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Chapter 1

What’s best for whom?
Exploring the evidence base for assessment in art therapy

Andrea Gilroy

How do art therapists assess clients for art therapy? What are the criteria for deciding whether a client should enter individual art therapy, join an art therapy group or attend an open studio? Are there different assessment practices for different client populations and does diagnosis have a role to play? In this chapter I explore how art therapists have described their assessment practices and consider how this relates to ‘what’s best for whom’. I begin with reviews of the British literature on assessment for art therapy, exploring the underlying principles and attitudes that influence practice before identifying specific factors which indicate suitability for art therapy. I go on to consider the use of art-based assessments in the USA and outline strategies for developing the evidence base for art therapy assessments.

But first, what does ‘assessment’ mean? Assessment comes from the Latin ‘assidere’ meaning ‘to sit beside’ or ‘assist in the office of a judge’. It also has legal overtones, referring as it does to the estimation of a person’s assets for the purposes of taxation (www.merriam-webster.com). This suggests, as Holmes (1995) points out, two aspects of clinical assessment, one suggesting an empathic response and the other a more distant calculation. Holmes calls this a ‘dual function’ (p. 28) of subjectivity and objectivity. I think this is a tension, one that sits at the heart of the assessment process and is central to thinking about the evidence base for assessment in art therapy.

Second, what do we mean by an ‘evidence base’? This refers to the paradigm that is evidence-based practice (EBP). This comprises a cycle of activities which seek to ensure that every clinical practice is based on rigorous research so that everyone is working according to what the ‘best evidence’ suggests are the most clinically effective and cost-efficient ways. This is achieved through research findings being pooled, critically appraised and assigned to a hierarchy of levels that represent the nature of the research and hence the ‘strength’ of the evidence it provides. The ‘evidence’ is then distilled into recommendations and guidelines that inform policy, provision and practice and from which standards of delivery can be determined; everything is then audited. The whole process identifies gaps not only in research but also in knowledge; this leads to further research and so the cycle continues (see Gilroy, 2006, for further discussion). What then, is the evidence base for assessment in art therapy?

Absence (of evidence) and presence (of knowledge)

Assessment is often mentioned in the British art therapy literature, sometimes accompanied by brief vignettes of practice (e.g. Wood, 1986; Case and Dalley, 1992/2006; Liebmann, 1994; Gale and Matthews, 1998; Rees, 1998; McNeilly, 2000; Edwards, 2004), but despite the ubiquitous nature of assessment in art therapy, there are just two research-based papers (Evans and Dubowski, 2001; Tipple, 2003). However, there are also two academically rigorous papers (Case, 1998; Dudley, 2004) and a clinical guideline (Brooker et al., 2007) which can also be considered as ‘evidence’: the former because they are situated within a well-sourced, critical context, are focused, relevant and directly applicable to practice; the latter because, although not primary research (i.e. an empirical study), it appraises and develops existing material and draws on the opinions of experts, practitioners and service users and so is a form of secondary research.

The evidence base for art therapy assessment in Britain is therefore rather thin, i.e. within the frameworks of orthodox EBP which requires large scale randomised controlled trials at best and other kinds of quantitative research at least. Here it must be acknowledged that there are other kinds of research and different kinds of evidence (Gilroy, 2006), and that the absence of evidence neither infers the ineffectiveness of an intervention nor equates with an absence of knowledge (Parry and Richardson, 1996; Richardson, 2001). It is also important to recognise that art therapists have an enormous amount of tacit knowledge and clinical experience of assessment. Our challenge is to access and articulate this in ways that contribute to our evidence base and do so in ways that make sense to the discipline.

In my view, assessment is critical to the construction of the evidence base for art therapy. Why? McNeilly (2000) gives an indication in his paper on failure in group analytic art therapy when he says that successful therapy depends on a thorough assessment of, and appropriate selection for, the right kind of therapy for every client. If an assessment is wrong then the subsequent therapy can ‘be like trying to fit a square peg into a round hole’ (p. 148). This makes the all-important link, as far as EBP is concerned, between the individual client, their particular difficulties and an assessment that identifies what is likely to be the most clinically effective treatment. With this in mind I have reviewed both the research literature and the more general literature on art therapy assessment in Britain and pooled the main points.

