Ethical Decision-Making Model for Art Therapists Working in Diverse Communities

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ABSTRACT

This study used an integrative literature review to provide a foundation for creating an ethical decision-making model tailored for art therapists working in diverse communities. Ethical codes for the art therapy profession describe ethical responsibilities of multicultural competence. However, current literature lacks emphasis on knowing the historical context and ecology of the place where clients live as part of diversity competence and ethical decision-making. The model integrates considerations of systems theory, ecology theory, and emotional arousal with existing ethical principles, and provides art-making and reflective questions for each step in the ethical decision-making process. Recommendations include field-testing of this model by art therapists working in diverse communities to determine its usefulness in practice.

Keywords: art therapy, ethics, ethical decision-making model, diverse communities, historical context, ecology theory.
DEDICATION

I would like to dedicate this thesis to my immigrant family who has instilled my passion for community work since I moved to the US. I would also like to dedicate this thesis to any community I’ve had the honor of working with. Community work has given me experiences that changed my life. It has helped me make sense of my passions, my purpose, and the great advocacy a Latina woman can have. To every community I’ve worked with, I will be forever grateful.
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CHAPTER I
INTRODUCTION

My idea for this research project emerged out of my witness of urban communities in the Indianapolis, Indiana area. Many of these communities house a variety of low-income families with a majority being marginalized populations. Many of the families living here are unconventional and shaped in areas that have become abandoned (Young, 2009). The residents living in areas like these are in desperate financial need. Some face troubles in paying water and heating bills, others struggle with employment and access to healthcare. Community initiatives attempt to aid in creating social services that provide an array of assistance that offer direct aid to many residents who are in need. Many community action groups look to these initiatives as a focal point for assistance. Every day they bring to life their idea of direct citizen action for the betterment of the entire community.

As I began to learn about these neighborhoods, many questions surfaced. Why do these programs continue to make efforts in restoring these places? Why do residents continue to stay in these areas? How can the history of this place give insight into the residents living there? After exploring these questions during my internship, I realized that knowing the history of a community is part of my ethical obligation as an art therapist working with the residents of an ethnically diverse community. The ethical codes for the art therapy profession describe ethical responsibilities of multicultural competence as a capacity whereby art therapists possess cultural and diversity awareness and knowledge about self and others, and at the same time ensure that this awareness and knowledge is skillfully applied in practice. However, current literature lacks
emphasis on the historical context of communities as a part of diversity competence in art therapy and related professions.

My experience has shown me how critical it is for me as a therapist to know the historical background of a community, in addition to multicultural competency, in being able to provide ethical treatment to my clients. My research questions are as follows: (1) What do art therapists who are working in diverse communities need to know about the historical background of the community in order to ethically treat their clients? (2) How do art therapists integrate considerations of the community into ethical decision-making? My goal is to challenge art therapists who are working in communities to learn about the historical context and ecology of the place where their clients live as part of their multicultural competency and ethical responsibility. Art therapists must look at the multidimensional layers that people possess, including historical context. Only then will we optimally help enrich the lives of our clients. The present paper aims to create an ethical model for community-based art therapy, that includes historical context and other community-based considerations.
Operational Definitions

Arousal- the degree of intensity of a feeling state which can range from quiet to aroused (Gaudine & Thorne, 2001).

Collective trauma- Also known as intergenerational trauma, is trauma passed down through past generations to a group of people (Harvey, 1996).

Ecology theory- Theory that examines the relationships between human beings and their interpersonal and organizational environments, helping to modify or to enhance the quality of transactions between people and their environments, and seeking to promote environments that support human wellbeing (Ecological Theory Origin from Natural to Social Science, n.d.).

Ethical codes- Specific to each profession and provide professionals with a set of standards to uphold in order to improve and enhance an environment of integrity (Allan, 2013).

Ethical decision-making model- models used to help guide professionals through ethical decision-making (Jennings, 2005)

Ethics- a moral compass that governs a person's behavior or the conducting of an activity (Jennings, 2005)

Ethical principles- Qualities and values that therapists need to possess in order to provide clients with ethical treatment (Jennings, 2005).

Feeling state- An emotion described as either negative or positive affect (Gaudine & Thorne, 2001)

Fixed mindset- A mindset believing that traits within an individual are “fixed” and cannot be developed (Kristjansson, 2016).
**Growth mindset**- A mindset thriving in resilience as they believe cultivation of the mind through continued learning will foster improvement (Kristjansson, 2016).

**Helping professionals**- An individual working in a profession that supports growth in psychological, emotional, and overall well-being of others (Talwar, 2017).

**Homeostasis**- is the tendency to remain in a stable equilibrium in which little to no change is present within environmental fluctuations (Ernest, 2001).

**Intersectionality**- a theoretical or analytical approach that simultaneously considers multiple categories of identity, difference, and inequality (such as gender, race, class, sexual orientation, disability, and religion, as well as others) (Abramowitz, 2005).

**Marginalization**- A group of people that suffer from multiple deprivations and do not possess the same privileges as others (Boccard & Zenou, 1999).

**Multicultural competence**- is a capacity whereby art therapists possess cultural and diversity awareness and knowledge about self and others, and at the same time ensure that this awareness and knowledge is skillfully applied in practice with clients and client groups (Advancing Multicultural and Diversity Competence in Art, n.d.).

**Privilege**- A benefit enjoyed by an individual or group of people beyond what is available to others, typically related to oppression for sexual orientation, socioeconomic status, age, ableness, and religious affiliation (Boccard, & Zenou, 1999).

**Redlining**- A discriminatory practice in real estate, typically involving mortgage lenders that refuse to lend money or extend credit to borrowers in certain areas of town therefore leading to forced separation amongst groups of people (Boccard, & Zenou, 1999).
**Self-reflexivity**- The process of continual reflection incorporating self-awareness (Talwar, 2017)

**Supervision**- The act of overseeing or mentoring someone (Talwar, 2017).

**Systems theory**- A theory rooted in the interdisciplinary acknowledgement of all systems (Ottemiller et al., 2016).

**Urban community**- system located within a city or other densely settled area or, in a broader sense, the greater system that makes up an entire metropolitan area (Riche, 2001).
CHAPTER II

METHODODOLOGY

The literature was examined using an integrative literature review methodology. This kind of study involves collecting and reviewing literature through critical appraisal and then integrating these findings (Fain, 2016). It also has the potential to identify gaps and inconsistencies within a specific area of focus (Fain, 2016). An integrative literature review enables the researcher to specialize in the subject matter in order to objectively critique, summarize, and identify conclusions that will aid in furthering the overall field of study (Christmals, Gross Aziato, & Armstrong, 2018).

This integrative review evaluated three key themes for data collection, analysis, and conclusions to findings. The reviewed literature aimed to gain a deeper understanding of the three following themes:

1. Historical context of communities
2. Existing ethical codes, guidelines, and principles
3. Existing ethical models across helping professions

By performing a review of the available literature through data collection, the three themes mentioned above were used to critically analyze the literature. The final product included an integrative ethical model for art therapists working in diverse communities along with a presentation of the literature review.
CHAPTER III

LITERATURE REVIEW

An understanding of urban communities will be the initial key factor in this literature review. Urban communities are the focal point in assessing historical context in relation to client treatment. Nevertheless, to take a specific area as an example of an urban community amongst a bigger nation, one must first take a look at the United States as a whole. What does this nation represent? How does the larger nation help us understand smaller cities and communities?

The United States is said to be the melting pot of all nations. It holds home to a vast group of families from all over the world. It is estimated that by 2043, current ethnic and racial majorities will become the minorities of the United States due to population diversification (Robb, 2014). Surprisingly though, Robb stated that:

Unless there is a significant shift in U.S. policy, it would take 228 years for the average black family (84 years for the average Latino family) to obtain the same amount of wealth as the average white family. (p. 29)

As more and more immigrants make their way into the United States, its population becomes more ethnically diverse. All professions should have a mirroring representation of the country’s people. This is because a proportional representation of people and professions would create a frame that reflects the overall public and limit a dominant narrative. Ultimately, varying multicultural perspectives are needed in order to best represent an array of voices that range from all areas of the world. The United States’ increasingly diverse population should ideally be reflected in demographics of all work fields; the opposite is seen in the field of art therapy as
evidenced by 90 percent of American Art Therapy Association’s (AATA) members being female and Caucasian. These demographics do not accurately reflect the ethnic and racial diversity of the United States (Robb, 2014), nor the client populations that art therapists serve, especially in urban communities.

