings, than exists in the broader art therapy community. It may be that the treatment setting informs clinician’s understanding of assessment.

Another area where the participants’ assessment goals were found to be consistent with the literature was regarding an emphasis on the assessment of insight. As seen in the literature, a client’s degree of insight is a key feature of psychiatric assessment (Hales et al., 2008). Participants emphasized the importance of insight. Additionally, they seemed to indicate that the assessment of insight occurs on two levels; in addition to the process informing the clinician, participant’s described the patient as an active participant in assessing their own behavior and experience. This feature of assessment represents a possibly unique feature of assessment performed by art therapists in the inpatient setting, and will be elaborated on later in this chapter.

**General Treatment Goals**

A second area where common themes were found to be consistent with the literature was in the area of general treatment goals. As revealed in the literature, changes in inpatient psychiatric services led therapists to move away from long-term, curative goals to more pragmatic, supportive aims (Brabender & Fallon, 1993; Edmond & Rasmussen, 2012). The present study suggests that art therapists working in inpatient psychiatry have indeed adapted their practice in this way. Participants report a focus on reducing immediate distress and anxiety in an effort to stabilize the individual and ease their transition into the hospital. They describe group work as a means for the patients to experience catharsis through the expression of emotion, and to develop rapport and understanding through enhanced communication. They describe this work as complementary to the goals of the treatment setting in that the group work provides patients with an opportunity for stability through support, containment, and experiential learning. Also consistent with the literature, the participants report that group time is a place for
patients to learn constructive new ways of managing their symptoms and emotions, so that they may be better able to function in the community.

Not only is the above finding broadly consistent with the literature, it also suggests that art therapists have internalized some of the recommendations seen specifically in the art therapy literature regarding adapting to the changing inpatient setting, for example Ulman’s early 1966 call for clinicians to support “…catharsis and emotional reeducation in the broadest sense” (p 4.).

**Merger of Assessment and Treatment**

Another theme that is consistent with the literature is the merger of assessment and treatment. Four of the five participants noted that due to time and staffing constraints they are often unable to meet with patients prior to seeing them in the group setting and that they gather much of their clinical information during group time. All participants report utilizing non-directed or “free” art made during therapeutic groups as a source of evaluation. Three participants noted that they also adapt standardized art-based assessments to the group setting, with the assessment becoming an informal “group assessment”. In the words of one participant:

“I’ve adapted some art therapy assessments to use them in group therapy. So I don’t necessarily sit down and fill out all the paperwork that has to do with the assessment …but we’ll process [the artwork] in group. You know, so it’s an art therapy assessment but it’s adapted as a group assessment so to speak.”

Notably, participants reported that a primary function of group time has become the monitoring of changes during treatment, and that reporting on patient functioning is one of their primary roles as team members. In the words of one participant, “I kinda always have my assessment hat on.” These findings are consistent with a notable theme in the literature where members of other
disciplines described assessment as a process occurring primarily during the course of normal patient care (Delaney, 2001; Hamilton et al., 2004).

**Work Related Experience of Art Therapists**

A fourth area where the present study revealed themes reflective of the literature regards the impact of changes in inpatient psychiatric care on the experience of art therapists. First, participants in this study report that changes in mental health services, including shortened length of stay, reduced work hours and/or staffing cuts, result in their not being able to consistently perform comprehensive, individual assessments. Regarding art-based assessment, three of the five participants stated that they had been able to perform individual art-based assessments in previous years while working in an inpatient psychiatric setting. In fact, a number of statements made by participants suggest that if it were not for the constraints imposed by current inpatient services, they might use a structured, if not formal, art-based assessment with each patient. For example, one participant stated:

“We really don’t get a chance to do formal [art based] assessment anymore. You know, nobody is willing to take the time, to pay the money… You know, there’s just, there’s other assessments out there that are so exciting, but everything is drive-by these days.”

In the words of another participant assessment in the inpatient psychiatric setting has become “…assessment on the run.” These findings reflect the literature where changes in inpatient mental health care were shown to have a direct and negative impact on assessment practice. This in turn results in frustration, and a feeling on the part of clinicians that assessment has become a cursory function. These findings suggest that art therapists working in inpatient mental health care may currently experience frustration and dissatisfaction regarding what they see as a compromise of assessment principles.
Another area where the experience of the participants was reflective of the literature was regarding role conflict and uncertainty. In response to Item 7 which asked participants to discuss any other ways the impatient setting impacts their assessment practice, as well as in their closing remarks, participants made statements that seem to implicate a questioning of their role and value such as:

“How you get to the point – because I have been here ten years now – that, what can I do? What else do I want to do? How can I change the system? The system is changing and the question, you know... am I really being utilized here?”

