Towards creating a description of art therapy for adults with trauma in Australia: A client-centred intervention

Henry Bowen, Jocelyn Kernot, Amy Baker, Miriam Posselt, Claire Hutchinson, Kobie Boshoff

Abstract

This study aims to start a discussion around describing art therapy practice for Australian adults with trauma, from the perspective of practising Australian art therapists. A survey of 51 therapists was conducted. The results indicate that Australian art therapists' practice for trauma is comparable to art therapists internationally and that restricting practice by developing strict prescribed guidelines would not suit this highly client-tailored practice. However, an overarching framework to guide practice and standardised reporting of art therapy practice for trauma is needed to ensure consistency and to deliver best client outcomes. Implications and recommendations are discussed.

Keywords

Art therapy, trauma, clinical practice, research

Introduction

Post-traumatic stress disorder (PTSD) is a debilitating mental health condition that can occur when individuals are exposed to traumatic situations (American Psychiatric Association, 2013), with up to 10 percent of the general adult population receiving a PTSD diagnosis in their lifetime (Benjet et al., 2016; Kessler et al., 2017). Art therapy involves purposeful use of visual art materials in therapeutic interventions (Edwards, 2014) and has been growing in popularity as a possible trauma-focused treatment for PTSD internationally (Nanda et al., 2010; Schouten et al., 2018). There have been several trauma models that have informed art therapy practices, such as the way that trauma is coded in the body (van der Kolk, 1994) and brain (Levine, 2010); and the understanding and use of the polyvagal theory in practice (Porges, 2007). For those with minimal benefit from traditional 'talk' treatments, the problematic connection between traumatic memories and language has been posited as a possible cause (van Marle, 2015). Difficulty verbalising traumatic experiences is common during clinical practice due to implicit memories being more emotional and sensory (Kolassa & Elbert, 2007), while explicit memory is required for verbalising memory recall (van der Kolk, 1998). Reduction in explicit memory recall has been demonstrated by reduced functioning in the Broca's area, the structure responsible for language and speech in the brain, when resting or recalling trauma (van Dalen, 2001; van der Kolk, 1998; Walker et al., 2016). This reduction in recall suggests that it is the mechanism of art therapy delivery, which allows for the non-verbal expression of explicit memory, that serves as the key difference between 'talk therapies' and art therapy, and helps explain why art therapy is effective for trauma. However, these associations have yet to be fully examined, in part because of lack of understanding around what elements make up art therapy practice. Many of the core principles of traditional 'talk therapies' overlap with trauma-focused art therapy practice; it is not that they are clear and separate models of therapeutic interventions, but rather elements of talk therapy appear to be at the core of art therapy practice, and it is the mechanism of delivery that sets them apart. However, while talk therapies such as Cognitive Behaviour Therapy (CBT) have been manualised to allow for discussion around the key components and principles of practice that make up that therapeutic intervention (Craske, 2010), art therapy does not have this level of protocolisation, making it difficult for direct discussion of differences in practice to occur.

Due to lack of protocols or practice guidelines, there is currently no way to confirm that the delivery of art therapy interventions for trauma is consistent between practitioners (Hass-Cohen et al., 2018; Hinz, 2009; Jones et al., 2019; Lahad, 2017; Malchiodi, 2011; Meekums, 1999; Naff, 2014; Rankin & Taucher, 2003; Spiegel et al., 2006; Talwar, 2007). Previous large-scale systematic reviews have been unable to draw firm conclusions regarding the effectiveness of art therapy as a trauma-focused treatment (Baker et al., 2018; Schnitzer et al., 2021; Schouten et al., 2015). One key recommendation from these reviews is that future research examine what elements of art therapy are most effective in the treatment of traumatised adults (Schouten et al., 2015). However, to do that we need to have a better understanding of how art therapy for traumatised adults is conducted (Hass-Cohen et al., 2018; Malchiodi, 2011).

To offer insight into this issue, a scoping review of the academic literature was performed (Bowen-Salter et al., 2021). This review aimed to understand the elements of art therapy practice for trauma with the aim of consolidating and understanding practice consistency and standardisations in five elements: design, training, delivery, receipt and enactment. In total, 44 studies were included and examined. Findings from this review established that there is a lack of consistency in the reporting and use of practice guidelines: a significant limitation to identifying best practice principles and the most effective elements of practice as Schouten et al. (2015) suggest. However, this review also identified that art therapy is focused on client exploration with therapists' support and recommended that exploring practitioners' intent around selection and use of practice guidelines is needed (Bowen-Salter et al., 2021).

It is clear we need to have a better understanding of how art therapy for traumatised adults is conducted. This is especially true for the practice of art therapy in Australia, where, historically, art therapy has not yet been accepted as a valid treatment for trauma (Westwood, 2010), resulting from uncertainty about how art therapy is conducted, who conducts the therapy and their therapy-relevant qualifications (Bowen-Salter, 2019). To be applicable for funding in Australia, funding bodies and medical advisory institutions, such as the National Disability Insurance Scheme (NDIS) (Australian Government, 2013) and the Department of Health and Human Services (DHHS), require trauma treatments to demonstrate effectiveness. We therefore need to have a better understanding of what represents good practice for art therapy before we are able investigate effectiveness in any meaningful way.

The aim of this study was therefore to gain a better understanding of how Australian art therapists report their practice for individuals who have experienced trauma.

Methodology

This mixed-method study consisted of an online questionnaire estimated to take 20 minutes to complete. Ethics approval was granted by the University of South Australia (approval number: 201471).

Development of the survey tool

This survey was designed to capture the following elements, reflective of categories outlined in Borrelli et al. (2005), and the scoping review used in Bowen-Salter et al. (2021):

- Demographics including age range, gender identity, ethnicity, current employment, location (state or territory of Australia), and the types of trauma clients they have worked with.
- Design including session frequency and length, whether sessions were one-on-one or in groups, structure of sessions, e.g., length spent 'making art' and discussing, presence of homework tasks, materials used, and who retains the art.
- Training including therapist training, and qualifications and therapist experience.
- Delivery including framework, definition of art therapy, and exercises given during individual sessions.
- Receipt including outcome measure(s), secondary outcomes, study results, and qualitative participant outcomes.
- Enactment including use of outcomes in activities of daily living.
- Financial including who funded the service, whether the therapist contributed personal funds to practice function, how finances were spent, whether or not clients paid a service fee and, if so, who paid that fee and how much.
- Additional Details including an opportunity for practitioners to discuss anything in addition about their art therapy practice in the context of trauma.

The survey was piloted with an art therapist and an artist, and reviewed by a content expert.