Understanding Communities

Urban communities. In speaking about demographics across urban areas, there is a clear majority in people of color, though clear ethnic and racial segregation is evident. According to Riche (2011), metropolitan areas are largely populated by racial minorities. Redlining has contributed to this disparity. Redlining is a discriminatory practice in real estate that typically involves mortgage lenders refusing to lend money or extend credit to borrowers in certain areas of town; this practice leads to forced separation amongst groups of people, often based on race (Boccard & Zenou, 1999). Many cities across the United States show this type of clear segregation that creates systemic barriers for minorities (Boccard & Zenou, 1999). Statistics indicate that Caucasian individuals choose to live in the outskirts of cities and main downtown areas, while more people of color live closer to the city, in pockets (Boccard & Zenou, 1999). Realtors and other home-sellers, job opportunities, as well as other factors contribute to this separation (Boccard & Zenou, 1999). This separation affects equilibrium of education, storefronts, and labor markets (Boccard & Zenou, 1999). Caucasian households have represented 89 percent of the nation’s homeowners, and Caucasian families are much more likely to own their homes than their racial minority counterparts (Riche, 2001). This varies considerably based on location, though typically this remains consistent throughout many areas of the United States.
Urban housing professionals must make a collaborative effort to understand the needs and resources of a much more diverse household population (Riche, 2001). Residential segregation and discriminatory action in living areas for minorities has historically been absent from policy debates (Boccard & Zenou, 1999).

Education in city areas shows that there is a correlation between residential area and quality of school (Nield & Balfanz, 2006). These schools serve primarily, and often almost exclusively, students with multiple risk factors for academic failure; however, they are often overlooked by policy makers, school reform programs, and district personnel (Nield & Balfanz, 2006). According to Nielf and Balfanz (2006), the worst school dropout rates in America cluster in urban neighborhood high schools. Neighborhood high schools in central cities enroll disproportionate numbers of low-income, minority students and students with special needs, in comparison to academically-selective magnet high schools within the same district; these schools also employ less prepared and less experienced teachers (Nield & Balfanz, 2006). Adolescents already face major transitions in their lives, and living in poverty broadens other dimensions such as social exclusion, lack of satisfaction of basic needs, relative deprivation, feelings of inferiority, and marginalization (Dashiff, Dimicco, Myers, & Sheppard, 2009). The continuing poverty increases adolescents’ risks for mental disorders, and access to mental health services are limited (Dashiff et al., 2009). Their exposure to violence also creates a layer of risk. According to Sheidow et al. (2001), between 50 percent and 96 percent of urban children have witnessed community violence in their lifetimes.
A chain reaction of factors continues with access to healthcare. These urban communities are typically of lower income; therefore, these areas have less access to physician care and health insurance (Grumbach et al., 1997). In addition, Ottemiller et al. (2016) stated that about 20 percent of U.S. adults have a diagnosable mental illness and only 38 percent of these receive mental health services (Substance Abuse and Mental Health Services Administration, 2011), leaving the majority of U.S. residents coping with a mental health diagnosis without the help they need. This lack of healthcare and mental health services affects life expectancy in all ages within these urban minorities (Grumbach et al. 1997). Community initiatives are created to combat these types of risks along with other factors these urban communities face. Many across America have been put into place, but overall, only a small dent has been made to change the overall betterment of diverse communities.

Many of these initiatives incorporate community strategies that address the needs of their residents. In the 1990s, Comprehensive Community Initiatives (CCIs) across the nation were developed and focused on combining the best of what had been learned from social, economic, physical and civic development in order to create transformation of distressed neighborhoods (Kubisch et al., 2011, p. 138). In contrast to other initiatives, CCI adopted a comprehensive approach to neighborhood change and worked according to community building principles that value resident engagement and community capacity building (Kubisch et al., 2011).

A focus on community is a common approach, as it is believed that reaching all generations will most effectively create transformation. Making Connections (MC) is an initiative in Chicago that believes that strengthening family connections will lead to economic
opportunity, positive social networks, and effective services and support (Theodos & Firschein, 2015). In order to create this community, social organization must be created first. This should be reflective of transformation, interests, and voices from the community (Theodos & Firschein, 2015). This type of program would then create social support and cohesion among neighbors, increase their sense of belonging, and allow supervision and mentorship of children/adolescents by other adults in the community (Theodos & Firschein, 2015).

In school settings policymakers, foundation program officers, and researchers have begun to pay more attention to the performance of high schools, and have developed initiatives in support of district-wide high school reform (Nield & Balfanz, 2006). These are created by getting to know the students in a district, paying more attention to educational demographics at the school level in order to understand them, and advocating for the level of educational and financial resources necessary to enhance high schools (Nield & Balfanz, 2006). These efforts are valuable and hold a lot of beneficial attempts to better the system of education, though these types of initiatives are scarce on a national scale.

Some initiatives are already taking place in some areas of Indianapolis, Indiana. The opportunity is large to help reframe and shape these communities. Following are the needs identified by Sagamore Institute (2016), a non-profit organization in Indianapolis developed to build and implement solutions through policy-conducted research:

- **Need for great schools**: Parents in some urban areas have limited options for high-performing schools.
- **Need for public safety**: The areas near any of the six crime hot spots identified by the City of Indianapolis.

- **Need to address social determinants of health**: Individuals living in certain areas have a life expectancy ten years less than individuals living just a few miles away. There is a need to improve the social determinants of health: the overall quality of life conditions affect a wide range of health risks and outcomes.

- **Need for opportunities**: The areas of Indianapolis that were once thriving communities. There is a significant need for adult education, workforce development, and financial coaching.

**Systems theory.** With helping professionals, a systems approach to community work will help create an atmosphere that is collaborative and empowering at large (Ottemiller et al., 2016). Systems theory is rooted in the interdisciplinary acknowledgement of all systems (Ottemiller et al., 2016). In communities like the ones previously mentioned, therapists would address issues of inequality and work toward social justice and acquisition of resources for underserved communities (Talwar, 2016). There is an emphasis on developing critical consciousness in order to address wellness models that promote social change at the community level (Ottemiller et al., 2016). Above all, systems theory encompasses intersectionality in a way that merges with ecology theory, described below.

**Ecology theory.** Social workers have developed an ecology theory for working in environments outside their own. In 1973, Carel Germain became the first social worker to formally apply ecological concepts to social casework, emphasizing the concept of ecosystem
Ecology is the science concerned with the adaptive fit of organisms and their environments and the means by which they achieve a dynamic equilibrium and mutuality (Naess, 1989). When translated into human application, this theory examines the relationships between human beings and their interpersonal and organizational environments, helping to modify or to enhance the quality of transactions between people and their environments, and seeking to promote environments that support human wellbeing (Ecological Theory Origin from Natural to Social Science, n.d.). When working in diverse communities from an ecology systems perspective, helping professionals must ask themselves what they are doing for this community and why. They may also ask themselves: How can I better understand a community's way of thinking within its ecological community? A subdiscipline emerging from ecology theory is homeostasis (Ernest, 2001). Homeostasis is the tendency to remain in a stable equilibrium in which little to no change is present within environmental fluctuations (Ernest, 2001). Little literature exists on this concept, but there are mirroring concepts such as fixed and growth mindsets. These concepts may suggest some insight on why some residents choose to stay in urban communities.

**Fixed vs growth mindset.** Mindsets come in these two distinct styles. A fixed mindset believes that traits within an individual are “fixed” (Kristjansson, 2016). On the other hand, people operating out of a growth mindset depict resilience as they believe cultivation of the mind through continued learning will foster improvement (Kristjansson, 2016). These mindsets can fluctuate on an individual basis, although culture and environment can certainly have a major
impact on which mindset a person most mirrors. For example, overbearing community leaders and systematic oppressions can have a negative impact on the mindset of communities.