Principles and attitudes to art therapy assessment in the UK

A series of underlying principles and attitudes can be discerned in the literature which characterise the psychodynamic nature of art therapy assessment in Britain. This concurs with the survey findings of Crawford et al. (2010) which discovered that most British art therapists (60 per cent) describe their practice as being psychodynamically oriented; others espouse an eclectic approach (14 per cent) or
use mostly cognitive methods (10 per cent). Nonetheless there seem to be general, mostly practical, points of principle that frame art therapy assessments, as can be seen in Box 1.1. Note that referrals are usually to a service, can be team based or discipline specific and that explanation and an experience of what art therapy involves is included in the assessment process. It seems, however, that very few clients are not offered art therapy: Dudley (2004), for example, says that her service takes on 98 per cent of those referred (p. 22).

The literature also indicates a particular attitude that British art therapists take towards their clients, as can be seen in Box 1.2. This shows that art therapists in the UK are, generally speaking, oriented towards the ‘sitting beside’ approach to assessment that concurs with their psychodynamic orientation, i.e. rather than an objective, diagnostically oriented function. Some explicitly situate their assessment practices within a psychodynamic framework, others do so implicitly. Several estimate their clients’ potential for engagement with art and with a meaning-making process; many aim to generate a ‘psychodynamic formulation’ of their clients’ problems, this being a tripartite construction which addresses the client’s ‘current life situation, the early infantile relations and the transference relationship’ (Hinshelwood, 1995: 155).

Richardson (2004) points out that if the underlying principle of practice is psychodynamic, an assessment is not about identifying what is wrong with the

**Box 1.1 General points of principle**

- Referrals are usually generic and to an art therapy service (Dudley, 2004; Brooker *et al.*, 2007).
- Assessment can be for art therapy alone (Case, 1998; Dudley, 2004) or be part of a team-based assessment (Gale and Matthews, 1998; Tipple, 2003).
- Assessment should be separate from therapy itself (Case and Dalley, 1992/2006; Case, 1998; Dudley, 2004; Edwards, 2004; Brooker *et al.*, 2007).
- Assessment can occur in a single session or a series over 2–8 weeks (Case and Dalley, 1992/2006; Case, 1998; Rees, 1998; Evans and Dubowski, 2001; Tipple, 2003; Brooker *et al.*, 2007).
- Assessment should be in the same room as the therapy (Case and Dalley, 1992/2006; Evans and Dubowski, 2001; Dudley, 2004; Brooker *et al.*, 2007).
- Art materials should be at least be available and at best be used (Case and Dalley, 1992/2006; Case, 1998; Gale and Matthews, 1998; Rees, 1998; Evans and Dubowski, 2001; Tipple, 2003; Dudley, 2004; Edwards, 2004; Brooker *et al.*, 2007).
- Assessment includes an explanation about art therapy (Case and Dalley, 1992/2006; Brooker *et al.*, 2007).
patient but about gaining an understanding of someone’s experiences and therapeutic needs in a way that cannot be captured in a diagnostic category. Assessment is key to clarifying the therapist’s task but, as he says, many factors influence the outcomes of psychotherapy independent of diagnosis and regardless of the nature of the therapy itself. Richardson suggests that the importance of diagnosis is reduced for an intervention like psychotherapy which has been shown to be helpful for a number of diagnostic groups, but therein lies a tension because, as he goes on to say, EBP requires that evidence of treatments’ effectiveness is established in relation to particular conditions. Despite psychotherapists’ concerns about diagnosis and the inferred link with psychiatry’s ‘illness model’ of human distress, the consensus is that: ‘If the evidence or the treatments we offer is sorted according to the “conditions” for which those treatments are designed, then an evidence-based approach to healthcare requires accurate identification of the condition to be treated’ (Richardson, 2004: xiv).