Participants also made statements that more explicitly reflect on how changes in the treatment setting have led to role conflict and uncertainty such as:

“…with changes in healthcare budget cuts and that kind of thing, as a therapist I’ve been asked to do a lot of things that, I guess, in some way makes you more of a valued member of the team, but in other ways devalues your value as an art therapist…you’re building rapport with the assessment, and introducing yourself as the art therapist, and the next time they see you you’re making sure that they don’t have any dirty linens. That kind of skews the whole relationship. It’s an interesting dance.”

These statements are consistent with the literature where beginning in the 1980’s, therapists in inpatient mental health settings reported that changes in therapeutic focus, reduced resources, and an increase in non-therapy related duties, contributed to a blurring of professional identity, dissatisfaction and burnout (Boronow, 2009; Cashell & Miner, 1983; Glenn, 2010; Wood et al., 1994). The present study then suggests that art therapists currently working in
inpatient mental health facilities do experience role conflict and uncertainty, and may be at risk for burnout.

**Common Themes Unique Relative to Available Literature**

The present study revealed a number of common themes that are unique relative to the available literature. These themes have been grouped into the following areas: The practice of assessment, the assessment of insight: patient as co-assessor, and the role of the art therapist.

**The Practice of Assessment**

As stated, the present study suggests that the general assessment process of art therapists working in the inpatient psychiatric facility is consistent with that of other disciplines, as represented in the literature; the participants reported using primarily a singular, informal assessment—a structured form or format developed by the facility, or the clinician herself, to meet documentation requirements. In elaborating though, participants’ descriptions suggest that their assessment practice is in fact more complex. As the interviews progressed, all participants described also using informal art-based assessment. In the words of one participant, the initial assessment is used to “get basic information and get it written down”. In fact two participants stated that they get much of their initial information from second sources, such as intake forms and reports given in treatment team meetings. The participants seem to view their art-based interventions as a more “personal assessment” where the art making is used to clarify or qualify initial assessments made by the treatment team. They feel that the art enables them to develop a deeper understanding of the individual, since they are able to draw upon the more complex information that multi-sensory processing and communication provides. These findings suggest that art therapists working in inpatient psychiatric settings may engage in multiple assessment formats with separate goals and purposes. In the words of one participant, the initial assessment
is “generic”, used to gather basic information and conform to documentation requirements, while the art-based assessment is more “genuine”, used to develop an expanded understanding of the individual and their needs.

In addition to benefiting the patient on the assessment and treatment level, this use of multiple assessment formats may help art therapists better maintain their assessment principles, and thereby sustain a positive perceived role. As discussed previously, this study suggests that art therapists in the inpatient setting may experience a great deal of role conflict and uncertainty. In fact a number of participants expressed a questioning of their value in this treatment setting. If using art-based information maintains a person-centered approach to human distress, and enables practitioners to gather more individualized clinical information, art therapists may moderate what is otherwise a frustrating compromise of assessment principles. Further, art therapists may be in a position to circumvent the constraints of assessment in inpatient mental healthcare.

While the above advantages of art-based assessment may give art therapists a comparative advantage here, the reliance on informal assessment methods on the part of all disciplines raises difficulties. The recovery model, of which the inpatient facility is a part, emphasizes evidenced-based practice and measurable outcomes. The inpatient facility then requires standardized assessment measures capable of attaining a base-line and detecting differences both between individuals and across time (Frank & Glied, 2006; Hales et al., 2008; Horsfall et al., 2010; Sharfstein, 2009). This type of accuracy is necessary not only for immediate treatment, but for enabling the facility to identify appropriate outpatient services. It was seen in the literature that a variety of structured and standardized assessments exist that might be useful in inpatient services (American Psychiatric Association, 2013; Cutcliff &
Despite this, the present study and the available literature suggest that clinicians across disciplines are not utilizing them (Coombs, 2012; Farley, 1994; Hamilton et al., 2004). By relying primarily on informal assessment, clinicians may not be meeting practice standards, and facilities may be providing services of questionable efficacy.

Regarding art therapy specifically, as seen in the literature, art therapists commonly build diagnostic impressions through the use of informal assessment, a feature of the profession that has been hotly debated (Bruscia, 1998, Dudley, 2004; Wadeson, 2002; Wadeson, 2002b). Although valuable in particular contexts, both the present study and the literature suggest that informal assessment is possibly of a different kind than necessary in the inpatient setting (Gantt & Tabone, 2001; Gantt, 2004; Sharfstein, 2009). This is despite the fact that informal assessment is the type of process most commonly used in inpatient care (Delaney et al., 2001; Farley, 1994; Hamilton et al., 2004). This observation is consistent with a recommendation in the literature to identify the type of information that is relevant to particular settings, and tailor assessments to fit the role they are to play in an individual’s treatment (Gantt, 2004; Wadeson, 2002b).