**Collective trauma.** Many underserved ecosystems experience collective trauma, also known as intergenerational trauma. Unfortunately, existing literature lacks an emphasis on environmental contributors to mental health recovery, including trauma (Harvey, 1996). This is because some clinical literature tends to overlook the phenomenon of resilience in these communities as well as factoring in the limited number of clinical mental health sites (Harvey, 1996). Data is often absent about the capacity of these communities’ ability to foster health among affected members (Harvey, 1996). If an individual recovers through the naturally occurring support of resilience within their ecosystem, data on what caused the change may be absent, but the results are still present (Harvey, 1996). A community has the power to instill its own recovery and resilience especially when discussing collective trauma.

Collective trauma positions social trauma as an overlap with individual trauma (Abramowitz, 2005). This means that social trauma can potentially be passed down generations, causing individual trauma. However, as suggested above, communities can also foster their own resilience to address this trauma. Collective community narratives are created by individuals in a community in response to evolving narratives associated with the physical, emotional, and social suffering of the community (Abramowitz, 2005). A study conducted on six Guinean communities that were victims of violence found that communities who had developed collective narratives of resistance to violence had lower rates of distress (Abramowitz, 2005). These individuals created community rituals and social supports that helped alleviate physical and
emotional trauma that could have potentially been passed down through generations (Abramowitz, 2005). It is important to note that these narratives were created by the community; in order to best work with these communities, trained professionals need to understand and learn about their narratives, especially those that foster resilience.

Harvey (1996) agreed that in response to trauma in particular, recovery will parallel the complex interactions among the person, event, and environment. The ecological model suggests a multidimensional view of trauma with an enhancement of person-community relationship, working towards achieving an “ecological fit” where communities foster health and resiliency among affected community members (Harvey, 1996, p. 7). Additionally, “community pollutants” must be understood as relating to ecological anomalies, as factors that foster a threat to health-promoting resources and poor health-based patterns (Harvey, 1996, p. 7). Some of these pollutants seen in underserved populations are racism, sexism, poverty, oppressive political climates, and violence. Combining an understanding of the individual, their environmental pollutants, and their traumatic events will aid the helping professional in defining the ecosystem that impacts the person with whom they are working (Harvey, 1996).

Ecological psychology suggests that all humans are best understood in the context of their ecological communities, and can assist professionals in identifying a person's values, behaviors, skills, and understandings; these factors act as determinants for how individuals react and cope with trauma (Harvey, 1996). Furthermore, knowledge of locality, local history, ecological environments, as well as an understanding of the deeply rooted culture and communal interactions with past and present history, will better enable helping professionals to serve
individuals in communities that have undergone the long-term consequences of collective trauma (Abramowitz, 2005).

**Ethics for Helping Professionals**

The concept of ethics will be pivotal in creating the proposed ethical model for art therapists working in diverse communities. Ethics is a moral compass that governs a person's behavior or the conduct of an activity (Acton, 2001). In the helping professions, ethics often involve grey areas, meaning that they are not universal to every ethical dilemma. Many helping professionals rely on their own individual morals and values when faced with unclear, or grey, ethical guidelines (Jennings et al. 2005). Therefore, it is important to look at the ways that therapists maintain ethical competence throughout their professional careers. Viewing the way helping professionals tackle ethics will give a general context before focusing specifically on art therapists.

In order to tackle the grey areas, maintaining ethical competence and building expertise both involve a continual relationship with others in the field, whether through supervision, collegial support, and/or personal relationships with peers (Jennings et al., 2005). Talwar (2017) also claimed that as part of ethical competence, it is necessary that therapists confront and address their discomfort in their own privilege and their insensitivity to potentially oppressive social dynamics within the therapeutic relationship, especially when working in diverse communities. Ultimately when working with others, particularly those with marginalized identities, it should be a priority to acknowledge race and/or culture. When therapists do not understand their own biases or their profession’s biases they could harm the therapeutic
relationship with clients of marginalized identities (Acton, 2001). The way we view issues in our society determines the course of action we take to address or rectify them (Goodstar, 2013). In creating a proposed ethical model for working in diverse communities, the following elements must be considered: (1) development of the self through critical self-reflexivity; (2) development of others; and (3) formation of a creative and just future (Talwar, 2017). Implementing these factors as part of ethical thinking and decision-making will help to develop the field of art therapy and enhance ethical competence in art therapists.

**Ethical Values, Principles, and Codes.**

Ethical codes are specific to each profession and provide professionals with a set of standards to uphold in order to improve and enhance an environment of integrity (Allan, 2013). Considering both the profession’s specific codes of ethics as well as the overarching ethical principles is important in creating an ethical model for art therapists. In the helping professions, codes of ethics address specific aspects of the professional culture and practice expected in therapeutic settings; overarching ethical principles address the qualities and values that a therapist needs to possess in order to provide clients with ethical treatment. Due to the specificity of ethical codes, the proposed ethical model will focus on defining overarching ethical values and principles for art therapists working with diverse communities. However, consulting the ethical codes of the practitioner’s profession is a critical step in ethical decision-making.

Jennings et al. (2005), identified nine ethical values they felt were critical for optimal clinical practice: (1) relational connection; (2) autonomy; (3) beneficence; (4) nonmaleficence; (5) competence; (6) humility; (7) professional growth; (8) openness to complexity and
ambiguity; and (9) self-awareness. These values correlate to ethical principles that have been
defined by art therapy and the related fields of counseling and psychology, which are covered
below. In addition, this review of literature uncovered two sets of ethical principles especially
pertinent for art therapists and other helping professionals working in diverse communities.
These are also included below under the header of community work.

**Counseling.** The American Counseling Association’s (ACA, 2015) ethical principles and
code of ethics were created to support its overall mission:

Enhancing the quality of life in society by promoting the development of professional
counselors, advancing the counseling profession, and using the profession and practice of
counseling to promote respect for human dignity and diversity. (ACA, p. 3)

The ACA’s Practitioner’s Guide to Ethical Decision Making (Forester-Miller & Davis,
2016) states that their ethical principles are autonomy, justice, beneficence, nonmaleficence, and
fidelity. *Autonomy* specifically addresses an individual’s freedom to make choices and take
actions. Considerations include: (1) understanding how the client’s choices will be received
amongst their societal context, and (2) considering the client’s ability to make competent choices
for themselves (Forester-Miller & Davis, 2016). *Justice* points at the equality a practitioner
brings to their service to all clients. This encompasses concepts of beneficence and
nonmaleficence (Forester-Miller & Davis, 2016). *Beneficence* directs the act of helping others
while *nonmaleficence* urges practitioners to be aware to not cause harm towards others. Their
final principle is *fidelity*, which involves notions of loyalty and honoring the client
(Forester-Miller & Davis, 2016). Fidelity is the idea of cultivating a therapeutic relationship that
is in the best interest of the client with no unfulfilled obligations (Forester-Miller & Davis, 2016).

The American Counseling Association's (ACA) code of ethics contains nine main areas that address (1) the counseling relationship; (2) confidentiality and privacy; (3) professional responsibility; (4) relationships with other professionals; (5) evaluation, assessment, and interpretation; (6) supervision, training, and teaching; (7) research and publication; (8) distance counseling, technology, and social media, and; (9) resolving ethical issues (ACA, 2015). Along with these codes, principles are additions to overall therapists’ competence.

**Art therapy.** Art therapy has ethical principles and codes of ethics that have similar areas of coverage as counseling. However, art therapy ethical principles add the discipline-specific value of *creativity* (AATA, 2013). Art therapy ethical codes additionally address the unique ethical challenges related to art-making in the therapeutic context and the art products produced in therapy sessions.