Participants and recruitment

To be eligible to participate in this survey, respondents need to be working clinically as art therapists, to have trained to work therapeutically using visual arts, and to have had regular adult clients with symptoms of post-traumatic stress. Participants were ineligible if they were creative arts therapists who utilised creative modalities other than visual art or did not have regular adult clients who had post-traumatic stress symptoms.

In Australia, there is no legal requirement for practising art therapists to register with a regulating body, making it difficult to track who is practising or provide accurate estimations of the number of art therapists currently working in Australia (ANZACATA, 2021; Bowen-Salter, 2019). Acknowledging that some art therapists choose not to register with a professional organisation, advertisements for this survey were made via social media in the form of a shareable link and shared amongst art therapist community groups on LinkedIn and Facebook. Additionally, we utilised the public directory of the following associations to contact art therapists via direct email: Australian, New Zealand and Asian Creative Arts Therapy Association (ANZACATA), Australian Counselling Association (ACA), and the Psychotherapy and Counselling Federation of Australia (PACFA). Permission for the survey link to be shared via social media channels was secured from the administrators for these organisations, alongside publicly advertising the survey in the newsletters and/or on the websites of ANZACATA, ACA, and PACFA.

Data analysis

For quantitative data, frequencies and descriptive statistics were utilised, as the purpose of this study was to understand what essential components make up trauma-informed art therapy reported by Australian art therapists. Therefore, the frequencies were determined for demographic statistics and multiple-choice questions. Qualitative short-response data was coded using content analysis (Hsieh & Shannon, 2005) for art therapy practice elements identified in an earlier scoping review (Bowen-Salter et al., 2021).

Results

Participants

A total of 63 individuals accessed the survey, with 51 responses that met the criteria. Of these, 48 respondents provided their demographic information, including training, and 35 participants completed the survey. Not all survey respondents answered every question. Given the small number of responses, incomplete data was examined as part of this analysis, with the response rates and percentages provided.

Participants overwhelmingly identified as female, were born and trained in Australia, and registered with a professional organisation (Table 1, overleaf). Nearly half of respondents practised in Victoria and were either employed part-time or self-employed part-time (fewer than 38 hours per week).

Respondents worked with people who had a wide range of trauma exposures, with most (31 of 35; 88.6 percent) working with childhood trauma (Table 2, overleaf).

Participant responses were examined under the six key areas of practice: design, training, delivery, receipt, enactment and financial.

Design

Modalities and session types

Survey respondents had no preferences regarding art modality, with most using a mix of painting, sculpting, drawing, crafting, mask-making and body-mapping. While most respondents (17 of 33; 51.5 percent) offered both individual and group sessions, 15 (of 33; 45.5 percent) offered individual sessions only and one (of 33; three percent) respondent offered group sessions only. On average, group sessions ranged from four to 16 participants, with a majority including six to ten participants per group.

Session length

Session length ranged from 30 minutes to three hours, with most sessions ranging from 60 to 90 minutes. However, many therapists noted that these timeframes were based on funding restrictions with NDIS, rather than practice rules, noting that they "work mostly with NDIS participants and sessions are usually one hour" (R24).

Whilst clear boundaries were often in place around the length of sessions to allow for structure, therapists reported that session length was client dependent and was more about how long they could

Demographic	Number of Respondents	% of Respondents
Gender Identity	**48**	**100%**
Female	46	95.8%
Male	1	2.1%
Non-Binary	1	2.1%
Age Range	48	100%
25–34	3	6.3%
35–44	9	18.8%
45–54	14	29.2%
55–64	18	37.5%
65+	4	8.3%
Country of Birth	**48**	**100%**
Australia	34	70.8%
Germany	4	8.3%
United Kingdom	3	6.3%
New Zealand	2	4.2%
Portugal	1	2.1%
Taiwan	1	2.1%
The Netherlands	1	2.1%
United States of America	1	2.1%
Zimbabwe	1	2.1%
Current State or Territory where practising	**48**	**100%**
Victoria	24	50.0%
New South Wales	9	18.8%
Queensland	5	10.4%
South Australia	4	8.3%
Western Australia	4	8.3%
Australian Capital Territory	2	4.2%
Employment as an art therapist	**48**	**100%**
Employed full time (>38hrs wk)	5	10.4%
Employed part time (<38hrs wk)	22	45.8%
Self-employed full time (>38hrs wk)	3	6.3%
Self-employed part time (<38hrs wk)	14	29.2%
Not employed (looking for work)	1	2.1%
Other	3	6.3%

Table 1. Characteristics of survey respondents.

manage a session, with one participant stating that "60 minutes works, the boundaries around time are clear for both of us, there is plenty of time to arrive, settle, work and I am mindful to leave time to bring the session to a close safely" (R27).

Structural elements

Whilst there were many differences reported by respondents, there was a general structure to art therapy practice for trauma to which 23 of 29

Trauma Population	Number of Respondents (of 35)	% of Respondents
Childhood trauma	31	88.6%
Domestic violence	25	71.4%
Sexual violence	22	62.9%
Substance abuse	22	62.9%
Refugees and asylum seekers	15	42.9%
Illness and hospitalisation	14	40.0%
Victims of crime	12	34.3%
Motor vehicle accidents	11	31.4%
Prison	11	31.4%
War and combat related	10	28.6%
Emergency services	9	25.7%
Maternity	7	20.0%
Military	7	20.0%
Natural disasters	7	20.0%
Migrants	6	17.1%
Other	3	6.3%

Table 2. Trauma populations of respondent clientele.

(79.3 percent) respondents adhered. Most practitioners reported that a session for clients with trauma followed the same basic elements, regardless of whether they were running individual or group sessions: an introduction or opening of the session, an art-making period of the session, a processing and discussion period of the session, and a closing of the session.

Within the introduction procedures, most included a debrief of the previous week or the previous week's session, with a focus on grounding. This was also when visual and verbal assessment of clients' moods/states of being happened and was an opportunity to 'check in with clients' about their week:

> *I generally inquire about how they are, this helps me to understand their level of stress and mood to know if certain topics or art therapy directives may be too emotionally heavy or if there is a discussion topic or art therapy directive I could use with them in that moment.* (R4)

Many therapists included some kind of routine or ritual, e.g., lighting a candle, or having a cup of tea, as one participant demonstrated: "Engage in simple un-named ritual for beginning (e.g., make a cup of tea, light a candle, or walk around the table and view previous artworks)" (R30).

Often these introductory activities served as an opportunity to check in about therapeutic goals with the client, and "Discussion about progress towards therapeutic aims and check in to see if these are still the same or may have changed" (R30).