**Assessment of Insight: Patient as Co-assessor**

The present study is consistent with the literature where evaluating an individual’s degree of insight is a key feature of psychiatric assessment (Hales et al., 2008). The practice of assessment by art therapists is *unique* where the assessment of insight seems to occur on multiple levels. Not only do the participants seek to understand the individual’s degree of self-awareness, the patient is encouraged to self-assess, to reflect on their own perception of their current state or
situation. In the words of one participant, “It’s not just me collecting data but it’s them seeing ‘maybe I need to think about this differently.’” Assessment here is merged with treatment in that during evaluation (most often during the art-based evaluation) the therapists are able to simultaneously support increased insight needed for the individual to transition into the next level of care. This study suggests that art therapists working in inpatient psychiatric settings may see engaging the individual in self-assessment as a pertinent part of assessment; the patient becomes a co-assessor.

The Role of the Art Therapist

It was seen in the literature that a prominent feature of current mental healthcare is that it is largely based on the medical model (Frank & Glied, 2006; Kendell & Jablensky, 2003; Kendler, 1990). The literature suggests that this feature may bias assessment, where patient verbalizations and behaviors are interpreted through the predetermined categories of pathology (Deegan, 1996; Hamilton et al., 2004; Mattaini & Kirk, 1991). When asked to discuss their role as a therapist, the participants described one of their primary roles as providing a forum for a “genuine” understanding of the patients, a chance for individuals to “be heard” outside the discourse of pathology. Three of the five participants also emphasized the importance of communicating the patients’ perspectives to the treatment team and described themselves as an advocate for the patient’s voice. In the words of one participant:

“When I talk about any patient on the unit at any time, I am often talking about their artwork and what they’ve said to me about their work, and their verbalizations about themselves. I feel like I’m the advocate for the patient on that level specifically. I am constantly bringing that into the team.”
The present study suggests that art therapists in the inpatient setting may have broadened their role to include advocacy, in response to a marginalization of the patient’s voice. Broadly, this supports the finding that art therapists have in some ways adapted to changes in inpatient mental health care in ways that support both their professional identity and the people they serve.

**Variant Themes**

The present study identified two variant themes that are notable in the context of art therapists’ adapting to changes in inpatient psychiatric work.

When asked to discuss other ways that the inpatient psychiatric setting impacts her practice, one participant stated that although reduced resources have necessitated her performing duties outside her role as a therapist, the result of this has not been wholly negative. Although at times she feels that this “devalues” her as an art therapist, it also makes her “part of the team”.

In the words of the participant:

> “Nowadays there are a lot of other things that we’re having to do that are important to the safety of the unit but don’t necessarily fall under the art therapy bracket. But they make you part of the team. It’s kind of interesting that way.”

This suggests that although changes in inpatient psychiatric care have contributed to role conflict and uncertainty for some art therapists, the challenges of inpatient work may also lead to enhanced teamwork, since staff members must collaborate in the face of reduced resources.

Another participant when asked to discuss ways that the inpatient psychiatric setting impacts her practice stated she has felt “lost” in the face of changing standards. She reported that her education did not prepare her for inpatient work as it currently functions. Specifically regarding assessment, this participant stated that her training in art-based evaluation focused on lengthy case studies, thinking which she has had difficulty translating into current documentation
requirements. Further, she expressed concern that current art therapy students seem equally unprepared for what she sees as the realities of inpatient work. In the words of the participant:

“I have a student [intern] currently who resists the appropriate clinical format. And it’s very difficult because they don’t get this teaching in the university… I remember not getting that myself. Our training was in writing a case study which was very long and lengthy, which is not what we have time for here.”

This finding suggests that some education programs may not fully prepare students for work in certain contexts. Some art therapists may have difficulty adapting to inpatient work, and may feel unprepared and unsupported by their education.

**Limitations**

The present study contains a number of limitations. First, the small number of participants may have skewed results by not fully representing the population.

Another important limitation regards the Participant Self-Reflection Guide. Prior to the interviews, participants were sent the guide and encouraged to reflect on their practice and experiences working in inpatient psychiatry. The use of the guide may have influenced or primed participants in a way that skewed results. For example certain results relied in part on the participants defining terms often vague within the field of art therapy. If participants researched terms prior to the study, as opposed to relying on their existing knowledge, the interviews may not accurately represent the relationship between understanding and practice.

Another set of factors that may have influenced this study were the experiences and assumptions of the researcher. Not only is the researcher of the present study a graduate student, she has been employed full-time as a therapist in the inpatient psychiatric setting for over three years, in addition to a yearlong internship in the same setting. Although it is the belief of this
researcher that said experience provided valuable motivation, sensitivity, and insight into the current subject, this same experience may bring biases and assumptions to the study that influence the results in unknown ways.