In terms of the principles, the American Art Therapy Association (AATA) works to promote ethical principles that act as a guide on the reflective safeguards therapists should have when working with others. AATA promotes five core principles that are identical to counseling, namely: *autonomy, nonmaleficence, beneficence, fidelity*, and *justice*. A sixth value, *creativity*, is unique to the profession of art therapy (AATA, 2013). *Creativity* is defined as the art therapist’s cultivation of the creative process for further understanding of self, others, and the world (AATA, 2013).
The AATA code of ethics includes specific codes related to art-making in session and how to treat artwork created by clients (AATA, 2013). For example, Section 5 of The Ethical Principles for Art Therapists (2013) addresses issues related to client artwork, “Art therapists regard client artwork as a form of protected information and property of client” (Moon, 2008, p. 76). Moon (2008) stated that artwork is a third entity in the art therapy therapeutic relationship, holding equal importance of the client and therapist. Images are independent from the artists that created them and should be treated as such. The code of ethics for the Art Therapy Credentials Board (ATCB; 2018) additionally provides guidelines for the kind of space used for art therapy practice with considerations such as privacy and confidentiality, safety, functionality, and security as well as attending to the safety hazards of certain art materials used in art therapy sessions.

**Psychology.** The Universal Declaration of Ethical Principles for Psychologists follows four principles they believe will lead to optimal ethical decision making (Gauthier Pettifor & Ferrero, 2010). These four are: (1) respect for the dignity of people; (2) competent caring for the well-being of people; (3) integrity, and (4) professional/scientific responsibilities to society (Gauthier, Pettifor, & Ferrero, 2010). These four components are believed to be pivotal in any code of ethics across psychology; however, they are used as an overarching standard, not reflective of specific people or populations.

**Community work.** There is little literature about what ethical principles individuals should keep in mind while working in a community. Corey et al. (2018) stated that practitioners must meet specifically with the community agencies they work alongside. This may look like
providing affordable group services to underserved populations. The therapist must keep in mind that group treatment and approaches must offer services for diverse populations with a wide range of problems (Corey et al., 2018). The therapist must also understand agency systems, including agency structures, policies, and political issues that might affect the client. The helping professional must be readily informed of available resources and serve as an active advocate for their clients’ communities in order to optimally help meet the needs of these clients (Corey et al., 2018). To hone in on the focal points, the therapist must be aware of the systems and environments that affect their respective clients. For this reason, it is important to consider approaches rooted in systems and ecology theory, described previously. Two sets of ethical principles were found in the literature review that seem especially pertinent for art therapists and other helping professionals working in diverse communities: (1) Clinical Manual of Anxiety Disorders for Psychiatric Services, and (2) Historical Perspectives on the Multicultural Guidelines.

**Clinical Manual of Anxiety Disorders for Psychiatric Services.** The set of ethical principles found in this manual provided the most extensive list found in the literature review that seem especially pertinent for work in diverse communities. They address eleven principles to follow when working as rehabilitation practitioners (Rizzi, 2006). The first principle is *psychosocial rehabilitation* (PSR). This means that practitioners accept that every individual has an ethnicity, as well as a gender, sexual orientation, level of ability/disability, age, and socioeconomic status; therefore, they view every human encounter as a cross-cultural encounter (Rizzi, 2006). The second principle is *self-awareness*. Practitioners must study, understand, and
accept their own cultures as bases for relating to other cultures while understanding their own biases (Rizzi, 2006). The third principle is recognition. The professional should recognize that differences, discrimination, and isolation continue to create unique situations in which culture may emerge. Fourth is understanding worldviews. Practitioners recognize each world view is valid and influences how clients perceive and define problems (Rizzi, 2006). Principle five is respect towards clients which value process or product (Rizzi, 2006). Principle six is autonomy. Practitioners accept that the solution to problems are to be sought within clients (Rizzi, 2006). Principle seven is strengths. Practitioners will apply a strengths-based wellness approach to all (Rizzi, 2006). The eighth principle is accommodating. All interventions are culturally syntonic and accommodated to specific clients (Rizzi, 2006). Principle nine is privilege and advocacy. Professionals recognize that discrimination and oppression exists within our society; these take many forms, including discrimination based on race, ethnicity, gender, sexual orientation, class disability, age, and religion (Rizzi, 2006). Professionals have a role and responsibility in mitigating the effects of these “isms,” advocating not only for access to the opportunity and resource structures, but for the elimination of all “isms” (Rizzi, 2006). The tenth and eleventh principles are release and training. Practitioners are responsible for actively promoting positive intergroup relations, particularly between clients and their larger communities, and engaging in ongoing cultural competence training in order to increase their knowledge and skills of appropriate effective cross-cultural interventions (Rizzi, 2006). This thorough investigation of principles provided a good reference in building a community-based ethical model; some of these principles felt like they could easily be converted into steps for the proposed model.
Historical Perspectives on the Multicultural Guidelines. This set of guidelines developed by The Ethical Principles of Psychologists and Code of Conduct provides a more multicultural focus on ethical principles (Ethical Principles of Psychologists and Code of Conduct, 2016). These principles seem to be the most relevant in the literature for addressing the ethical need to research and understand the historical background of the communities where helping professionals, including art therapists, work. Arredondo and Perez (2006) addressed competency with a multicultural lens that involves eight principles. These are: (1) personal awareness, (2) knowledge building, (3) orientations, (4) acculturation, (5) ethnic and racial identity, (6) worldview, (7) forms of oppression, and (8) privilege (Arredondo, P., & Perez, 2006). It is believed that these concepts should be infused into every ethical decision in order to consider clients holistically. They also reflect one dimension to my overall goal: to challenge therapists to look at the multidimensional layers that both the clients and therapist possess.

Ethical Decision-Making Models

It is important for the development of a new ethical model to look at existing ethical models available to helping professionals, in order to critically analyze correlate important steps and areas that are not considered. Ethical decision-making models are used to help guide professionals through ethical decision-making. They are needed in order to address dilemmas, tailoring the step-by-step process to the specific situation the therapist is experiencing. These models are used as a guide and it becomes the therapist's responsibility to navigate and address dilemmas in an appropriate way. Each dilemma is different and each therapist differs in how they practice. The unique situations that comprise practice and the subjectivity of the therapist both
create grey areas in what is morally right and wrong. Many helping professionals today rely on their own individual morals and values in the face of these grey areas (Jennings, 2005).

It was pivotal to take a deeper look at the literature for more data on a variety of models to make informed choices on what is important to include or consider in the proposed model.

**Counseling.** The American Counseling Association (ACA) Practitioner’s Guide provides the Ethical Decision-Model for practitioners to follow (Forester-Miller, H., & Davis, 2016). This model includes seven-steps designed to help practitioners with tough decision-making during practice. The model’s components are as follows:

1. Identify the problem.
2. Apply the ACA Code of Ethics.
3. Determine the nature and dimensions of the dilemma.
4. Generate potential courses of action.
5. Consider the potential consequences of all options and determine a course of action.
6. Evaluate the selected course of action.
7. Implement the course of action.

These general steps leave room for interpretation in course of action. Therefore, guidance of another professional is recommended as necessary to provide objectivity.

**Art therapy.** Art therapy ethical decision-making models address dilemmas in what seems to be a more specific manner with considerations of the therapist's concerns and awareness. The profession of art therapy provides two models to help guide art therapy professionals towards best practice in navigating work with others.
**ACTION.** The acronym ACTION provides an easy framework that may be helpful when making tough decisions. The A stands for acknowledgement of concern, which means that the therapist will realize there is a problem or concern and consider potential implications while evaluating their own rights and the rights of the client (American Art Therapy Association [AATA], n.d.). C stands for codes, values, laws, and regulations which are all evaluated and reviewed (AATA, n.d.). Later, the therapist looks at T for talk; they will talk to supervisors and mentors for consultation of the issue. They will then be able to complete I, which refers to identifying the course of action. During this time, all possible consequences are explored, and a plan emerges. O and N go hand in hand; while ownership of decision is selected and action transpires, and notes are recorded along with any follow-ups. ACTION provides therapists with a tool they can carry into their practice.