**Box 1.2 Attitudinal indicators**

- Art therapy assessments are not concerned with diagnosis (Case, 1998; Dudley, 2004).
- Art therapy assessments offer something different from those of other psychiatric/psychological therapies (Case, 1998; Evans and Dubowski, 2001; Dudley, 2004).
- Background information/diagnosis from referrer/multidisciplinary team should be noted but ‘put aside’ (Case and Dalley, 1992/2006; Case, 1998; Dudley, 2004).
- The assessor aims to learn about the person, their experiences and their social context (Dudley, 2004; Edwards, 2004; Brooker et al., 2007).
- The assessor aims to learn about the person’s ‘art history’ (Wood, 1986).
- Assessment is exploratory and aims for the client to feel understood (Case and Dalley, 1992/2006; Case, 1998).
- Assessment aims to establish a rapport between client and art therapist (Case and Dalley, 1992/2006; Evans and Dubowski, 2001).
- The therapeutic relationship begins in the assessment, inferring assessor and therapist are the same (Case and Dalley, 1992/2006; Evans and Dubowski, 2001; Dudley, 2004).
- Assessment is a mutual, collaborative process (Case and Dalley, 1992/2006; Case, 1998; Gale and Matthews, 1998; Tipple, 2003; Dudley, 2004; Edwards, 2004; Brooker et al., 2007).

It is therefore interesting to note that the two British art therapy researchers (Evans and Dubowski, 2001; Tipple, 2003) consider diagnosis a key part of their task but take an intersubjective approach to their assessment of people on the autistic spectrum. Tipple’s purpose is to ‘describe individual children through observation of their interaction with the art materials and with the therapist’ (p. 48). His assessments have a simple, clearly defined structure with periods of self-directed activity, turn-taking with the therapist and directed activity, all of which contribute to a multidisciplinary assessment and a differential diagnosis that leads to recommendations for future assessment and management (see also Chapter 6). Evans and Dubowski (2001) describe very detailed, minute-by-minute analysis of video-recorded meetings that attend to issues such as spontaneity, attunement, interaction, behaviour and so on, plus, interestingly I think, an estimation of the autistic child’s awareness of and sensitivity to objects, people and to the environment – that is to the ‘vitality affects’ of hardness, softness, colour and texture that Stern (1985) describes. The extraordinary degree of detail in their video analysis captures fleeting communications from which therapeutic strategies are devised for each individual. Here a particular kind of assessment is central to the subsequent, highly tailored art therapy intervention. These researchers make explicit links between their clients’ difficulties, particular factors within their assessment process, diagnosis and treatment recommendations in the way that EBP requires.

However, most British authors are oriented towards more generic, psychodynamically based art therapy assessments that are applicable to all client populations, although it must be acknowledged that the current literature may not represent the range of practice that Crawford et al. (2010) describe. Nonetheless suitability criteria can be discerned (see Box 1.3) which focus on clients’ capacity

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<td>• Psychological mindedness, i.e. response to transference interpretations (Case, 1998; Dudley, 2004).</td>
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<td>• Developmental stage (Case and Dalley, 1992/2006; Rees, 1998; Evans and Dubowski, 2001).</td>
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<td>• Difficulties are to do with the internal world (Case and Dalley, 1992/2006; Case, 1998).</td>
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<td>• Motivation for change, ‘a small spark of hope’ (Case, 1998).</td>
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<td>• Capacity for art-making and symbolic/metaphorical thinking about images/objects (Case and Dalley, 1992/2006; Case, 1998; Evans and Dubowski, 2001; Tipple, 2003; Dudley, 2004).</td>
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for relationship and change and for thinking psychologically and metaphorically. This situates practice within a psychodynamic frame that does not address the ‘distant calculation’ of diagnosis.

A series of questions thus frame the assessment encounter, foremost amongst which is:

- Is art therapy a suitable form of treatment for this individual?

If the answer is ‘yes’, others follow:

- What are the aims/goals of art therapy with this client?
- Which form of art therapy should be offered?
- Which art therapist should work with this client?
- When, where, how often and for how long should art therapy be offered?

Circumstances that might support or sabotage the therapy may also have to be considered:

- Will there be emotional support from family, parents, friends, carers?
- Will there be practical support, e.g. financial, transport, time-keeping?

The British literature describes another sequence within the assessment itself: an introduction to the therapist, to art therapy, to the room and to the art materials; a narrativising by the client of their experiences and difficulties; perhaps an engagement with art-making; and some thinking about the artworks and how both the work and the feelings generated by it, within and between the assessor and the client, relate to the client’s story. There follows a formulation by the therapist about the nature and origin of the client’s presenting problems which may or may not be discussed with him or her, and discussion between both parties about whether or not art therapy is suitable and, if so, which approach might be best. If not, what are the alternatives? Further information and negotiation of the contract, or onward referral, conclude the assessment.