**Clinical Implications**

**Questions for Future Research**

A thread running through this study – from the literature review through the results – is a question of the principles of a profession vs. the role of specific treatment settings. Tensions at this intersection were seen to impact practice in a number of ways that warrant future study.

Researchers might investigate:

- The assessment needs of clinicians in the context of specific treatment settings, and re-visit the ways that each profession might best contribute – what type of information and in what format is most useful?

Regarding art therapy specifically, the present study suggests that a structured, if not standardized art-based assessment may be valued by art therapists working in inpatient mental healthcare. A number of participants expressed loss in no longer being able to perform individual art-based assessments with patients, and shared interest in and experience with some existing, standardized art-based tools. Additionally, this study found that in inpatient facilities, art-based evaluation occurs primarily in a group setting. Future research might ask art therapists currently working in this setting:

- What qualities would be most valued in a structured assessment tool?
- What assessment format would be most useful?
- What type of information would be most relevant to art therapists’ practice in the inpatient psychiatric setting?
• What is the impact of the therapeutic group setting on individual assessment?
• How might the group setting be meaningfully harnessed in a structured assessment tool?

It was seen in the present study that the participants have adapted their practice to changes occurring in the treatment setting. Participants utilized multiple assessment formats in order to meet the documentation requirements of the setting, while maintaining the values and principles of the profession. The participants’ assessment practices were generally self-developed; three participants reported that they designed the initial, non art-based documentation themselves, though only one clinician was able to consistently integrate art-based evaluation as part of the format. These findings suggest that art therapists in the inpatient setting may have some flexibility and input at the local level of development. Future research might ask:

• What are the specific factors that prevent some art therapists in the inpatient psychiatric setting from integrating their modality into hospital/state mandated assessments?
• How can the profession of art therapy support practitioners in developing assessments at the local level?

Recommendations

The present study resulted in three specific recommendations: first, that the above questions for future research be investigated in the context of recovery oriented care, second, that the profession of art therapy evaluate and expand the content of education programs in the area of career preparedness, and third, that art therapy partner with psychiatry in ongoing efforts to develop a more person-centered approach to mental healthcare.

It is the opinion of this researcher that the values and tenants of the profession of art therapy are uniquely suited toward the principles of a recovery model. Both emphasize a person-centered approach to mental health evaluation, with a focus on understanding the unique
experiences and perspectives of the individual. Both encourage the individual to be an active participant in guiding their own healing, and assume that individuals have the capacity to initiate this regardless of their clinical state. Both believe that individuals have a natural potential for creativity and, given a supportive environment, will use that creativity to heal both their inner and outer lives. Both believe that health is more than just symptom reduction, but encompass the individual’s roles, goals and relationships, the latter including that with regards to the self (Karkou & Sanderson, 2006; Naumberg, 1966; Rubin, 1999; Mabe et al., 2014; Thornton & Lucas, 2011). In the present study these values helped define participants’ self-perceived roles. This suggests that a mindful, recovery oriented perspective might be naturally integrated into existing practices. Further, if the above questions for future research are investigated in the context of the recovery model, art therapists may be in a unique position to contribute to a more meaningful assessment in the inpatient setting.

As suggested by the small amount of current literature regarding art therapy in inpatient psychiatry, and as expressed in some of the sentiments made by participants in this study, the profession of art therapy seems disconnected from the realities of current practice in this treatment setting. It is the opinion of this researcher that the profession may need to expand training programs in the area of career preparedness, particularly with regards to prevailing treatment models and the roles of various treatment settings. Art therapy training programs might encouraged specialization not only in population served (e.g. child vs. adult, specific diagnoses) but in level of care. Regarding inpatient psychiatry specifically, it is the opinion of this researcher that art therapy education and research explore more deeply the changes, realities, challenges and goals of current practice. This might include the role(s) of assessment and treatment in this setting as well as an emphasis on the skills needed for clinicians to identify
possible new roles and practices, in the spaces made available by an evolving healthcare system. This supports recommendations in the literature, for professions to educate students more pragmatically, including supporting the ability to develop tools and practices that meet their specific professional needs (Allen, 1992; Riley, 2009; Wadeson, 2000).