**DO ART.** This model, developed by Hauck and Ling (2019), provides a process of ethical decision-making using art, and includes a series of suggested art directives for considering dilemmas. Art-making is a pillar of art therapy practice. This model supports the idea that art can provide insight into decision making and guide therapists to externalize their thought process by utilizing their strengths (Hauck & Ling, 2019). The model includes six steps using the DO ART acronym: D-Dilemma, O-Options and Outcomes, A-Assistance, R-Responsibility and T-Take Action. Art-making enters the model with the Options and Outcomes component. In this step, art therapists visually represent weighing their options either through a libra scale or two lenses on a pair of glasses. In Assistance a therapist might represent sources that can offer them assistance, for example creating a trifold representing external
information acquired from literature and acquired supervision being funneled into a container that represents the therapist. The next step of the model, Responsibility and Risk uses the Draw-a-Person-in-the-Rain art directive with which art therapists are familiar. Take Action, the final step in this model, uses another familiar directive, the Bridge Drawing. Overall this model supports a visual thinking style that fosters insight and supports the natural way that art therapists might process information.

**Emotional intelligence model.** The Emotion Incorporated Ethical Decision-Making Model, developed by Alice Gaudine and Linda Thorne incorporates the important aspects of how emotions affect an individual’s ethical decision-making process. The model was composed by integrating research findings that consider the two dimensions of emotion, arousal and feeling state, into a cognitive-developmental ethical decision model (Gaudine, & Thorne, 2001). This perspective is important because attention to one’s emotions may result in better ethical decisions (Gaudine, & Thorne, 2001). Arousal is the degree of intensity of the feeling state which can range from quiet to aroused (Gaudine & Thorne, 2001). Feeling state describes the emotion as having either negative or positive affect (Gaudine & Thorne, 2001, p. 32). Positive affect includes emotions such as joy and optimism while negative affect includes feelings such as frustration and anger. Components that help move one through the model are listed in Appendix A.

**Community-work model.** A Community Based Art Therapy model was created by Dylan D. Ottemiller and Yasmine J. Awais that illustrates considerations for art therapists working in communities. The rationale central to this model is that clients working with
therapists who are not of the same race or ethnicity may fear that the therapist will not understand them; this often causes resistance in seeking treatment (Awais & Yali, 2013).

Bridging the racial or ethnic gap between therapist and client becomes paramount in an effective therapeutic relationship. This model highlights the importance of goal setting in collaboration with participants (Ottemiller et al., 2016). Ottemiller et al. (2016) emphasize that goals are strengths-based and created with the goal of empowering the participants, reducing stigma, and increasing social inclusion. The model is centered under the belief that individual work will strengthen the community collectively (Ottemiller et al., 2016). For this reason, an emphasis on rapport building with community members, leaders, and organizations is pivotal (Ottemiller et al., 2016). The therapist must be self-aware in order to have knowledge of the limitations they can or cannot provide. This will lead to a cohesive collaboration with members of the community through shared decision making. Ultimately this model is centered around an egalitarian relationship that is rooted in a systems theory and social justice framework (Ottemiller et al., 2016).
CHAPTER IV
RESULTS

In this study an integrative literature review was used to examine three key themes across helping professions related to art therapy. The literature reviewed aimed to gain a deeper understanding of the three following themes:

1. Historical context of communities
2. Existing ethical codes, guidelines, and principles
3. Existing ethical models across helping professions

The purpose of this integrative literature review was to create an ethical model that challenges the way therapists work in diverse communities and helps them to navigate a fuller understanding of clients. This model incorporates current principles and ethical decision-making models used in art therapy and helping professions related to art therapy, with the addition of concepts like ecology theory in order to best obtain full competence in working with clients in diverse areas.

Based on the literature, the researcher identified three key areas where information was lacking or recognized limitations. These key findings have been identified below:

1. Despite the clear divide in communities around the US, helping professionals lack consideration of ecology theory as a basis for understanding community members’ homeostasis way of thinking and deep cultural roots.

Limitations
• Ecological psychology suggests that all humans are best understood in the context of their ecological communities, however, this understanding is often missing in actual practice. Lack of further knowledge of locality, local history, ecological environments, a deeper understanding of the deep rooted culture and communal interactions with past and present history of communities exists from helping professions due to the dominant narrative (Abramowitz, 2005).

• Existing literature lacks an emphasis on environmental contributors to mental health recovery, therefore if an individual recovers through the naturally occurring support of resilience within their ecosystem the data is absent, but the results are still present (Harvey, 1996).

• Little literature exists on the concept of homeostasis, the tendency to remain in a stable equilibrium in which little to no change is present within environmental fluctuations; a highlight of two mindsets would be of relevance in community intervention efforts (Ernest, 2001).

2. Ethical codes and principles are consistent for professions related to art therapy. However, art therapy codes and principles add ethical consideration related to artwork and creativity.

Limitations

• Consistency in codes and principles is evident in the American Counseling Association (ACA), the American Art Therapy Association (AATA), and The Universal Declaration of Ethical Principles for Psychologists.
• Codes emphasize: the counseling relationship, confidentiality and privacy, professional responsibility, relationships with other professionals, evaluation, assessment, and interpretation, supervision, training and teaching, research and publication, distance counseling, technology, and social media, and resolving ethical issues.

• Ethical principles across multiple professions related to art therapy are also relatively parallel, such as: relational connection, autonomy, beneficence, nonmaleficence, competence, humility, professional growth, self-awareness, fidelity, and advocacy.

• Under consideration of artwork, ethical principles for art therapists (AATA, 2013) provides specific guidelines related to client artwork, such as considering artwork as a form of protected information and property of the client, and guidelines for duplication, storage, and exhibiting.

• The code of ethics for the Art Therapy Credentials Board (2018) additionally provides guidelines for the kind of space used for art therapy practice with considerations such as privacy and confidentiality, safety, functionality, and security as well as attending to the safety hazards of certain art materials used in art therapy sessions.

3. Ethical decision-making models lack consideration of arousal of emotions and the value of art-making as important for ethical decision making. Both are pillars in art therapy and could provide deeper insight and a strengths-based approach.

Limitations
• Emotional arousal is an important element to consider because attention to one’s emotions may result in better ethical decisions, this concept has not been noted in models other than Gaudine and Thorne’s model (2001).

• Art-making as part of the decision making process seems to be unique to art therapy; this new modality provides a visual thinking style that offers therapists a tool that can foster deep insight (Hauck & Ling, 2019).
CHAPTER V
DISCUSSION

Overview of Results

Results of the integrative literature review confirm the lack of research related to considering historical context as an ethical consideration for therapists working in diverse communities. The key findings presented in the results section above were used to create an ethical model that supports a better understanding for helping professionals, particularly art therapists, while working in urban, marginalized communities. This chapter gives context to these findings and describes the model I created to address the limitations identified. This chapter also presents the strengths and limitations of this integrative literature review as well as a discussion on implications for the new ethical model presented.

In line with my speculation, there seems to be lacking a consideration of theories that support holistic views of communities and community work. This may result from the lack of diversity in some helping professions, including art therapy. The increasing diversity across the United States suggests the need for more diversity across professions and a deeper understanding of urban communities for professions working with a variety of populations (Robb, 2014). Art therapists cannot be adequate helping professionals if they do not understand the history of the community where they are working.

Creating a model that values the strength of resident engagement will reflect transformational work only as long as the voice of the community is heard (Theodos & Firschein, 2015). Helping professionals must gain knowledge of community resources and
strengths and work to develop social support and cohesion among neighbors, and increase community members’ sense of belonging (Theodos & Firschein, 2015). A knowledge of ecology and systems theories will help professionals gain a better understanding of the needs in these communities as well as identify major resilience in the community (Ernest, 2001). Ecology theory prioritizes the importance of the environment for the overall health of an individual. This means that the environment greatly affects the individual and if the individual has been living in the community for years, the history of the community is pivotal for a full understanding in treatment (Ernest, 2001). Deep cultural and transcendent ways of thinking are lost if a deep view of ecological environments are not present (Abramowitz, 2005). Using a system theory within urban communities is in compliance with a therapist’s overall competence.

While working with marginalized communities, therapists must be willing to address issues of inequality and work toward social justice and acquisition of resources for underserved communities (Talwar, 2016). This being said, many professionals often lose sight of the increasingly resilient nature these communities hold. When one hears “the streets are holding secrets,” they might see this as an ineffective characteristic of urban communities and fail to understand the value of tight knit relationships and homeostasis. Even though little literature exists on the concept of homeostasis, this idea highlights the benefit of seeing the inherent resiliency that is evident in urban communities (Ernest, 2001).