Following this introduction period, most therapists move on to an art-making period, although there were times when this period was considered inappropriate or was reduced, to allow for higher engagement with verbal counselling, as one participant noted: "we may engage in some verbal counselling and then we may make art about a theme discussed to further explore this topic" (R4).

While the art modalities and the length of time these were engaged in varied, this portion generally made up roughly "half to three quarters of the session" (R31). Throughout the art-making period, most art therapists engaged in active processing and discussion of art-making, dependent on the client. Therapists monitored body language and responses as part of their therapeutic engagement. As one participant stated, "They usually make art and chat, but sometimes no words are spoken, and I shadow and assist. I watch for signs of hypervigilance, change in breathing, change in body movements and tone of voice." (R24).

Following the art-making period, therapists reported there was a set period for discussing the art-making, if the client could do so. This was time for reflecting, and processing the works created. Some noted using a bottom-up approach to process or discuss artwork while it was being made, but the focus remained on discussion:

> *Usually, the last 20 minutes of the session is spent in verbal discussion about the creative process, however, this may also happen at times throughout the art-making depending upon the client's level of anxiety and the client's need to work with more or less silence.* (R38)

This was also reported to include, or lead into, an opportunity for grounding clients before they closed the session and checking in with them about their thoughts and feelings about the session or the therapist themselves, as indicated by one participant's example: "At the end I sometimes ask the client what they feel they got out of the session or give them an art therapy directive to help with grounding if we have discussed something that has brought up stress" (R4).

When closing the art therapy session, there was generally a discussion of the week ahead and the next appointment, especially around "setting a goal for the next session" (R43), and making "sure they feel safe" (R43) to move on beyond the session, allowing for the "Closing of process and discussion, ensuring client is in a space to reconnect with their everyday life, homework 10–15 minutes" (R10).

Some closing routines also included a ritual reflective of opening rituals, for example, "Conclude with an un-named ritual (e.g., adding artwork to the folder, blowing out the candle, doing a five minute 'return to the outside world' meditation)" (R29).

Assigning homework

Roughly half of respondents (18 of 32; 56.2 percent) assigned homework to their clients. Respondents noted that they primarily only set homework when they believed the client would engage with the exercises. The most common example was journaling (ten respondents) and engaging in mindfulness or emotional regulation practices (nine respondents).

> *I will suggest homework and at times supply paper or a journal for this so they have a place to mark… their uncomfortable emotions as a way of having something – the paper that will accept what they are feeling at any moment.* (R26)

Overall, art therapy for individuals who had experienced trauma focused on having consistency in how the therapy was conducted for a single person, but ensured that there was flexibility in how sessions might be adjusted to allow flexibility between individuals.

Training

Of 48 respondents, 43 (89.6 percent) indicated that they had a master's level training qualification, with a third citing that their training was undertaken at La Trobe University in Melbourne (Table 3, overleaf).

Most therapists were also registered with a professional association such as ANZACATA, ACA, and PACFA, with most being registered with ANZACATA. Nine respondents (of 48; 18.75 percent) were registered with more than one body, and seven (of 48; 14.6 percent) were members of additional associations.

Delivery

This section explores the specific nature of how interventions were delivered to clients and whether

Training	Number of Respondents	% of Respondents
Level of Art Therapy Qualification	**48**	**100%**
Diploma	1	2.1%
Bachelor	1	2.1%
Graduate Diploma	2	4.2%
Master	43	89.6%
PhD	1	2.1%
Art Therapy Qualification Training Provider	**48**	**100%**
La Trobe University, Australia	16	33.30%
MIECAT Institute, Australia	8	16.70%
Western Sydney University, Australia	7	14.60%
Edith Cowan University, Australia	3	6.30%
University of Queensland, Australia	2	4.20%
Ikon Institute, Australia	1	2.10%
La Trobe University, UK	1	2.10%
RMIT, Australia	1	2.10%
University of Derby, UK	1	2.10%
Training provider not stated	8	16.70%
Registered with an Association?	**48**	**100%**
No	6	12.5%
Yes, Australian, New Zealand and Asian Creative Arts Therapy Association (ANZACATA)	30	62.5%
Yes, Australian Counselling Association (ACA)	2	4.2%
Yes, Psychotherapy and Counselling Federation of Australia (PACFA)	1	2.1%
Yes, ANZACATA & ACA	5	10.4%
Yes, ANZACATA & PACFA	3	6.3%
Yes, ANZACATA, ACA & PACFA	1	2.1%
Also Registered with Other Associations		
British Association of Art Therapists	2	4.2%
Australian Psychological Society	1	2.1%
Health and Care Professions Council (UK)	1	2.1%
Society of Australian Sexologists	1	2.1%
Australian Association of Social Workers	1	2.1%
Somatic Experiencing Trauma Institute	1	2.1%

Table 3. Training for art therapists.

the program was delivered 'as intended', following a structure or treatment protocol. When asked about structure, 17 of 30 respondents (56.7 percent) noted they did not have a set structure for individuals with trauma. They clarified that this is specifically due to the client-centred approach of the therapeutic intervention, as one participant pointed out: "I find each client and their experience of trauma calls for an individual approach" (R10).

When funding constraints were not mentioned, treatment plans were largely dependent on the individual. When asked about length of therapeutic intervention before discharging from services, most therapists noted that it was "hard to say" (R8), noting issues around funding, and that individual, client-centred therapy often does not allow for pre-determined structure:

> *Impossible to answer this! Some people it is six months, other people are still feeling very much in recovery process after five years. After 20 years of this work, I do not think complex trauma can be treated adequately in any time frame under six months (weekly or fortnightly sessions). Single incident trauma is different.* (R31)

Overall, respondents indicated a preference for a minimum of weekly sessions for a year.

In a similar vein, treatment plans for clinical practice were intentionally flexible, with 14 of 30

(46.7 percent) reporting that they were dependent on the needs of the client themselves. Reflective of the design of individual practice sessions, there were some consistencies around principles of practice:

1. Creating a safe space or building a therapeutic alliance to have trust.
2. Engaging in art-making and expression in a way that is client dependent.
3. Exploring aspects of the 'self' to build understanding.