Finally, the present study confirms previous suggestions for a broad re-evaluation of mental healthcare. The most recent revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) suggests that this may be occurring. It seems that the field of psychiatry is in the process of embracing a more person-centered view of mental health. Practitioners of art therapy may be able to contribute by more fully partnering with psychiatry. It is the opinion of this researcher that the profession of art therapy suspend differences of approach and theory, and re-focus on areas of agreement both within the profession and across disciplines. Regarding inpatient psychiatry, this might occur as suggested above, by focusing on more fully integrating the principles of recovery oriented care into existing practice. The profession of art therapy may be able to facilitate a creative collaboration that will enable both disciplines to uphold their responsibility toward the people they serve.
Chapter 6: Summary

The objective of the present study was to increase knowledge within the field of art therapy regarding the assessment practice of clinicians working in inpatient psychiatric settings. This investigation is significant because while inpatient psychiatry continues to be a common employment setting for art therapists, and assessment a valued aspect of the field, no literature was found regarding the current assessment practice of art therapists working in this specific setting. Further, it is necessary for any profession to continually evaluate itself, to insure that they are meeting the needs of clinicians while upholding their responsibility to clients. A review of available literature revealed that drastic changes have occurred in mental healthcare. These changes have lead to an emphasis on clearly specified assessment goals, largely defined by the role of the treatment setting. In general, clinical assessment is a key feature of inpatient psychiatric care, as this setting has become the gateway to long-term, outpatient care. This adds value to the present study in that state-of-the-field information is necessary if professions are to adapt to the changing role of treatment settings, and thereby maintain their relevance and effectiveness in those settings. Finally this study explored the experiences of art therapists working in inpatient psychiatry, with an emphasis on the ways that this specific setting impacts their assessment practice, as well as their perceived role(s). This information is necessary if the profession of art therapy is to support clinicians, enhance education programs, maintain constructive relationships with partner disciplines, and generally grow as a profession.

To meet these objectives, the researcher created a descriptive survey intended to elicit in-depth, qualitative information. The survey took the form of an interview containing seven open-ended questions. Five individuals were recruited through a convenience sample, met inclusion criteria, and were interviewed via telephone. Participants were from five different states, all
credentialed professionals, and represent a range of experience from 13 to 40 years in the field of art therapy.

The survey highlighted a number of common themes. Participants emphasized that assessment, including the monitoring and reporting of changes during treatment, is one of their primary roles. It was found in fact that participants use multiple assessment formats with separate goals and purposes. They complete a non art-based assessment to comply with the requirements of the treatment setting, but also use art-based assessment. They use primarily informal assessments in both cases; the non art-based assessment is generally a structured, though not standardized, tool or format focused on gathering basic information and recording initial clinical impressions. The art-based assessment is informal in that participants do not use a standardized tool, and often use art works collected during group sessions. The latter indicates that the participants merge assessment with treatment, with the group room becoming a forum for gathering clinical information.

Although the above findings are generally consistent with the literature review, and suggest that art therapists have adapted to the changing function of the inpatient setting in much the same way that other disciplines have, the use of informal assessment is in contradiction to broader standards of care, which emphasizes evidenced based assessment with measurable outcomes. Although this identifies a possible concern, the literature revealed that this is not a unique concern to the profession of art therapy. The use of a structured tool to meet documentation requirements suggests that a structured, if not standardized art-based tool may be valued by art therapists in this treatment setting.

Regarding the focus of assessment, the interviews suggest that art therapists see insight as a primary focus. In fact, a unique finding was that participants seem to consider the patient as an
active participant in the assessment of insight, encouraging them to self-reflect, thereby gaining a better awareness of their current state or situation. This again speaks to the finding of a merger of assessment and treatment, particularly in that learning is emphasized in both the literature and the interviews as a primary treatment goal in the inpatient setting.

Another notable theme was that the participants consider their art-based assessment to be more genuine than assessment required by the facility. They use information derived from the art work/sessions to clarify and qualify initial diagnoses. Initial information gathering via facility mandated, non art-based assessments is viewed by some participants as a more cursory task. Expanding on this, participants see themselves as advocates for the patients. As members of the treatment team, they see providing a forum for the patient’s voice, as well as a more sensitive, person-centered evaluation of the individual as a primary role.

Regarding the influence of the inpatient setting, the study found that limitations posed by the current model of care have indeed impacted both assessment practice and the experience of art therapists. Notably consistent with the literature, participants expressed feelings of frustration and uncertainty concerning their current practice and role(s). They expressed conflict between the role of the treatment setting and the values of their profession. Also, the interviews suggested a sense of loss regarding participants no longer being able to perform individual assessments.

Broadly, findings suggest that the practice of art therapists in inpatient psychiatry is both consistent with and complementary to the role of the treatment setting. In addition, by serving as an advocate for the patient, and encouraging the patient to be an active participant in assessment, art therapists may take on a compensatory role for what the literature describes as a discourse of pathology, and a medicalization of human experience.
The findings of this study suggested a number of questions that may inform future research including: What qualities would be most valued in a structured art-based assessment tool for use in inpatient psychiatry? What type of information would be most relevant to art therapists’ practice in this specific setting? What is the impact of the group setting on individual assessment? How might the group setting be meaningfully harnessed in a structured assessment tool? What are the specific factors that prevent some art therapists from integrating their modality into hospital/state mandated assessments? How can the profession of art therapy support practitioners in developing assessments at the local level? Answering these questions may support the profession of art therapy, and its practitioners, by developing tools and/or processes that serve the contexts in which a particular type of information is relevant and useful.