Generally speaking, British authors are not explicit about which clients with what diagnoses, problems or conditions are suitable for art therapy, nor have they specified who might benefit from a particular treatment approach. Apart from Tipple (2003) and Evans and Dubowski (2001), neither have they (until now, see Marshall-Tierney, Chapter 7; Thomas and Cody, Chapter 8) outlined standardised or systematic assessment procedures. Instead authors, and inferentially practitioners too, have focused on the unique and ‘subtle interaction between two “strangers”’ (Ghaffari and Caparrotta, 2004: 73) that occurs in psychodynamically based assessments. In terms of constructing an evidence base for effective and efficient art therapy assessments that require the diagnostic clustering of people and their problems which many art therapists resist, there is much work to do.
What’s different about art therapy assessment?

Ghaffari and Caparrotta (2004) identify two generic suitability factors for a psychological intervention: a motivation for change and the capacity to form a therapeutic relationship. They also identify specific tasks in a psychotherapy assessment, namely the identification of problems, articulating a psychodynamic formulation of the difficulties, ascertaining the suitability of the intervention for the person and deciding which modality, where and by whom, can the person be helped best (pp. 27–28). There is significant synergy here with the principles and suitability criteria underlying British art therapy assessments that affirm its psychodynamic orientation. Some assert that an art therapy assessment offers something different from other kinds of psychological assessment (e.g. Dudley, 2004). What, apart from the availability of, and engagement with, art material might this be? Crawford et al.’s (2010) respondents do not mention any assessment criteria linked to art, focusing on motivation to attend and a capacity for change, thought and reflection. However, if the art therapy specific items are drawn out from Boxes 1.1 and 1.2 (pp. 13–14), particularly from research, something interesting emerges (see Box 1.4).

These speak to the significance of context, place and materiality. Why and how are these significant in an art therapy assessment? Evans and Dubowski (2001) offer us the significance of the client’s sensory responses to objects, people and place and to the associated ‘vitality affects’: hardness, softness, colours and textures. Wood (1986) suggests that the assessor should also learn about the person’s ‘art history’. This caught my attention not only in terms of how to ease clients past any initial discomfort with art-making but also in terms of facilitating play. Play is, as Winnicott (1971) reminds us, central to therapy. Art therapy enables the potential for, and development of, play to be assessed in a very practical, material, tangible and different way through art. An ability to use metaphor, imagination and symbolic thinking can also be addressed through the process of making some ‘thing’ (Case and Dalley 1992/2006; Dudley, 2004), as can the capacity for making meaning collaboratively with the therapist about an object, as well as about a thought or feeling, in a way that enables a trial interpretation to be made. This represents a particular kind of visual, material, sensual and phenomenological assessment that

**Box 1.4  Art therapy specific factors**

- Assessment should be in the same room as the therapy (Case and Dalley, 1992/2006; Dudley, 2004).
- Art materials should be at least be available and at best be used (Case and Dalley, 1992/2006; Case, 1998; Dudley, 2004; Edwards, 2004).
- Client participation in ward-based, open art psychotherapy groups can serve as an informal assessment for longer term group or individual art therapy (Brooker et al., 2007).
could usefully be elaborated and researched as the different and specific approach to assessment, and to treatment, which art therapy offers. This leads us to explore the American literature on art-based assessments.

**A more distant calculation?**

Art-based assessments are not usually part of art therapy practice in Britain but have been widely debated and researched in the USA. Perhaps this derives from the American ‘managed care’ system of private, insurance-led health care which (a) requires a diagnosis before treatment; and (b) links diagnosis with specific treatment plans. It may also be influenced by practitioners’ wish to offer something different in their assessments so they can survive in the health care marketplace, as inferred by Gantt’s (2004) suggestion that the development of art-based assessments should be guided by a number of questions, one of which was: ‘What are we assessing that other related fields are not or cannot?’ (p. 25). Surviving in the EBP marketplace is important to practitioners on both sides of the Atlantic, hence the importance of articulating and theorising the unique properties of an art therapy assessment.