The ethical principles and ethical decision-making model I created recognizes these historical and ecological underpinnings of communities. Art directives and reflective questions related to each step of the model allow the therapist to reflect on a variety of topics such as
oppression, resilience, biases, and privilege. They will be addressed specifically in the following sections.

**Ethical principles and codes.** There was a consistency in the ethical codes, guidelines, and principles across the helping professions reviewed. The American Counseling Association, American Art Therapy Association, and The Universal Declaration of Ethical Principles for Psychologists (Psychology) were some resources used to compare and contrast important concepts. Ethics are a pillar in understanding and working competently in urban communities, therefore knowledge of these codes is important for professionals. Codes are updated fairly frequently so it becomes a therapist’s obligation to continue to keep current knowledge on the appropriate codes and principles in order to abide by their profession’s ethical standards.

Defining overarching ethical principles related specifically to community work was a valuable part of creating my model. These emphasize a therapist's responsibility to a higher level of competence and depict qualities that would be most favorable in providing treatment for urban communities. My model, *Appendix B*, provides a description of each principle I included. It is important to note when looking at these principles that they are tailored for community work. A unique perspective of these principles is that they view the community as the client. Overall, as a helping professional the intention should be to give the community the ability to independently organize initiatives on social, cultural, economic, educational, and political affairs (Rizzi, 2006). Optimally the therapist is providing services that reflect the voice of the community and is aware of strengths, resources, and history in order to provide treatment. In a perfect world the community would gain the durability to sustain itself without the therapist.
Art therapists have a unique set of skills that include additional codes and principles related to the therapeutic process (AATA, 2013). Community art therapists working in diverse communities (i.e., community art therapists) are responsible to follow these codes while also adapting to the needs of the community. Community art therapists must consider specifications about confidentiality of artwork, as client artwork is regarded as a form of protected information and the property of the client (AATA, 2013). Additionally, the art therapist must clearly explain to their client where art will be stored, and in the case of exhibition weigh the benefits of exhibiting against the potential unintended consequences for the clients (ATCB, 2018). Working in urban communities may seem unconventional to some therapists because the space where therapy is provided may vary from more traditional settings. Regardless, art therapists must seek to provide a safe, private, and functional environment in which to offer art therapy services (ATCB, 2018).

While these overarching principles and codes give standard guidelines to professionals, a therapist must encompass an understanding of their personal biases as well as their profession’s biases in order to prevent harm to the therapeutic relationship with clients of marginalized identities (Acton, 2001). Though these principles and codes are placements to begin working ethically across populations, these guidelines are not black and white and often become blurred; in these cases the therapist will begin to use their own moral judgement and values, which may be biased (Jennings et al., 2005).

Ethical decision-making models. A combination of ethical-decision making models were used to formulate the final model I created. Though core steps in every model I reviewed
were fairly consistent, there was a lack of consideration about arousal of emotions and art-making as integrative components of ethical decision-making. Due to the unique circumstances art therapists are placed in while practicing, utilizing these strengths, in addition to the core steps, will aid in the navigation of the grey areas (Jennings, 2005).

The model I created is an integrative model that consists of the same steps as many existing models for the helping professions. The process I designed includes identifying the problem, reviewing codes and values, supervision, course of action, and implementation/follow up. In addition, emotion and art-making are the new components I added to my model. Art directives and reflective questions included for each step add a deeper muti-dimension to the model. These directives and questions were created to challenge the helping professionals who are working in diverse communities. Therapists should always take time to pause and reflect, because inevitably it will lead to a deeper understanding of themselves and others. The art-making prompts and reflective questions help to slow down the process and provide an opportunity for reflexivity. Due to the lack of diversity in the art therapy profession, challenging questions like the ones I provide, may be absent from ethical conversations today.

**Emotion.** Paying close attention to one’s emotions is incorporated in this model through the use of challenging questions that guide the therapist to attune to their arousal and feeling state during decision-making (Gaudine, & Thorne, 2001). *Arousal* is the degree of intensity of the feeling state which can range from quiet to aroused and *feeling state* describes the emotion as having either negative or positive affect (Gaudine & Thorne, 2001, p. 32). Positive affect includes emotions such as joy and optimism, while negative affect includes feelings such as
frustration and anger. Paying close attention to one's state of arousal brings insight and self-awareness. Biases can be teased out by identifying positive versus negative affect. This awareness provides a more holistic way of approaching ethical decision-making.

**Art-making.** The use of art in ethical decision-making can specifically help those in the art therapy profession. It provides a framework that works with the skills they have already acquired and helps to bring deeper insight into the problem and consider implications visually (Hauck & Ling, 2019). Using art directives and processing visually provides a natural way for art therapists to tackle ethical decision-making. The emotional component directs the professional to look at themselves internally, while art-making helps them to externalize their thought processes (Hauck & Ling, 2019).

**Ethical Decision-Making Model for Art Therapists Working in Diverse Communities**

The first step of my model is to *identify the problem*. The initial art directive begins by acknowledging possible feelings of frustration, anger, or confusion as these are some of the initial responses one may have to a developing ethical dilemma. I felt it was important to be aware of these internal feelings and externalize them before moving forward. After taking a moment to acknowledge these feelings the therapist is asked, on the back of a sheet of paper, to begin to think about the dilemma presented, and depicting the problem. They are asked while depicting the problem: What does this look like? What does the “problem” say to you? What would it say to the population you work with? The reflective questions begin to challenge the therapist as they explore the dilemma presented, these include: What are the strengths and weaknesses I see in this community? How is this influenced by my biases and privilege? What
oppressions have I addressed and not addressed? In what historical context is this problem? Who thinks that this is a problem? These questions are aimed to overarch an anti-oppressive view of what the problem is and why it is an issue in the first place (Kapitan, 2018). Refer to complete art directives and questions in Appendix B.

The second step, *reviewing codes and values*, asks therapists to view possible codes and values that relate to the dilemma. The therapist is challenged to depict if codes appropriately address the community or not. They are asked the reflective question: What do the code(s) do for the community you are working with?

During the third step of this model, *supervision*, the therapist considers their responsibility towards the community and client. The therapist and supervisor will explore ways to confront, contain, or defeat the externalized problem. This collaboration enables the therapist to reflect on multiple viewpoints and assess their potential to incorporate different perspectives. This directive is helpful to visualize the therapist’s own perspective while collaborating with a supervisor and their perspective in order to assess risks and contradictions.

In closing up the decision-making process, the *course of action* purposefully places the therapist in the context of the community. They are asked the “miracle question” (Corey & Corey, 2018): “Suppose tonight while you slept, a miracle occurred. When you awake tomorrow you see yourself in the community where you currently work. You notice that things are running optimally, the dilemma is gone...what would be some of the things you notice that would tell you life here had suddenly gotten better?” Reflective questions are aimed to examine external assistance they have acquired as well as visibly represent potential paths in resolving the
dilemma. One question asks: This is what you want to see; what would the community want to see? Completing this step allows for the justification and validation of actions the therapist takes.

In the final step, *implement and follow-up*, the therapist applies change, ponders on the implemented change, and wonders whether they are “able to breathe” again. This step is meant for deep reflection of the overall experience. Hope for a deeper understanding of self and growth moving forward is desired. Insight on how the therapist confronts ethical issues will be evident alongside their reflection of resilience and lesson(s) they have moving forward.

All art directives are intended to be constructed using paper and markers/colored pencils/pens/pencils. These materials will provide the creator with support and control over materials so that they are able to explore the emotion-evoking dilemma. They also provide accessibility and portability so that the therapist is able to explore the dilemma at any given location.

This model offers helping professionals a step-by-step breakdown that could help guide them through a process that implements components like emotions and art. It is anticipated that following this model will help keep therapists accountable to their own biases, professional codes, and multi-cultural competence, particularly for those working in marginalized communities.

**Limitations and Considerations**

Limitations of this literature review include the amount of information published on specific concepts. Some of those topics being theories like ecology theory and homeostasis related to psychology. Another limitation of this study is the time limit within which it was
completed. Due to time constraints, literature may not have been exhausted on the subject, leaving more research to be reviewed.