It was recommended that the proposed future research questions be framed in the context of a recovery model, given the natural similarities between art therapy and recovery oriented care. Further, it was recommended that the profession evaluate art therapy education programs regarding career preparedness and specialization, and expand content to include the structure of current mental healthcare services. Finally, it was recommended that the profession of art therapy take part in ongoing efforts within psychiatry to develop more person-centered practices. It was suggested that the profession suspend differences in theory and approach, and focus on areas of agreement between the disciplines. This may foster greater collaboration, broaden the field’s relevance and efficacy across mental health contexts, and ultimately improve client care.
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APPENDIX A: Survey

1. If you assess your clients what are your current assessment practices?

2. What are your primary goals in using assessments with clients at your current employment setting?

3. If you are familiar with the concepts of “formal assessment” and “informal assessment” what is your understanding of these terms?

4. What is your relationship with the treatment team at your current employment setting?

5. What do you feel is your primary role in working with clients at your current employment setting?

6. Please discuss your role(s) in working with clients in terms of the role you see your current employment setting play in your clients’ treatment.

7. In what other ways do you feel that the inpatient psychiatric setting impacts your assessment practice?
APPENDIX B: Invitational E-mail

Art Therapists’ Assessment Practices in the Inpatient Psychiatric Facility: A Descriptive Survey

Dear AATA Member,

The Drexel University Institutional Review Board (IRB) has approved recruitment for a graduate level thesis study investigating the assessment practices of art therapists working with adults in inpatient psychiatric facilities. The primary objective of the study is to broaden the knowledge base of the field of art therapy regarding if and how art therapists working in the inpatient setting utilize clinical assessment. The study is designed to develop a meaningful understanding of the rational and contributing factors behind chosen assessment practices in this particular employment setting. I am writing to request your participation in this study. The study will take the form of a telephone interview. The interview is estimated to take approximately 45 minutes to complete.

Inclusion Criteria

- At least 2 years of employment practicing art therapy with adults in an inpatient psychiatric facility (can be more than one facility) within the last five years
- A minimum of half-time employment, to be defined as at least 20 hours per week on site
- Completion of coursework and internship in an AATA approved masters level degree program in art therapy (all but thesis) or be a credentialed professional

Instructions: If you are interested in participating in this study, please reply to this e-mail or contact the researcher at atassessmentstudy@gmail.com or (267) 349-6778. Please reply by March 15th.

Your contact information will not be used for any purpose other than communications regarding this study. No personal information will be collected as part of the study. You will choose a pseudonym. Interviews will remain anonymous. For more information on research participant’s rights and the responsibilities of the researcher, contact Drexel University’s Institutional Review Board (IRB) at (215) 255-7857.

Thank you in advance for your time.

Sincerely,

Kirsten Knoblauch
Betty Hartzell PhD, ATR-BC, LPC, Faculty Advisor
APPENDIX C: Participant Self-Reflection Guide

1. Which of the following art therapy assessment methods, if any, are you familiar with?
   - Diagnostic Drawing Series (DDS)
   - Ulman Personality Assessment Procedure (UPAP)
   - Formal Elements Art Therapy Scale (FEATS) developed for use with the Person Picking and Apple From a Tree (PPAT)
   - Brief Art Therapy Screening Evaluation (BATSE)
   - Sheppard Pratt Art Rating Scale (SPAR)
   - Bridge Drawing
   - Bird’s Nest
   - Descriptive Assessment of Psychiatric Art (DAPA)
   - Other

2. What other assessments are you familiar with or have training in that might be used in your current employment setting. This might include other art-based assessments such as traditional projective drawings (e.g. House-Tree-Person, Draw-A-Person), structured clinical interviews, mental status exams, etc.

3. If you assess your clients in your current employment setting, what form of assessment do you primarily use?
   - Art therapy assessment
   - Traditional projective tests/drawings
   - Structured Clinical Interview
   - Unstructured Clinical Interview
   - Mental Status Exam/Mini Mental Status Exam
   - Psychological testing
   - Other
   - I have developed my own clinical assessment

4. What form of assessment do you secondarily use in your practice?
   - Art therapy assessment
   - Traditional projective tests/drawings
   - Structured Clinical Interview
   - Unstructured Clinical Interview
   - Mental Status Exam/Mini Mental Status Exam
   - Psychological testing
   - Other
   - I have developed my own clinical assessment
5. When do you assess your clients?
   - During psychiatric triage (crisis evaluation)
   - Immediately upon admission (patient has been stabilized and formally admitted to the inpatient unit)
   - During the first session (group or individual session?)
   - Periodically throughout the client’s stay at the hospital
   - At another time

6. What are your primary goals in using assessments with clients at your current employment setting?
   - Diagnosis
   - Monitoring progress/change
   - Treatment planning
   - Assessing appropriateness for art therapy
   - Documentation
   - Sharing information with treatment team
   - Other

7. If you attend treatment team meetings, what is your primary role as a member of the team?

8. What do you feel is your primary role in working with clients at your current employment setting?

9. Do you believe that what you view as your primary role in working with clients is consistent with the role that your current employment setting plays in your clients’ treatment?