How have American art therapists approached the development of an evidence base to their practice? Art-based assessments have been the subject of fierce debate: some art therapists passionately advocate their use, others equally passionately oppose them. Betts (2006, Chapter 11 this volume), in her overview of this debate, says that art therapists use art-based assessments ‘to determine a client’s level of functioning; formulate treatment objectives; assess client’s strengths; gain a deeper understanding of a client’s presenting problems; and evaluate a client’s progress’ (p. 422). This indicates that these assessments – also called instruments, tests and tools – are used not only as part of the ‘entry process’ into art therapy but also to evaluate therapy at the beginning, middle and end. It seems to me that here the focus is on gathering information, often with the distant, objective, explicitly diagnostic function that contrasts with the ‘sitting beside’ approach which many British and some American art therapists prefer (see Henley, Chapter 3; McNiff, Chapter 5).

Lots of research, sometimes descriptive but often the controlled, comparative studies that EBP requires, has been done in the USA about different kinds of ‘drawing procedures’. These usually focus on the production of a particular image with specific art materials. They range from Cohen’s Diagnostic Drawing Series (DDS) to the Ulman Personality Assessment Procedure (see Thayer Cox *et al.*, 2000). Psychological states, cognitive skills and developmental levels are measured, greater understanding of clients’ presenting problems is sought and the goals of art therapy are formulated. This practice and research operates within a framework that is about the administration of a test and so is clearly situated within the distant, objective, diagnostic function of assessment.

Given the amount of attention paid to art-based assessments in the US literature, I was interested to read that a survey of AATA’s members (Elkins *et al.*, 2003) found that only 31 per cent of respondents included assessments and tests in their practice. Some wonder why these procedures continue to be popular.
because theoretical and philosophical problems abound and, more importantly, because the evidence base that supports them has been seriously called into question in terms of its validity and reliability (Kaplan, 2003; Gantt, 2004; Betts, 2006, Chapter 11 this volume).

Some American art therapists argue for a middle ground. This involves research that gathers enormous databases of drawings and then tries to describe and rate their ‘global qualities’ so that norms can be established regarding ‘age and gender, as well as socioeconomic, educational, cultural and ethnic group membership’ (Gantt, 2004: 24). Here I refer to art-based assessments like Gantt and Tabone’s Formal Elements Art Therapy Scale (FEATS, 1998; see also Chapter 10 this volume). This looks at the form of a drawing – in this instance of a person picking an apple off a tree – not the content. The purpose is ‘primarily gathering information to formulate an art therapy treatment plan – not to construct a differential diagnosis’ (Kaplan, 2003: 29). However, comparative studies have indicated that the FEATS is useful in diagnosis for example, of substance disorders (Rockwell and Dunham, 2006) and attention deficit hyperactivity disorder (ADHD; Munley, 2002).

These ‘global’ art-based assessments have highlighted that research on the developmental characteristics of children and adolescents’ art work has not developed significantly since Lowenfeld in the 1940s (Kaplan, 2003; Gantt, 2004). This was thrown into relief by Hagood’s (2003) research which showed that features thought to be associated with sexual abuse in children’s drawings were actually associated with their cognitive development. Gantt developed this when she asked the question:

How do people draw in their 70s, 80s or 90s who have no significant psychiatric or physical problems? Is there a ‘late style’ . . .? We simply do not know. And we will not know until we collect and rate thousands of drawings.

(2004: 25)

I suspect that a developmental chronology of drawing across the lifespan would indeed be useful to the development of the evidence base of art therapy assessments.

It is interesting also to note the links being made in some American literature between art-based assessments, the selection of a particular kind of art therapy and its outcome. For example, Francis et al. (2003) describe an assessment that involved substance misusers in making a ‘bird’s nest drawing’, their argument being that it is easier for clients to draw birds in their nest rather than their family and that what emerges will, within the framework of attachment theory and other research about theory and different art therapy approaches to substance misuse, inform the assessor about treatment aims and strategies. What is key here, so it seems to me, is that the assessment ‘tool’ matches the client group and the particular therapeutic approach and that both reflect organisational and systemic needs. McLeod (2001) reminds us that the way we research and write about therapy is ‘a political act’ (p. 72); so too is practice. No matter where in the world, researchers and practitioners are engaged through their work in political acts, ones that reflect...
the highly competitive health care marketplace in which we all exist and one where the main currency for us all is the evidence base.