These principles were best captured by one practitioner. R4 demonstrated creating a safe space and building trust:

> *I use a person-centred approach with trauma clients and adapt some interventions from cognitive and behavioural approaches. It looks different for everyone, as what works for one client may not work with another. I generally establish rapport and trust with client and do "get-to-know-you activities" to help the client open up about themselves and clarify their strengths and values. We may do this in different ways over a prolonged period of time, depending on need.*

This was followed by engaging in art-making and expression in a way that is client dependent, "I mostly let the client discuss and express what they want to and we can work in creative interventions depending on their goals" (R4). This creative expression was intertwined with exploring the self to build understanding:

> *Sometimes we do body mapping for emotional awareness, sometimes we make art to help the client with exploring aspects of themselves, sometimes art is about helping the client to express and talk about what's on their mind, sometimes we make art to reduce stress and improve mindfulness, and sometimes we just make art to help the client gain more feelings of confidence in themselves. It is really different every person I work with.* (R4)

With that in mind, very few practitioners discussed specific treatment protocols that were followed in their treatment delivery for trauma. Four practitioners (of 30; 13.3 percent) named specific treatment protocols they followed in their practice:

- Trauma-Informed Approach to Expressive Therapies (Malchiodi, 2011)
- Four-Phase Trauma Protocol (Hass-Cohen et al., 2018)
- Phase-Oriented Art Therapy (Naff, 2014)
- Trauma-Informed [Art Therapy] Treatment Protocol (Schouten et al., 2018)

Two practitioners use Somatic Experiencing and two additional practitioners named Trauma-Informed Treatment Protocol and Psychodynamic Framework and Trauma-Informed Care Approach when asked about protocols of practice. These respondents did not outline treatment protocols for art therapy, but rather appeared to use general trauma-focused treatment protocols.

Receipt

Overall, 26 of 31 respondents (83.9 percent) reported that they measured outcome or evaluated progress as part of their regular practice, either within every session or spaced dependent on the client. Most of these assessments incorporated observational client-centred assessments. Noting that some practitioners are "mandated to provide NDIS progress reports" (R4), there was a mix between working with validated psychometric tests and using clinical expertise to gauge changes in well-being in clientele over time.

Of those who performed assessments, eleven therapists (of 26; 42.3 percent) also reported the use of self-report mental health outcome measures within their practice, with the Kessler Psychological Distress Scale (or K10) (Kessler et al., 2002) being the most frequently used (eight of eleven participants; 72.7 percent) (Table 4, overleaf).

Enactment

Therapists were asked to report on the outcomes clients would normally receive and provide an estimation of the percentage of clients who would experience that outcome as part of their treatment. Improved emotional and psychological well-being was the highest rated, with 30 of 34 respondents (88.2 percent) reporting that clients experienced this as an outcome. Of those who provided estimations, ten of the 14 respondents (71.4 percent) estimated that 90 percent of clients experienced this outcome. Return to work was the lowest rated, with only 15 of 34 respondents (44.1 percent) indicating that this outcome was experienced, and the highest estimation being only 70 percent (Table 5, overleaf).

When provided with an open-ended question to discuss any additional outcomes therapists felt

Reported Outcome Measures	Number of Respondents (of 11)	% of Respondents	Scale Reference
Kessler Psychological Distress Scale (K10)	8	72.7%	Kessler et al., 2002
Depression, Anxiety, Stress Scale (DASS)	4	36.4%	Lovibond & Lovibond, 1995
Clinician Administered Psychological Scale (CAPS)	2	18.2%	Blake et al., 1995
Post-traumatic Check List (PCL)	2	18.2%	Weathers et al., 2013
Health of the Nation Outcome Scales (HoNOS)	2	18.2%	James et al., 2018
House–Tree–Person Test (HTP)	2	18.2%	Gordon & Rudd-Barnard, 2011
Kinetic Family Drawing (KFD)	2	18.2%	Burns & Kaufman, 2013
The Diagnostic Drawing Series (DDS)	2	18.2%	Cohen, Mills, & Kijak, 1994
Ruminative Response Scale (RRS)	1	9.1%	Roelofs et al., 2006
The Piper Fatigue Scale (PFS)	1	9.1%	Piper et al., 1998
The Recovery Assessment Scale – Domains and Stages (RAS-DS)	1	9.1%	Hancock et al., 2019
Life Skills Profile (LSP)	1	9.1%	Rosen et al., 2001
The Positive and Negative Affect Scale (PANAS)	1	9.1%	Watson, Clark, & Tellegen, 1988

Table 4. Reported use of outcome measures in art therapy practice.

Outcome	Client's experience	Provided estimated percentages	Additional comments provided by participants
Improved emotional and psychological well-being	30 of 34	14 of 34: • 2 x 100% • 1 x 99% • 7 x 90% • 2 x 80% • 1 x 70% • 1 x 60%	• Client always reports some type of emotional or psychological improvement. • Able to articulate their improvement, lighter in affect, more confident and have understanding of self, their past, their trauma and of being human. • In mood disorder inpatient unit this is a bit of a rollercoaster, good days and bad days.
Improved physical health	21 of 34	8 of 34: • 1 x 99% • 1 x 85–90% • 3 x 70% • 1 x 60% • 1 x 30% • 1 x 20-80%	• Able to be more active in their life. • Hard to say what percentage has an obvious change, but one would assume physical health would improve with improved psychological well-being. • Difficult to gauge but if not using drug of choice health generally improves.
Improved social engagement/ society engagement	28 of 34	14 of 34: • 1 x 99% • 1 x 90–95% • 1 x 90% • 4 x 80% • 3 x 70% • 2 x 50% • 1 x 40-70% • 1 x 40%	• The art-making supports the clients coming together in a different way, often bringing them together. • Able to get out and be around other people.
Returned to work	15 of 34	5 of 34: • 1 x 70–80% • 1 x 70% • 1 x 30% • 1 x 25% • 1 x 10%	• When applicable and if focus of personal goals; 100% even if intermittent depending on AOD factors. • Or returned to studies or moved into a new line of work.

Table 5 (cont)

Outcome	Client's experience	Provided estimated percentages	Additional comments provided by participants
Returned to or engaged in other productivity roles	22 of 34	9 of 34: • 1 x 98% • 1 x 80% • 1 x 75% • 2 x 70% • 1 x 40% • 1 x 30% • 2 x 20%	• When applicable and if focus of personal goals; 100% even if intermittent depending on AOD factors.
Returned to enactment of family roles	20 of 34	9 of 34: • 2 x 90% • 1 x 80% • 2 x 70% • 1 x 60% • 2 x 30% • 1 x 20%	• When applicable and if focus of personal goals; 100% even if intermittent depending on AOD factors.
Reduction in health risk behaviours	25 of 34	11 of 34: • 1 x 90% • 1 x 85% • 2 x 80% • 2 x 70% • 1 x 60% • 1 x 50% • 1 x 40% • 1 x 30% • 1 x 25%	• When applicable and if focus of personal goals; 100% even if intermittent depending on AOD factors.