10. In what other ways do you feel that the inpatient psychiatric setting impacts your assessment practice?
APPENDIX D: Participant Information Sheet

Participant Pseudonym _____________________

1. Age ____________

2. Geographic location _________________________

3. Total number of years practicing art therapy in the inpatient psychiatric setting ________

4. Total number of years practicing art therapy __________________

5. Highest degree/credential attained in art therapy if any _________________________

6. Other credentials if any ______________________________

7. Specific job title at current employment setting _________________________________
APPENDIX E: Exemplar Quotes Organized by Theme

**Common Themes**

Art therapists working in the inpatient psychiatric setting do assess their clients, and use multiple assessment formats with separate goals and purposes.

- “We usually use the [non art-based] assessment to assign them to groups. …Our [non art-based] assessment isn’t as long because I think we all feel like we assess people when we write our notes, after we see them in group”
- “I guess I basically use my art therapy intervention as a kind of personal assessment. There are the mandated assessment and treatment plan, which are very generic. But as we deliver art therapy treatment, we use our fund of theoretical and clinical knowledge to do the genuine assessment. From this assessment, we document for the team through clinical notes and also formulate a personal treatment plan.”

When using art-based assessment, art therapists working in inpatient psychiatric settings use primarily informal processes.

- “I do assess my clients and I tend to use a more open-ended art making experience…When we’re in the group setting, I kinda always have that assessment hat on …trying to monitor if their artwork is changing, are there significant shifts …maybe their medication is affecting them in a certain way… just constantly taking that back to the treatment team.”
- “I mostly assess informally with my experience as an art therapist.”
- “I don’t use anything formal in the hospital. In my private practice, but that’s not adult inpatient psych”

Art therapists working in inpatient psychiatric settings merge assessment with treatment.

- “The artwork used for the assessment is typically created during the first art therapy group.”
- “I’ve adapted some art therapy assessments to use them in group therapy. So I don’t necessarily sit down and fill out all the paperwork that has to do with the assessment … but we’ll process [the artwork] in group. You know, so it’s an art therapy assessment but its’ adapted as a group assessment, so to speak.”
- “…as we deliver art therapy treatment, we use our fund of theoretical and clinical knowledge to do the genuine assessment. From this assessment, we document for the team through clinical notes and also formulate a personal treatment plan.”
Art therapists working in inpatient psychiatric settings see insight as a primary focus of both assessment and treatment.

- “I think the biggest thing is … the idea of communication, self-communication, self-knowledge, self-awareness.”
- “It’s not just me collecting data but it’s them seeing ‘Maybe I need to think about this differently.’”
- “[I am] trying to encourage them to gain some insight, to understand what the recovery process looks like for them.”
- “I use more of a here-and-now approach, to really help people to look at their behaviors, and how they’re impacting each other in the hospital, and how that’s a reflection of their lives.”

Art therapists working in inpatient psychiatric settings view their art-based assessment as separate and more genuine then assessments required by the facility.

- “Our [non art-based] assessment isn’t as long because I think we all feel like we assess people when we write our notes, after we see them in group”
- “I guess I basically use my art therapy intervention as a kind of personal assessment. There are the mandated assessment and treatment plan, which are very generic. But as we deliver art therapy treatment, we use our fund of theoretical and clinical knowledge to do the genuine assessment. From this assessment, we document for the team through clinical notes and also formulate a personal treatment plan.”
- “Afterwards we discuss it … you know, ‘What made you think about this house today’ … but I sort of started with the idea to kind of, hopefully have the art material touch their unconscious a little bit and bring some stuff forward. So, that’s really how I assess. You know what I’m saying? … Doing the actual initial assessment is merely to the point – get basic info and get it written down. … as we see the patients in the groups, we have much more information to report back to the clinical team.”

Art therapists working in inpatient psychiatric settings see providing support as a primary therapeutic goal.

- “[I help them cope] with their current condition, things that they are dealing with. Sometimes if it’s a new psychiatric diagnosis, that can be really scary. Sometimes it’s just the first time in the hospital and it’s just decreasing hospital anxiety.”
- “It’s a very positive psychology, person-centered kind of approach… we’re all in this together, everyone heard, everyone has this, you know – confusions – and the artwork allows for that universality of the human condition.”
• “I see my role as being someone who is pragmatic, and offers empathic support, and listens and hears their feelings …their freedoms are stripped. I mean, they don’t have their clothes, they don’t have their comfort, you know. And this is the one place where their imagination can be free, and where they have choices, and where they can express whatever they need to express.”
• “Working the patients is really trying to help them adjust to this setting.”