**Strategies for developing the evidence base**

I have described elsewhere (Gilroy, 2006) how Parry and Richardson (1996) devised standards through which a discipline can demonstrate that it is evidence based. Clinical guidelines are key. This leads me to think that one of the first things art therapists could do to develop the evidence base for art therapy assessment (in the UK) is to replicate Parry’s (2001) seminal guideline about referral and selection for psychotherapy in the British National Health Service. This was specifically developed for professionals who refer to the psychological therapies in order ‘to aid decisions about which forms of psychological therapy are most appropriate for which patients’ (p. 3). It describes different kinds of psychotherapy and matches approach with what the cumulative research suggests would generate the best outcomes for different client populations. Parry emphasises that the guideline is based on critical appraisal and systematic review of the research literature, but adds that when developing the guideline they ‘used structured methods to ascertain expert consensus on treatment choice’ (p. 3). The result is a series of General Principles and Recommendations about particular therapies for particular problems, each principle and recommendation being rated from A–D according to the strength of the evidence that supports it. Examples include recommendations about treatment length, suitability and patient preference.

Brooker *et al.*’s guideline (2007) was modelled on Parry’s and aimed to guide art therapists in various aspects of their work with people prone to psychotic states. Like Parry we undertook a critical appraisal and systematic review of all the relevant literature which graded it according to its relative strength. For example, findings from the first randomised controlled trial of group art therapy with people diagnosed as schizophrenic (Richardson *et al.*, 2007) led to a recommendation about the referral process and equity which ensured ‘that these potential clients are aware of, and can easily access, the Art Psychotherapy services that are available to them’ (Brooker *et al.*, 2007: 43). Another drew on local practitioners’ views that clients prone to psychotic states were likely to be acute inpatients and suggested that ‘client participation in ward-based, open Art Psychotherapy groups can serve as part of the initial, informal discussion and assessment for longer-term group or individual Art Psychotherapy’ (p. 44).

We also drew on the knowledge and experience of two ‘expert panels’: one of art therapists experienced with this client population, nominated by the (then) BAAT Council, and another of local service users. It is worth highlighting here that the process of developing clinical guidelines can be a collaborative procedure which enables users’ voices to be heard (Gilroy, 2006). In Brooker *et al.* (2007) user views were significant, for example, with regard to consent to art therapy that was truly informed and to the importance of a brief and timely assessment of those returning to a service, especially when their health was deteriorating (p. 45).
Users also made recommendations related to language and, inferentially, to art therapists’ approach to assessment:

Art Psychotherapists should use descriptive rather than diagnostic language in the assessment and ensure that clients’ experiences and circumstances are articulated in the client’s language.

Diagnostic language need not be entirely excluded from an assessment as it may be useful for the client. Art Psychotherapists should be transparent about any diagnosis they, or anyone else, has given.

(Brooker et al., 2007: 46)

The narrative accompanying these recommendations suggests that the client’s language should be used to articulate their problems, thus ensuring that links are maintained between the person, their social context and the origins of their distress. However, it adds: ‘Whilst users were in broad agreement with this recommendation they thought that the language of diagnosis could also be helpful’ (pp. 46–47). According to service users, the ‘sitting beside’ function that many British art therapists prefer could usefully incorporate transparent and collaborative thinking about the more ‘objective’ function of assessment embodied in diagnosis. Could ‘sitting beside’, when appropriate, therefore ‘sit alongside’ thinking about diagnosis?

The views of the two expert panels, together with local practitioners’ tacit knowledge, filled the gaps in our literature about art therapy with people prone to psychotic states and made a contribution to thinking about what constitutes best practice. This, I suggest, is how the gaps in our present evidence base on assessment could be addressed in the short term.