Table 5. Reported outcomes and estimations of percentage received.

were significant, one therapist added the outcome "reduction in self-harm behaviours (e.g., picking, hair pulling, cutting)" (R10). Additionally, one therapist noted that the outcomes that their clients experienced were in conjunction with a multi-disciplinary team and may not be solely the result of their therapeutic practice.

Financial

Overall, 22 respondents nominated to provide financial information about their art therapy program. Of these 22, 14 practitioners (63.6 percent) received financial support to run their art therapy practice, with most receiving this from the government through NDIS, DHHS, or the local health department as part of a hospital setting. However, participants noted that even those who received funding were likely to also input personal funds in the form of purchasing materials for practice. Funding, whether it was externally supplied or provided by practitioners themselves, was utilised for rental fees, wages, insurances, registration costs with associations, website or marketing expenses, and materials. Most art therapists worked with clients who did not pay a fee to access the service, either because the service was offered for free, or because the client was covered under a health scheme. For the six respondents who charged fees, hourly rates ranged from A$75 per hour as a 'concession', to A$120 per hour. NDIS sessions were billed at A$193 per session.

Art therapy for trauma clients compared to non-trauma clients

Within this survey, the intention was to gain a better understanding of how practitioners viewed their practice of art therapy for trauma specifically, compared to their practice with non-trauma clients in terms of specific or unique practices. Participants were prompted to report "not applicable" if they did not believe their practices differed for trauma clients.

Eleven of the 28 respondents (39.3 percent) said that there was nothing specific or unique about their art therapy practice for individuals with trauma symptoms. Of the 17 participants who reported differences in their practice, four reported that they treated all of their clientele as though they had a trauma background, regardless of presentation; as one participant stated, "I treat everyone as if they have a trauma background. [More than 90 percent] of the time they do" (R24).

Several respondents (four of 17; 23.5 percent) noted that trauma clients are likely to be more vulnerable and that there is a higher risk of them being "on the edge, often in flight or fight mode, and often find it difficult to self-regulate" (R40), and "distressed and deregulated" (R46). As such, respondents reported that trauma clients required a slower pace than other clientele. This was to allow the client time to build trust and feel safe in the therapy room, which one respondent noted was "paramount" (R48), and to allow them to process slowly and "with sensitivity" (R36) to avoid triggering a trauma reaction, with a focus on the therapist being "patient, more alert, listening more, and attun[ing] more to their body responses" (R40). They also noted that the length and frequency of therapy needed to be longer than with non-trauma clients:

> *Often the work is much slower, for example, a client's trust may have been broken throughout their life so it may take ten sessions until a client feels safe in the room with me. The trauma is often cumulative, so there are many experiences and deep pain that need to be processed. Yet, in order to keep the client in control and feeling safe, therapy is slow and steady. The sessions will go on for a year or two at least.* (R34)

One participant asserted that trauma clients require more developmental work in the initial therapeutic relationship, noting that they require a greater plan for "identifying self-soothing strategies and personal resources" (R29) for their clients with trauma, to help them manage "an increase in symptoms which can sometimes happen in earlier stages of therapy" (R29).

Discussion

This study aims to describe Australian art therapists' practice for clients with trauma, to gain a better understanding of the core elements of art therapy practice when working with trauma populations. The findings indicate that Australian art therapists' practice for trauma is comparable to the reporting standards of other art therapists internationally (Bowen-Salter et al., 2021). This comparability indicates that, while standardising art therapy practice may not be possible for this intervention, standardising the reporting of art therapy practice may be possible. This is especially true around the reporting of the design, training, delivery, receipt and enactment of art therapy practice for trauma.

Consistency in training is essential for improving the quality of health care (Parsley & Barnes, 1995). However, Westwood (2010) noted that the theoretical concepts which underpinned the teaching of Australian art therapy master's level qualifications differed, with only some having a 'trauma' focus in their training delivery (Westwood, 2010), indicating that even though almost all practising art therapists are master's level qualified, they may not be similarly equipped for working with clients experiencing trauma. This may explain some of the differences in practice for art therapy for trauma in Australia, and suggests a need to standardise training courses across the country. Previous investigations of art therapy education in Australia have noted that there is a movement towards increasing an emphasis on master's level qualifications (Westwood, 2010). No formal requirement for a master's level qualification exists, but it was noted that in this study most respondents held master's level qualifications.

There is a need to better understand the treatment design and delivery when considering influences on practitioners' practice. In the international literature, several attempts have been made to create protocols for art therapy to support consistent practice (Hinz, 2009; Jones et al., 2019; Lahad, 2017; Meekums, 1999; Naff, 2014; Rankin & Taucher, 2003; Spiegel et al., 2006; Talwar, 2007), published in books rather than peer-reviewed articles (Hass-Cohen et al., 2018; Malchiodi, 2011). However, these protocols do not appear to be consistently adopted by trauma-focused art therapists to generate standardisation in practice. While there were some existing treatment protocols utilised by study participants (Hass-Cohen et al., 2018; Malchiodi, 2011; Naff, 2014; Schouten et al., 2018), more than half of the respondents indicated they did not use a set structure for individuals with trauma, as they were operating in a 'client-centred' way. The suggestion of being 'client-centred' harks

back to Carl Rogers by encouraging working in such a way as to facilitate clients to reach their own solutions to their problems, to seek meaning and build understanding of their own directions in life (Joseph, 2004; Rogers, 1959). This process is not exclusive to trauma-focused art therapy but is used extensively by trauma-focused talk therapists. This supports the idea that the inherently individualised nature of art therapy is not conducive to the development of standardised intervention protocols that exist for other 'gold standard' treatments for trauma (Raphael et al., 2013). Instead, focusing on core principles, and specifically the mechanisms of practice, may be more useful for guiding practice.

The core art therapy principles identified in this study include creating a safe space or building a therapeutic alliance to have trust, and exploring aspects of the 'self' to build understanding. These principles were underpinned by engaging in art-making and expression in a way that is client dependent. These principles can be seen mirrored within previous attempts to build consistent practice protocols (Hass-Cohen et al., 2018; Malchiodi, 2011), but are also similar to those in trauma-focused talk therapy (Raphael et al., 2013; van der Kolk, 1994). The overlap between trauma-focused art therapy and trauma-focused talk therapy is implicit. For example, when considering Stephen Porges' neuroscience-based considerations around trauma and the brain, the establishment of a 'safe space' is usually an impossible task (Porges, 2007); rather, the therapists – regardless of practice type as a talk therapist or as an art therapist – endeavours to create a space of relative safety, or a 'safe enough' space. These key principles of practice are also underpinned by two key factors: flexibility, and consistency in delivery, to help a client build familiarity with the processes and engage with the treatment. It has been suggested that this consistency–flexibility duality represents the element of art therapy that is most effective in the treatment of traumatised adults (Schouten et al., 2015).