Art therapists working in inpatient psychiatric settings see themselves as active, valued members of interdisciplinary treatment teams.

• “I feel like it’s a really positive experience, very inclusive experience. We’re looking at the patient from many angles rather then, you know, just a diagnostic version… I’ve had people come to me and ask me what my take is on a certain individual because, you know, they might be stumped, or they might be seeing something that’s new.”
• “…the doctor will say, ‘I’m trying to understand this a little bit better, trying to get a grasp of this,’ or ‘Can you meet with this patient?’ …in general management is very supportive of art therapy.”
• “When I talk about any patient on the unit at any time, I am often talking about their artwork and what they’ve said to me about their work, and their verbalizations about themselves …I’m constantly bringing that into the team.”

Art therapists working in inpatient psychiatric settings see themselves as an advocate for patient, by providing a forum for the patient’s voice.

• “When I talk about any patient on the unit at any time, I am often talking about their artwork and what they’ve said to me about their work, and their verbalizations about themselves. I feel like I’m the advocate for the patients on that level specifically.”
• “I keep forgetting this and I’m glad you asked that. It comes down to giving them a place to be heard… [the art making] gives them a forum to be heard, which often times they feel, you know, they’re misunderstood.”
• “I think the role that I take on in the treatment team at that setting is to kind of give and opportunity for the patient to communicate.”

Limitations of time and resources posed by current inpatient, mental health services have had a major impact on the assessment practice of art therapists working in this setting.

• “It’s kind of assessment on the run ‘cause there is not time to do a long assessment.”
• “Once the length of stay shortened to three to five days, I was finding it difficult to sit with a patient separately to have them make art and then complete the eval form… my assessment became less of a priority.”

• “Because it’s short-term, because they’re in, they’re out, I can’t, I mean we see… Monday I walked in and there were 13 new patients. It’s impossible to do a formal art therapy assessment with 13 patients, and round groups, and do everything else that I’m expected to do… Ideally, I would wanna be able to do an art assessment with each patient but it’s just not possible.”

• “We really don’t get a chance to do formal assessment anymore. You know, nobody is willing to take the time, to pay the money… You know, there’s just, there’s other assessments out there that are just so exciting, but everything is drive-by these days.”

Art therapists experience role conflict and uncertainty as a result of changes that have occurred in the inpatient psychiatric setting.

• “You know, you get to this point – because I have been here ten years now – that what else can I do? What else do I want to do? How can I change the system? The system is changing and the question, you know… am I really being utilized here?”

• “There are improvements going on, and you kind of wanna make sure, you know, you change with it and not, not get disregarded.”

• “Um, well, assuming my primary role is an art therapist, which is my title, which is why I’m hired to be here, I think my primary role is to introduce patients to the idea of using art materials in an expressive manner as a coping skill.”

• “…I’ve been asked to do a lot of things that, I guess, in some way makes you more of a valued member of the team, but in other ways devalues your value as an art therapist.”

**Variant Themes**

Art therapists working in inpatient psychiatric settings sometimes use second hand sources of information to make their initial assessment of patients.

• “I can take information provided in report about the clients, what’s going on, what brought them into the hospital, feedback from other practitioners who have seen the patients already… My goal is to know what I am going to be facing, if there are any behavioral issues… I will then determine what might be a more appropriate art directive.”
Reduced resources have both challenged and supported the professional identity of art therapists working in inpatient psychiatric settings.

- “Nowadays there are a lot of other things that we’re having to do that are important to the safety of the unit but don’t necessarily fall under the art therapy bracket. But they make you part of the team. It’s kind of interesting that way.”
- “…with changes in healthcare budget cuts and that kind of thing, as a therapist I’ve been asked to do a lot of things that, I guess, in some way makes you more of a valued member of the team, but in other ways devalues your value as an art therapist… you’re building rapport with the assessment, and introducing yourself as the art therapist, and the next time they see you you’re making sure that they don’t have any dirty linens. That kind of skews the whole relationship. It’s an interesting dance.”

Art therapists working in inpatient psychiatric settings may feel lost, and have difficulty adapting to the current demands of inpatient psychiatric work.

- “You feel lost. You know, you want to do what’s more or less appropriate within a clinical standard. And over the last ten years that I’ve been here the documentation has evolved… and I have a student [intern] currently who resists the appropriate clinical format. And it’s very difficult because they don’t get this teaching in the university… I remember not getting that myself. Our training was in writing a case study which was very long and lengthy, which is not what we have time for here.”