**Selection and outcomes**

Earlier I outlined criteria that art therapists in the UK explicitly or implicitly use to select clients who are, generally speaking, thought suitable for psychodynamically based art therapy. However, when it comes to selection of clients for a particular art therapy approach – which, in this context, I take to mean studio-based work, individual art therapy or group art therapy – the literature has only the briefest of comments to make, there being little description and no research. There is some disagreement about who is suitable for what, and indeed whether developing criteria for such a thing is even possible (Edwards, 2004: 78). While it may be neither possible nor desirable to devise criteria that are universally applicable, I think it would be helpful to generate guidelines that guide, not prescribe, which art therapy approach is suitable for whom and so begin to articulate the link between referral, assessment, selection for art therapy, treatment approach and outcome.

Several art therapists have offered general opinions about selection for individual, group and studio-based art therapy that could be built upon (see Box 1.5). These criteria are very general and not associated with diagnosis. This, of course,
Box 1.5 Suitability for art therapy: individual, group, open studio

**Individual art therapy indicated for:**

- internalised problems, difficulty articulating feelings, speech/language difficulties, depressed, too confused, withdrawn or vulnerable for a group (Case and Dalley, 1992/2006; Edwards, 2004).
- particularly vulnerable, seriously at risk (Brooker et al., 2007).
- disruptive or hostile behaviour makes them unsuitable for a group (Brooker et al., 2007).

**Contraindicated for:**

- problems with intimacy of one to one (Edwards, 2004).

**Group art therapy indicated for:**

- interpersonal problems, relationship difficulties, developmental problems, neurotic/character problems; anxieties/inhibitions; those with ego strength; ability to differentiate between inner/outer realities; capacity for relationship with therapist and a group; aware of vulnerabilities (Case and Dalley, 1992/2006).
- people who are isolated, lack confidence (Brooker et al., 2007).
- wish to explore interpersonal relationships (Dudley, 2004).
- social problems, problems with intimacy of one to one (Edwards, 2004).

**Contraindicated for:**

- severe and complex problems, psychopathy, hyperactivity (mania), severe LDs, problems with intimacy, limited tolerance of others, inability to share therapist’s attention (Case and Dalley, 1992/2006).
- narcissistic personality, severe personality disorder, people with low self-esteem, adults abused as children, those with severe trauma (McNeilly, 2000).

**Open studio indicated for:**

- highly disturbed clients, especially in acute settings (Edwards, 2004; Brooker et al., 2007).
- focus on art-making, in need of support and encouragement (Case and Dalley, 1992/2006; Dudley, 2004).
is problematic as far as EBP is concerned, but different kinds of art therapy are offered to different client populations in different settings, as I discovered when I reviewed the evidence base for art therapy practice (Gilroy, 2006). Thus we could, quite legitimately and I think relatively painlessly – and without resorting to DSM-IV (American Psychiatric Association, 2000) or ICD-10 (World Health Organization, 2004) – begin to assess and select clients from different populations and/or with different ‘conditions’ for different kinds of art therapy with specific assessment criteria in mind. This could relate not only to how we conduct assessments but also to recommendations about different art therapy approaches, i.e. in relation to thinking about whether group, individual or studio-based art therapy is best for a particular individual.

For example, there are two identifiable approaches in the literature about art therapy with adult clients who have been abused or suffered trauma: one uses art to ‘go right into’ the trauma (McClelland, 1992, 1993), another ‘witnesses’ trauma in a ‘non-invasive’ way (Schaverien, 1998). Short-term individual approaches seem effective for these clients (e.g. Peacock, 1991) and self-monitoring through art outside sessions is empowering (Brooke, 1995). Thus an assessment could consider whether it would be helpful for the person to discuss their artwork or better for the art therapist to simply witness the trauma visually, and whether or not he or she could self-monitor.

Turning to the literature on art therapy with children, specifically those diagnosed with ADHD, structured approaches seem to be indicated for group and individual art therapy that enables the self-management of behaviour (Henley, 1998, 1999). Changing art activities, games and physical place also seem to improve these children’s social skills, self-control and self-esteem. Assessment could therefore address their suitability for group or individual art therapy and for different kinds of activities in sessions. Art therapy with children who have been sexually abused again indicates different approaches: time-structured art therapy groups seem to reduce post traumatic stress disorder (PTSD), anxiety and disassociation (Brown and Latimer, 2001; Buckland and Murphy, 2001) and a group that combines art therapy with cognitive analytic therapy seems to enable the processing of emotional responses and restores capacity for thought (Brown and Latimer, 2001). Long-term individual art therapy enables containment and management of the sensual properties of art materials and mess-making which leads to emotional and cognitive development and repair (Prokofiev, 2011). Assessment of these children could therefore consider their need for containment and to ‘evacuate’ material in long-term, dynamically oriented individual art therapy, or whether emotional responses can be accessed and thought about in manageable ways in a short-term, structured group.