Figure 1 summarises the findings of this study – which are also consistent with our scoping review (Bowen-Salter et al., 2021) – highlighting the principles and key elements of art therapy practice for trauma. While there are some components that overlap with traditional talk therapy, what sets it apart is art engagement and expression, and extended length of access to therapy. It should be noted that this figure may be representative of well-structured art therapy practice in general, and not specifically for trauma, as respondents in this survey noted that

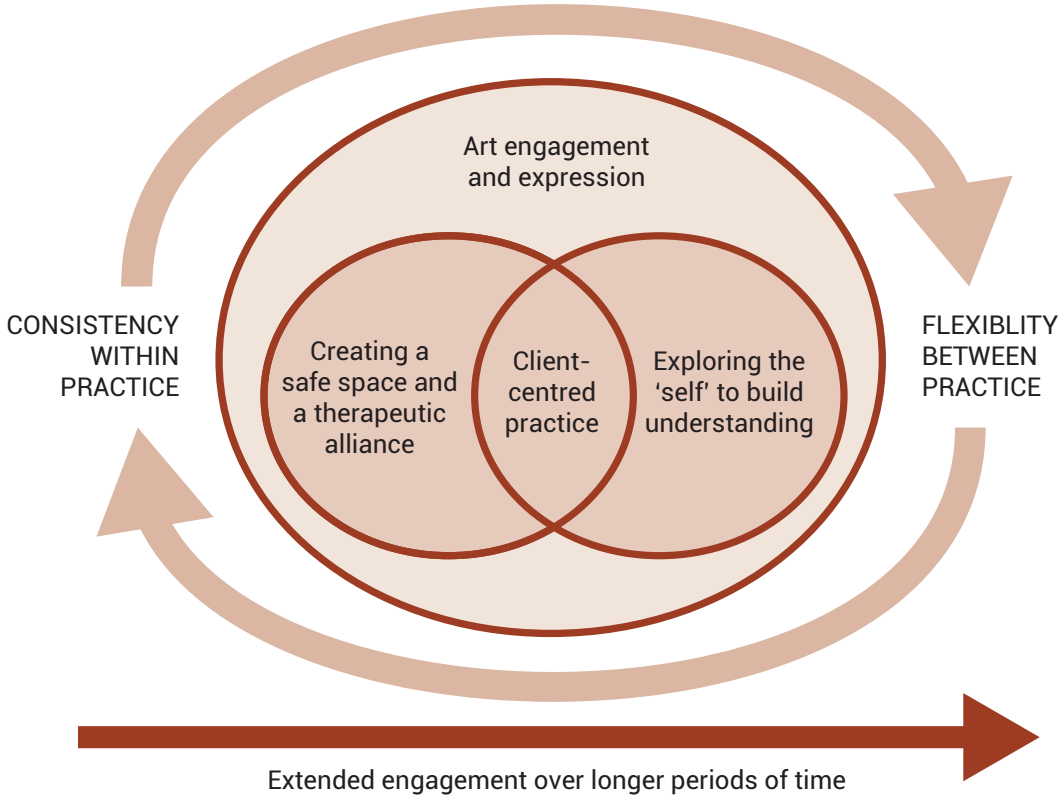

Figure 1. Art therapy practice for trauma.

while their principles of practice are unlikely to change when working with trauma clients compared to non-trauma clients, their pacing and engagement levels are adjusted.

Therapists highlighted funding as a factor that impacted on their service delivery (and their ability to implement the key elements/principles of art therapy practice outlined in Figure 1). In Australia, the NDIS was reported as the main supplier of art therapy funding. Many therapists noted that the practice design, session length and the number of sessions a client could access were determined by funding requirements, rather than the needs of the client. Therapists who were not restricted by funding requirements were focused on client-responsive timeframes, which were notably longer than the reported funding allowance. Similarly, two thirds of therapists reported undertaking assessments that were related to progress reports, with most incorporating observational assessments.

To fund services such as art therapy, many funding bodies and medical advisory institutions are increasing their focus on trauma treatments that can demonstrate effectiveness, with a rising emphasis on treatments that are underpinned by evidence-based practice principles to support ongoing investment (Cusack et al., 2016; Schnitzer et al., 2021; Steenkamp et al., 2015). Without standardisation for treatment practices, effectiveness studies become inherently more difficult to perform, as practice consistency, replicability and treatment fidelity are impossible to accurately determine across practitioners. Previous literature has recommended the standardisation for practice reporting to best reflect practice principles (Bowen-Salter et al., 2021; Steenkamp et al., 2015), and while the fact remains that guidelines are needed, it is clear that these guidelines should align with a framework, i.e., at a broader level, which allows for an emphasis on customised and flexible approaches in how they are implemented by therapists in practice. Having these guidelines would allow for more consistent practice and practice reporting in the future, helping to build a more rigorous and methodologically sound evidence base to support art therapy practice for trauma.

Limitations

This study faced several limitations. Firstly, while there is no recorded list of the number of practising art therapists in Australia, this study had a relatively small sample size, with only 35 respondents completing the survey in full. As such, this study may not be a genuine reflection of the perspectives of trauma practice of art therapists in Australia. A combination of association-specific emails and public advertising of the survey on social media was undertaken in an attempt to combat this, but it is very possible a portion of Australian art therapy practitioners was not represented by this study.

While professional associations for art therapists maintain a professional development stream for their membership, details around whether therapists engaged in continuing professional development was not collected in this survey. Having a better understanding of the additional training that art therapists engage with would help determine consistency in their training upkeep. This should be explored in future studies.

Conclusion and recommendations for practice and research

This review indicates that attempts to standardise practice for art therapy into a traditional clinical practice manner with strict protocols may be too restrictive. Both this study and in a previous study (Bowen-Salter et al., 2021) indicate that standardising the reporting of trauma-focused art therapy would be more important than trying to standardise practice itself. Therefore, our results allude not to restricting practice by developing a strict set of prescribed guidelines but rather an overarching framework of practice that allows for standardised reporting. Effectiveness studies such as randomised clinical trials would continue to be difficult to implement, due to the non-standardised way art therapy is applied, but the adoption of a central framework would allow other research designs, such as program evaluations, to be considered. This would support consistency in Australian art therapists' reporting of their practice and demonstrate the impact of art therapy for trauma to Australian funding bodies more broadly. This is the first study to present the perspectives of art therapists in Australia on their practice with clients who have experienced trauma. It is hoped that this study may serve to start a conversation regarding the development of best practice guidelines and professional frameworks to support the work of art therapists with this population.