Something to consider while moving through this model is to remember that the dilemmas art therapists and other helping professionals face are often complex; therefore, a useful guideline is to examine the problem from several perspectives and avoid searching for an overly simplistic solution. As the researcher I attempted to give valuable information that I felt was relevant but must recognize my own biases and the biases of the literature gathered. Due to the lack of diversity of some professions, a completely competent approach for urban community work may also be lacking.

Additionally those who are not art therapists may not be able to use this model as effectively without some guidance on how to understand art as a way to gain a deeper comprehension of the self and others. Actual application of this model with practitioners working in these communities would help better determine these implications and ultimately enhance the strength of this model.
CHAPTER VI
CONCLUSIONS AND RECOMMENDATIONS

This integrative research project served as a purpose to study and create a model that would guide helping professionals to honor and ethically consider the history of the community their clients live in. Initially I asked myself questions like: What do art therapists who are working in diverse communities need to know about the historical background of the community in order to ethically treat their clients? How do they best obtain this information? How do art therapists integrate considerations of the community into ethical decision-making? The expectation was to gather information on existing models in order to identify holes in the approach to community work. By analyzing these models, the results matched many key principles and decision-making steps which provided a foundation for this particular model. With the inclusion of art-making through specific art directives and reflective questions which aimed at identifying arousal of emotion and the model encompasses a process that will hold therapists accountable in their work with marginalized communities.

Working from an ecological and historical immersion perspective shifts the focus towards the overall community in encouraging both individual and collective change. To better understand the implications and effectiveness of this model, future research should address the implementation of the model in accordance with art therapy practitioners. As the field continues to expand, therapists have the opportunity to challenge each other and advise new innovative directions for the appropriate practice of therapy. This model specifically expands on the
capacity to improve and maintain community wellness which will inevitably enhance the wellness of our society.

Based on these conclusions, my recommendation for this model is that future research be focused on field testing the model in order to refine it. Partnerships with art therapists working in diverse communities would be ideal as they have the adequate skills to interpret artwork and directives would magnify on their strengths. More fieldwork would help identify errors and areas of improvement, and increase effectiveness. As a researcher I must acknowledge my own biases that went into this model so multiple perspectives would only reinforce its value.
CHAPTER VII

REFERENCES


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**APPENDIX A**

| Component 1: Ethical Sensitivity and the identification of an ethical dilemma. | Proposition 1: There is a positive association between arousal and an individual’s likelihood of identifying an ethical dilemma. |
| Component 2: Prescriptive reasoning and prescriptive judgement | Proposition 2: Individuals experiencing positive affect are more likely to recognize an ethical dilemma |
| Component 3: Ethical motivation and intention to resolve an ethical dilemma | Proposition 3: Individuals experiencing low arousal and positive affect are less likely to recognize an ethical dilemma than individuals experiencing high arousal and positive affect |
| Component 4: Ethical character and ethical behavior | Proposition 4: Arousal is positively associated with an individual’s tendency to formulate a prescriptive judgement consistent with his/her level of moral development |
| | Proposition 5: Positive affect is positively associated with an individual’s tendency to formualte a prescriptive judgement at a level of moral reasoning consistent with his/her level of moral development. |
| | Proposition 6: Positive affect increases an individual’s tendency to select an ethical decision choice consistent with his/her judgment. |
| Component 5: Ethical character and ethical behavior | Proposition 7: There is a positive association between arousal and an individual’s propensity to comply with his/her ethical intention |

APPENDIX B

Ethical Decision-Making Model for Art Therapists Working in Diverse Communities

Principles

In order to have best practice in the field, helping professionals use principles as the foundation to ethical decision-making. The following principles serve as groundwork for a healthy therapeutic relationship specifically tailored for community work. Notice they take a perspective that views the community as the client. The ninth principle, creativity, is addressed as a principle specific to art therapists. A description of the principles are as follows:

**Autonomy** is related to addressing independence and freedom of choice with the community. It is the ability of the community to take independent organized initiatives on its social, cultural, economic, educational and political affairs (Rizzi, 2006). Helping professionals should accept the responsibility in allowing clients to make their own decisions and actions, working to empower this independence (Rizzi, 2006). When giving this encouragement to clients therapists should consider how age and an individual’s mental competence could impact their decision-making within the context of society and avert any actions that jeopardize the safety of themselves or others. Consideration of history may help aid in this deliberation.

**Beneficence** emulates the helping professional's responsibility for the well-being of the client. This can be thought of as the moral obligation in contributing to the welfare of the client through preventative care, competent treatment planning, etc. In community work the therapist should be aware of what the needs look like for the community. The community’s voice should
be heard. This would be evident in an established collaborative relationship that is centered on community strengths such as stigma reduction, empowerment of residents, and increased social inclusion of the community (Ottemiller et al., 2016).

**Nonmaleficence** is often confused with beneficence though it refers to the concept of not causing harm to others and maintaining respect for the dignity of people (Gauthier, Pettifor, & Ferrero, 2010). Critical thinking of potential harm and risks to clients is an obligation important to helping professionals. Therapists strive to engage people with a goal to change the environment, which in turn has a positive impact at the individual level (Ottemiller et al., 2016). Continued relationships with community members and leaders can help the therapist prevent harm unknowingly.

**Competence** describes the quality of care practitioners offer their clients related to the required skill, knowledge, qualification, or capacity they have. Practitioners are responsible for actively promoting positive intergroup relations, particularly between clients and their larger communities, and engaging in ongoing cultural competence training in order to increase their knowledge and skills of appropriate effective cross-cultural interventions (Rizzi, 2006). The therapist must also be aware of the systems and environments that affect their respective clients. They should be aware of the resources available to the community and acknowledge and address differences in power from the beginning, rather than pretend that they do not exist (Talwar, 2016). In the initial engagement phase, patience and immersion are critical to the overall success of community work (Talwar, 2016).
**Professional Growth** is the principle that promotes continued professional development through sought out formal and informal training. Additionally, continued supervision, peer consultations and personal therapy is advised as this type of development could minimize the potential for unethical behavior (Jennings, 2005). Continued professional relationships with community members and leaders can help the therapist grow while informing the therapist of common modalities practiced in the community. For example, many non-profit organizations in Indianapolis that are in urban communities focus on trauma-informed treatment. The therapist working here would seek specific training on this modality in order to showcase familiarity of this practice in the context of this community.

**Self-Awareness/Self Care** requires a therapist's deep commitment to themselves and their own life issues. Self-awareness/self care are focused on three main points: 1) understanding and fulfilling their personal emotional and physical needs; 2) understanding, and accepting their own cultures as bases for relating to other cultures while understanding their own biases; and 3) awareness of their own unfinished business, personal conflicts, defenses, and vulnerabilities may interfere in therapy sessions (Rizzi, 2006). Only addressing the importance of learning about the other’s culture is not sufficient as it eliminates individuals from learning and understanding the impact of their own sociopolitical and ethnocentric biases on their work with communities who are racially/ethnically or culturally different from themselves (Negi, Bender, Furman, Fowler,& Prickett,2010).

**Advocacy** relates to both privilege and justice. Professionals must not only recognize that discrimination and oppression exists within our society but must take responsibility in mitigating
the effects of “isms,” advocating not only for access to the opportunity and resource structures, but for the elimination of all “isms” (Rizzi, 2006). This principle challenges therapists to look at the multidimensional layers and historical oppressions of a community as well as the “isms” the therapist possesses. The therapist must be transparent with themselves and the ethical advocacy they are embodying on a day-to-day basis in order to promote true authentic advocacy.

**Fidelity** involves discernment of loyalty and faithfulness to commitments of the therapeutic relationship. Practitioners must fulfill obligations to therapeutic relationships and cultivate relationships that are in the best interest of the community (Bunting & Webb, 1988). The therapists must work towards enhancing the lives of the community members and clarify their role and responsibilities in order to prevent misunderstandings (Ottemiller et al., 2016).