Thus the literature is beginning to articulate and suggest different art therapy approaches that ‘work’ with different client groups. This could be elaborated through clinical consensus procedures that access the tacit knowledge of experienced practitioners and through collaboration with service users, both of whom are critical to guideline development in the absence of research.

Research

I have left research until last because it takes time and often requires funding and so has to be part of a medium to long-term strategy for developing art therapy’s evidence base. Remembering that both research and writing are political acts, I would suggest that the first thing art therapists need to do is document our assessments in research-based case studies, both descriptively and visually. These would be what Denscombe has described as ‘single examples of a broader class of things’ (1998: 36) that are specific about the referral, the setting and the client population. These could be linked to the treatment approach and its outcome. Clusters of such descriptive, inductive research can lead to comparative studies, and so the evidence base is built.

Second, I think we should take close, careful and long looks at the art works (Gilroy, 2008) made in art therapy assessments and see what they tell us. Visual and phenomenological research methods are, I suggest, inherently sympathetic to the ‘sitting beside’ function of an art therapy assessment.

Third, I think art therapists should tune their antennae to noticing which clients seem to benefit from which approaches, as well as who does not, and then deduce backwards, as it were, about how this might be assessed. This came to mind having read about inductive research on assessment for cognitive behavioural therapy (CBT) (Segal et al., 1995). The authors describe noticing over time that some of their clients benefited more from the 20 sessions of CBT they offered than others. They decided to investigate this with an eye to identifying which kind of patient would respond best. They began by exploring what they describe as ‘soft’ sources, i.e. therapists’ intuition and impressions of patients who had difficulty with their approach; this indicated that people who had problems with endings did not do well with a short-term treatment. They also noticed that particular kinds of ‘patient presentation’, regardless of diagnosis, were linked to a greater ease with CBT and that those with depression and anxiety seemed to benefit the most. From this Segal et al. devised an assessment that explored clients’ perceptions of short-term work and which included trial CBT interventions. Inductive qualitative research such as this, of groups or ‘cohorts’ of clients with particular ‘conditions’ which draw on practitioner observation and description, have much to offer art therapy.

The development of an evidence base for art therapy assessments, whilst being systematic and specific to a particular approach, context and client population, need not be constrained by diagnostic criteria nor by research methods. Rather it can take a pluralistic approach, investigating how best to assess for different approaches to clinical work with different client populations.

Conclusion

Whilst art therapy remains without a critical mass of research I suggest that practitioners draw on other forms of evidence and develop clinical guidelines, accessing the tacit knowledge of ‘expert’ and local art therapists and drawing on
the views of service users. Guidelines could address best practice in the referral process, suitability for art therapy per se and identify selection criteria for group, individual and studio-based art therapy, providing useful information for referrers, practitioners and clients alike.

It may be that ‘sitting beside’ clients in a psychodynamically oriented assessment and the ‘more distant calculation’ linked to diagnosis and treatment plans have become polarised in the art therapy literatures on either side of the Atlantic. We may agree that diagnosis is by no means central to psychological understanding and to beginning a relationship, but researchers, clients and therapists alike suggest that the transparent articulation and identification of problems or ‘conditions’ or diagnoses can and does happen in art therapy and psychotherapy assessments and that this can be helpful to all concerned. Categorising and clustering illnesses, problems and behaviours are central to EBP and to current systems of mental health care. Indeed, British art therapists will have to think about how to assess within a new NHS that has single points of entry, a system which looks likely to require that art therapy assessments are directly linked to diagnostic clusters, care pathways and treatment packages, similar to the ‘managed care’ system in the USA. This may be uncomfortable but, as art therapy’s evidence base expands and different treatment approaches are found to work better for some clients than for others, practitioners may find themselves able to integrate the sitting beside approach to art therapy assessment with a more distant calculation.

References