References

American Psychiatric Association. (2013). Trauma- and stressor-related disorders. In *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Publishing, Inc.

Australian Government. (2013). *National Disability Insurance Scheme Act 2013*. https://www.legislation.gov.au/Details/C2013A00020

Australian, New Zealand and Asian Creative Arts Therapies Association. (2021). *Standards of professional practice and Code of Ethics of the Australian, New Zealand and Asian Creative Arts Therapy Association Ltd.* https://www.anzacata.org/resources/Files/3_ABOUT/ANZACATA_CodeofEthics.pdf

Baker, F.A., Metcalf, O., Varker, T., & O'Donnell, M. (2018). A systematic review of the efficacy of creative arts therapies in the treatment of adults with PTSD. *Psychological Trauma: Theory, Research, Practice and Policy, 10*(6), 643–651. https://doi.org/10.1037/tra0000353

Benjet, C., Bromet, E., Karam, E.G., Kessler, R.C., McLaughlin, K.A., Ruscio, A., Shahly, V., Stein, D.J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J.M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., … & Koenen, K.C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. P*sychological Medicine, 46*(2), 327–343. https://doi.org/10.1017/S0033291715001981

Blake, D.D., Weathers, F.W., Nagy, L.M., Kaloupek, D.G., Gusman, F.D., Charney, D.S., & Keane, T.M. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*(1), 75–90. https://doi.org/10.1002/jts.2490080106

Borrelli, B., Sepinwall, D., Ernst, D., Bellg, A.J., Czajkowski, S., Breger, R., DeFrancesco, C., Levesque, C., Sharp, D.L., Ogedegbe, G., Resnick, B., & Orwig, D. (2005). A new tool to assess treatment fidelity and evaluation of treatment fidelity across 10 years of health behavior research. *Journal of Consulting and Clinical Psychology, 73*(5), 852–860. https://doi.org/10.1037/0022-006X.73.5.852

Bowen-Salter, H. (2019). *Understanding art therapy as a trauma intervention for Australian defence and emergency services personnel: Barriers and enablers to research development and program implementation. Oral Presentation.* Paper presented at the Inaugural Global Alliance for Post-Traumatic Stress Conference, 6-8 November, Adelaide, Australia.

Bowen-Salter, H., Whitehorn, A., Pritchard, R., Kernot, J., Baker, A., Posselt, M., & Boshoff, K. (2021). Towards a description of the elements of art therapy practice for trauma: A systematic review (forthcoming). *International Journal of Art Therapy*. https://doi.org/10.1080/17454832.2021.1957959.

Burns, R.C., & Kaufman, S.H. (2013). *Action, styles, and symbols in kinetic family drawings.* Routledge.

Cohen, B.M., Mills, A., & Kijak, A.K. (1994). An introduction to the Diagnostic Drawing Series: A standardized tool for diagnostic and clinical use. *Art Therapy, 11*(2), 105–110. https://doi.org/10.1080/07421656.1994.10759060

Craske, M.G. (2010). *Cognitive-behavioral therapy*. American Psychological Association.

Cusack, K., Jonas, D.E., Forneris, C.A., Wines, C., Sonis, J., Middleton, J.C., Feltner, C., Brownley, K.A., Olmsted, K.R., Greenblatt, A., Weil, A., & Gaynes, B.N. (2016). Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review, 43*, 128–141. https://doi.org/10.1016/j.cpr.2015.10.003

Edwards, D. (2014). *Art therapy*. Sage.

Gordon R.M., & Rudd-Barnard A. (2011) House–tree–person test. In J.S. Kreutzer, J. DeLuca, & B. Caplan (Eds), *Encyclopedia of clinical neuropsychology.* Springer. https://doi.org/10.1007/978-0-387-79948-3_2029

Hancock, N., Scanlan, J.N., Bundy, A.C., & Honey, A. (2019). *Recovery assessment scale – domains & stages (RAS-DS) manual – version 3*. University of Sydney.

Hass-Cohen, N., Bokoch, R., Clyde Findlay, J., & Banford Witting, A. (2018). A four-drawing art therapy trauma and resiliency protocol study. *Arts in Psychotherapy, 61*, 44–56. https://doi.org/10.1016/j.aip.2018.02.003

Hinz, L.D. (2019). *Expressive therapies continuum: A framework for using art in therapy*. Routledge.

Hsieh, H.F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687

James, M., Painter, J., Buckingham, B., & Stewart, M.W. (2018). A review and update of the Health of the Nation Outcome Scales (HoNOS). *British Journal of Psychiatry Bulletin, 42*(2), 63–68. https://doi.org/10.1192/bjb.2017.17

Jones, J.P., Drass, J.M., & Kaimal, G. (2019) Art therapy for military service members with post-traumatic stress and traumatic brain injury: Three case reports highlighting trajectories of treatment and recovery. *Arts in Psychotherapy, 63*, 18–30. https://doi.org/10.1016/j.aip.2019.04.004

Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice, 77*(1), 101–119. https://doi.org/10.1348/147608304322874281

Kessler, R.C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E.J., Cardoso, G., Degenhardt, L., de Girolamo, G., Dinolova, R.V., Ferry, F., Florescu, S., Gureje, O., Haro, J.M., Huang, Y., Karam, E.G., Kawakami, N., Lee, S., Lepine, L-P., Levinson, D., … & Koenen, K.C. (2017). Trauma and PTSD in the WHO World Mental Health Surveys. *European Journal of Psychotraumatology, 8*(sup5), 1353383. https://doi.org/10.1080/20008198.2017.1353383

Kessler, R.C., Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Normand, T.S-L., Walters, E.E., & Zaslavsky, A.M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*(6), 959. https://doi.org/10.1017/S0033291702006074

Kolassa, I.T., & Elbert, T. (2007). Structural and functional neuroplasticity in relation to traumatic stress. *Current Directions in Psychological Science, 16*(6), 321–325. https://doi.org/10.1111/j.1467-8721.2007.00529.x

Lahad, M. (2017). From victim to victor: The development of the BASIC PH model of coping and resiliency. *Traumatology, 23*(1), 27–34. https://doi.org/10.1037/trm0000105

Levine, P.A. (2010). *In an unspoken voice: How the body releases trauma and restores goodness.* North Atlantic Books.

Lovibond, S.H. & Lovibond, P.F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Psychology Foundation.