**Creativity**, the final principle values the cultivation of the creative process for further understanding of self, others, and the world (AATA, 2013). This principle is unique to those practicing art therapy. Creativity can be viewed as a guiding principle that provides an outlet for expression, self-understanding, and transformation for those otherwise marginalized (Hinz, 2017). Art cultivates spaces for the portrayal and conversation around challenging and otherwise stigmatizing life experiences. Art therapy work supports cultural exploration and acknowledges those influences on the individual's life. The therapist must consider ethics around choice of material and population representation in addition to considering using unconventional materials like recycled or found objects with more traditional art materials such as paints. The therapist must also have awareness of a community’s previous exposure to art, therapy, and art therapy in
order to recognize what materials, processes, and structures will be most effective (Moon & Nolan, 2020)

**Ethical Decision-Making Model**

Following an ethical decision-making model may help professionals who feel specific examination of a particular dilemma will bring clarity beyond the principles provided. I have fused work of Forester-Miller and Davis (2016), American Art Therapy Association (2016), Hauck and Ling (2019), Gaudine and Thorne (2001), and Ottemiller (2016) into a five step model that encompasses two key components whose combination is unique to this model: art and emotion. Together these components have lacked presence in previous models. Additionally I have included art directives and specific questions helping professionals should ask themselves while processing decision-making. All art making is intended to be created using paper and markers/colored pencils/pens/pencils. These materials will provide the creator with control over materials as most people have comfortability with this art media. The chosen materials were also selected due to their accessibility and portability so that therapists are able to explore the dilemma at any given location. These materials contrast the uncomfortability of the emotion provoking questions they are challenged with. A description of the steps follow:

1. **Identify Problem**

   During this stage the helping professional must gather as much information on the dilemma as possible. Be specific. Ask yourself questions like: Is it an ethical, legal, professional, or clinical problem? Is it a combination of more than one of these? If a legal question exists, be sure to seek legal advice.
Art Directive: Begin by depicting an image and externalizing any internal feelings about the dilemma on a large sheet of paper. Become aware of feelings of arousal that may present themselves. Any fears, frustrations, anger, confusions? Take a moment to breathe and acknowledge these feelings...be present with them. Now on the back of this sheet of paper as you begin to think about the dilemma presented start by depicting the problem. What does this look like? Does it have a name? What does this “problem” say to you? What would it say to the population you work with?

Reflective Questions:

In what historical context is this problem?

Who thinks that this is a problem?

What are the strengths and weaknesses I see in this community? How is this influenced by my biases and privilege? What oppressions have I addressed and not addressed?

Who is being affected by the situation?

How do I feel I belong or don’t belong here?

Do I feel competent to fulfill the needs of this community? Why or why not?

The questions shown begin to challenge the therapist as they explore the dilemma presented. These questions are aimed to overarch an anti-oppressive view of what the problem is and why it is an issue in the first place (Kapitan, 2018).

2. Review Codes and Values
Once you have identified the problem, refer to any codes of ethics that may be applicable to the dilemma. Review any professional codes that apply to you, this may be the ACA code of ethics, the AATA code of ethics, the ATCB code of ethics, etc. This being said, even if the issue is addressed in these codes your dilemma may not be resolved, further investigation of the dilemma may be necessary. This is due to the lack of diverse perspectives that currently exists in these fields. You must constantly ask yourself: Am I honoring and supporting the worth, dignity, potential, and uniqueness of the community?

**Art Directive:** What would this code look like if it were depicted in an art form? What does it do for the community you are working with?

**Reflective Questions:**

What are the inherent power dynamics that exist when an outside professional enters a community?

What are the larger contexts that might be influencing the situation?

Are there contradictions between art and the code?

What is my feeling and arousal state?

This step asks therapists to view possible codes and values that relate to the dilemma. After depicting if codes are appropriately addressing (or not) to the community the therapist will examine if power dynamics have inevitably also impacted the therapeutic relationship.

3. **Supervision**
In order to ensure you have considered the complexity of your dilemma it is important you consult with professional peers, supervisors, or even your state/national professional association. In addition, speaking to someone who specifically understands the community you are in would be favorable. As they review with you they are able to provide you a fresh set of eyes into the dilemma and help ensure you are abiding by codes of ethics.

**Art Directive:** In this step you will create several pieces of art. You will start with two single sheets of paper, one for you to make and one for your supervisor to make. Now begin to explore and depict ways to confront or defeat this “dilemma.” Maybe you confront and defeat, or maybe all you can do right now is contain it? After completing this think about how you can incorporate the two pieces into a new single art piece that incorporates these multiple perspectives. How can multiple perspectives view this community? How can I use multiple perspectives to challenge my own biases?

**Reflective Questions:**

How is the therapeutic relationship collaborative? In what ways is it not?

What are areas of uncomfortability or fear with working in this community or population? Why do these exist?

How do these images show the way each person perceives situations?

What is the rationale for these perceptions?

What feelings and emotions are presenting themselves?

What were the differences between yourself and your supervisor’s initial images?

How do your incorporated images give you insight on the dilemma moving forward?
During the supervision step of this model, the therapist considers their responsibility towards the community and client. The image making emphasizes awareness of multiple perspectives which is helpful to visualize when thinking about how multiple perspectives view and impact the community. This time also allows the therapist to reflect on their own perspective while collaborating with a supervisor in order to assess risks and contradictions.

4. **Course of Action**

Once you have met with your supervisor you can begin to formulate a course of action to take. Keep in consideration diversity issues involved in the particular situation as well as the principles mentioned previously. Working through this step with a supervisor is optimal. This will help prevent new ethical issues though the possibility of reevaluating the whole situation exists. Once you are satisfied that you have selected an appropriate course of action, then you are ready to move on to implementation and follow-up.

**Art Directive:** Suppose tonight while you slept, a miracle occurred. When you awake tomorrow you see yourself in the community where you currently work. You notice that things are running optimally, the dilemma is gone...what would be some of the things you notice that would tell you life here had suddenly gotten better?

**Reflective Questions:**

This is what I want to see; what would the community see?

Have I shown patience and immersion in these communities?
What outcomes would I (and the community) wish to achieve?

What is happening already in the community?

During this step, therapists can examine external assistance they have acquired as well as visibly represent potential paths in resolving the dilemma. Completing this step allows for the justification and validation of actions the therapist takes.

5. **Implement and Follow-up**

You are now able to implement your course of action, following up on the situation to assess the outcome of your actions best practice. Again this can be done with your practicing peers or supervisor.

**Art Directive:** Now you are safe and comfortable. You can breathe again, what does this feeling look like for you? Have you achieved this, or do you feel unfinished business is still lingering over your head? Pay attention to the internal feelings and emotions that are coming up for you.

**Reflective Questions:**

How has this individual and/or community shown resilience?

What strengths and resilience did I not see before? Why?

How has an immersion in community and knowledge of historical context contributed to my growth?

What lesson(s) will I carry with me moving forward?
The final step depicts the conclusion and resolution of the dilemma. It is meant for deep reflection of the overall experience. A deeper understanding of self and growth moving forward is evident.

Additional Components

Throughout the process of ethical decision-making it is important to pay close attention to two pivotal components: art and emotion. Paying close attention to one’s emotions specifically arousal and feeling will result in more effective ethical decision making. Stating feelings of anger, frustration, joy, etc. through this process can not only enhance objectivity but also promote self-awareness for the helping professional. Additionally, making art can help therapists consider potential implications, view the dilemma through a different lens, and help enhance self care throughout the tough decision making process. The art directives can help to see how the therapist deals with this dilemma and where their personal power lies. Both components will provide insight to this procedure, but are individualized elements that are to be tapped into at the user’s discretion.

Overview of Ethical Decision-Making Model

1. **Identify Problem**

2. **Review Codes and Values**

3. **Supervision**
4. Course of Action

5. Implement and Follow-up

*Additional Components: Emotion and Art

Conclusion

It is important to consider that every situation is unique therefore complex dilemmas will rarely follow parallel steps to solutions. This model offers helping professionals a step-by-step breakdown of a model that could help guide them through a process that considers multicultural issues as well as an inclusion of emotions and art. Though this model can be challenging for art therapists to implement due to the intense self-awareness it addresses, it could help keep art therapists responsible and competent particularly for those working in marginalized communities.