Malchiodi, C.A. (2011). *Handbook of art therapy*. Guilford Press

Meekums, B. (1999). A creative model for recovery from child sexual abuse trauma. *The Arts in Psychotherapy, 26*(4), 247–259. https://www.academia.edu/655274/A_Creative_Model_for_Recovery_From_Child_Sexual_Abuse_Trauma

Naff, K. (2014). A framework for treating cumulative trauma with art therapy. *Art Therapy: Journal of the American Art Therapy Association, 31*(2), 79–86. https://doi.org/10.1080/07421656.2014.903824

Nanda, U., Barbato Gaydos, H.L., Hathorn, K., & Watkins, N. (2010). Art and posttraumatic stress: A review of the empirical literature on the therapeutic implications of artwork for war veterans with posttraumatic stress disorder. *Environment and Behavior, 42*(3), 376–390. https://psycnet.apa.org/record/2010-07375-006

Parsley, K., & Barnes, J. (1995). Do or die. *International Journal of Health Care Quality Assurance, 8*(7), 9–13. https://doi.org/10.1108/09526869510101575

Piper, B.F., Dibble, S.L., Dodd, M.J., Weiss, M.C., Slaughter, R.E., & Paul, S.M. (1998). The revised Piper Fatigue Scale: Psychometric evaluation in women with breast cancer. *Oncology Nursing Forum, 25*(4), 677–684.

Porges, S.W. (2007). The polyvagal perspective. *Biological Psychology, 74*(2), 116–143. https://doi.org. 10.1016/j.biopsycho.2006.06.009

Rankin, A.B., & Taucher, L.C. (2003). A task-oriented approach to art therapy in trauma treatment. *Art Therapy, 20*(3), 138–147. https://doi.org/10.1080/07421656.2003.10129570

Raphael, B., Forbes, D., Bryant, R., Creamer, M., Devilly, G., Kenardy, J., McDermott, B., McFarlane, A., & Matthews, L. (2013). *Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder.* Phoenix Australia.

Roelofs, J., Muris, P., Huibers, M., Peeters, F., & Arntz, A. (2006). On the measurement of rumination: A psychometric evaluation of the ruminative response scale and the rumination on sadness scale in undergraduates. *Journal of Behavior Therapy and Experimental Psychiatry, 37*(4), 299–313. https://doi.org/10.1016/j.jbtep.2006.03.002

Rogers, C.R. (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework. In S. Koch (Ed.), *Psychology: A study of a science: Vol. 3. Formulations of the person and the social context* (pp.184–256). McGraw.

Rosen, A., Trauer, T., Hadzi-Pavlovic, D., & Parker, G. (2001). Development of a brief form of the Life Skills Profile: The LSP-20. *Australian and New Zealand Journal of Psychiatry, 35*(5), 677–683. https://doi.org/10.1080/0004867010060518

Schnitzer, G., Holttum, S., & Huet, V. (2021). A systematic literature review of the impact of art therapy upon post-traumatic stress disorder. *International Journal of Art Therapy,* 1–14. https://doi.org/10.1080/17454832.2021.1910719

Schouten, K.A.M., van Hooren, S.P., Knipscheer, J.W.P., Kleber, R.J.P., & Hutschemaekers, G.J.M.P. (2018). Trauma-focused art therapy in the treatment of posttraumatic stress disorder: A pilot study. *Journal of Trauma & Dissociation, 20*(1), 114–130. https://doi.org/10.1080/15299732.2018.1502712

Schouten, K.A., de Niet, G.J., Knipscheer, J.W., Kleber, R.J., & Hutschemaekers, G.J. (2015). The effectiveness of art therapy in the treatment of traumatized adults: A systematic review on art therapy and trauma. *Trauma, Violence, & Abuse, 16*(2), 220–228. https://doi.org/10.1177/1524838014555032

Spiegel, D., Malchiodi, C., Backos, A., & Collie, K. (2006). Art therapy for combat-related PTSD: Recommendations for research and practice. *Art Therapy, 23*(4), 157–164. https://doi.org/10.1080/07421656.2006.10129335

Steenkamp, M.M., Litz, B.T., Hoge, C.W., & Marmar, C.R. (2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *JAMA: The Journal of the American Medical Association, 314*(5), 489–500. https://doi.org/10.1001/jama.2015.8370

Talwar, S. (2007). Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). *Arts in Psychotherapy, 34*(1), 22–35. https://doi.org/10.1016/j.aip.2006.09.001

van Dalen, A. (2001). Juvenile violence and addiction: Tangled roots in childhood trauma. *Journal of Social Work Practice in the Addictions, 1*(1), 25–40. https://doi.org/10.1300/J160v01n01_04

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1*(5), 253–265. https://doi.org/10.3109/10673229409017088

van der Kolk, B.A. (1998). Trauma and memory. *Psychiatry and Clinical Neurosciences, 52*(S1), S52–S64. https://doi.org/10.1046/j.1440-1819.1998.0520s5S97.x

van Marle, H. (2015). PTSD as a memory disorder. *European Journal of Psychotraumatology, 6*(1), 27633. https://doi.org/10.3402/ejpt.v6.27633

Walker, M.S., Kaimal, G., Koffman, R., & DeGraba, T.J. (2016). Art therapy for PTSD and TBI: A senior active duty military service member's therapeutic journey. *The Arts in Psychotherapy, 49*, 10–18. https://doi.org/10.1016/j.aip.2016.05.015

Watson, D., Clark, L.A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*(6), 1063. https://doi.org/10.1037/0022-3514.54.6.1063

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). *The PTSD checklist for DSM-5 (PCL-5).* U.S. Department of Veterans Affairs. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Westwood, J. (2010). *Hybrid creatures: Mapping the emerging shape of art therapy education in Australia* [Doctoral thesis, Western Sydney University, Sydney, Australia]. Research Direct. https://researchdirect.westernsydney.edu.au/islandora/object/uws:11151

JoCAT
Journal of Creative Arts Therapies

Volume 16 Number 1 2021

Editorial team

Peer review

The editorial team wishes to thank all the peer reviewers who have generously contributed their time and expertise to this edition of *JoCAT*. Accepted submissions are reviewed by people well-versed and respected in the subject or methodology of the submission. Articles 5, 6, 7, 8, 9, 10 and creative contribution 11 were double anonymously peer-reviewed.

Volume 16, Number 1, 2021
Published by The Journal of Creative Arts Therapies
Online and open access at https://www.jocat-online.org/vol16no1page

ISSN: 2652-9459

Design and production Vic Segedin

JoCAT is produced by the School of Social Sciences, Western Sydney University on behalf of the Australian, New Zealand and Asian Creative Arts Therapy Association.