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Abstract

The use of arts therapies in medicine has become a popular form of treatment in the United States. Arts therapies are a form of psychotherapy. Music therapy, art therapy, dance/movement therapy, drama therapy and poetry therapy, are all considered forms of arts therapy. Although they have been used for decades in American medicine, they have experienced tremendous growth in the last twenty years. Once viewed by the general public as a "fringe" type of therapy, the arts therapies are now finding acceptance, and have become a therapy of choice by many medical patients each year. Medical patients who are choosing this form of therapy are finding that arts therapies can help them battle their disease on both a psychological and physical level and are thus perceived as "humanizing" healthcare. How mainstream these therapies will become remains to be seen as they are unable to be tested through conventional methods, and excluded from many medical insurance plans.

Integrating Arts Therapies into American Medicine

In the field of medicine, the usage of the terms "complementary" and "alternative" are often used within the same context, and are perceived as having the same definition and serving the same purpose. In actuality, they are quite different. When one refers to the term, "alternative medicine," one is referring to a type of treatment that is used instead of, and not integrated with, traditional medicine. However when the term "complementary medicine" is used, one is referring to a form of medicine that has the compatibility to be used alongside conventional medicine (Cohen & Markman¸ 2008, p. 4).

In years past, the field of Complementary and Alternative Medicine (CAM) has struggled to gain credibility and acceptance within American medicine. This is due, in part, to the fact that its approach is much different from that of conventional medicine. For example, Western biomedicine concentrates on curing a patient's medical problems while complementary and alternative medicine focuses on creating harmony within the body, and promoting health (Snyder & Lindquist, 2006, p. 322).

These conflicting views have caused an ideological divide between advocates

of conventional medicine and those who support complementary and alternative medicine that has lasted for centuries. However, although there has been, and continues to be, a rivalry between these two groups, the medical community is beginning to acknowledge the appeal of complementary and alternative medicine, and consequently, the general public is, too. Therefore, negative stereotypes associated with this form of medicine, the arts therapies included, are beginning to change. Signs of these positive changes include the implementation of educational courses focusing on complementary and alternative medicine, as well as the humanities, in medical schools. In years past, alternative forms of treatment and medicine which were not taught in medical schools were perceived as being fraudulent (Udani, 1998, p.1620).

This paper focuses on arts therapies, a branch of complementary and alternative medicine. Because arts therapies are becoming widely used in American hospitals as a valid form of therapeutic treatment, they have been one of the reasons why the awareness of complementary and alternative medicine has increased and why complementary and alternative medicine have become more accepted in the general public. The first section of this paper addresses the current impact complementary and alternative medicines are having on healthcare, while the second portion of the paper discusses the relationship between complementary and alternative medicines and the arts. The following section will provide a definition of arts therapies. The role of the arts therapist will be addressed in the next portion of the paper, followed by an overview of the most popular forms of arts

therapies. This discussion will include the areas of dance, music, poetry, drama and art. The disadvantages of arts therapies is the focus of the following section, and the paper concludes with a summary of the current state of complementary and alternative medicines, and what lies ahead for the future of arts therapies.

Complementary and Alternative Medicines: Redefining Healthcare

American hospitals can trace their beginnings to the founding of the Pennsylvania Hospital in 1751, the result of a collaboration of efforts by Dr. Thomas Bond and Benjamin Franklin. The hospital's establishment was designed to offer medical services to the sick and the poor (Snook, 2004, p. 5). Now, over two hundred and fifty years later, the purpose of American hospitals remains unchanged, but their presence and subsequent effect on America's economy have changed dramatically. For example, there are now over 6,000 hospitals in America with the capacity of over one million hospital beds. In 1998 alone, these hospitals handled more than 34 million admissions. Outpatient totals were even higher, totaling over 330 million (Snook, 2004, p.9).

These staggering figures explain why the health care industry is the largest employer in the United States, accounting for over 3% of the nation's workforce. In 2005, the US health care industry accounted for nearly 20% of the gross domestic product (Shi & Singh, 2008, p. 230). The impact of the health care industry on the American economy is due in part to societal changes that can be attributed to "a rise in prevalence of chronic disease, increasing access to health information, increased democratization of medical care decision-making, a declining faith that scientific

breakthroughs will have positive effects on personal health, and an increased interest in spiritualism" (Kelner, Wellman, Pescosolido, & Saks, 2000, xiii).

The increased interest in complementary and alternative medicine has been spurred by the desire for new medical technology and methods of treatment. And with this desire comes a need for individuals to work in positions made available by new forms of treatment. This results in a continual process of evaluation and re-evaluation of therapeutic methods and how they are performed. Consequently, "the delivery of health care undergoes constant change in response to social, economic, political, educational and ethical considerations as well as developments in research" (Kilhorn & Gamlin, 2001, p.100). However, in attempting to implement change, not all results have been positive. For example, while efforts have focused primarily on medicine and treatment, the relationship between physician and patient has been overlooked. As a result, medical patients often feel a sense of disconnect with their health care provider. The relationship they are able to form is largely impersonal. As Snyder (2007) notes:

> In addition, patients and physicians often feel rushed and constrained by time pressures in conventional medicine office visits, despite evidence that actual visit time has not changed. This affects patient and clinician satisfaction with care, quality of care, [and] can create ethics, communication, and other concerns in the patient-physician relationship. (p.3)

Therefore, it would appear that as the healthcare industry has become more technologically advanced, it has regressed in providing patients with one of things

they seek most: compassion. Medical patients desire compassionate care that will address not only their physical but also their emotional needs. Thus, because complementary and alternative medicine addresses both physical and psychological needs, it is becoming the choice for treatment that many medical patients are seeking.

While the increased popularity in complementary and alternative medicines may seem like a new phenomenon, the practicing of complementary and alternative medicines has been in existence for centuries in cultures worldwide. Even in its earliest beginnings, they have been at odds with conventional medicine. Vincent & Furman (1997) note how complementary medicine has been perceived when they write that, "The term 'complementary medicine' embraces a wide range of therapeutic practices and diagnostic systems that stand separate from, or in some cases opposed to, conventional, scientifically based modern based Western medicine" (p. 7).

However, in the United States, many proponents of complementary and alternative medicines would argue that their methods are not meant to be a replacement to conventional medicine, but rather, their desire is simply to offer patients other treatment options. Thus, practitioners of these therapies view themselves as simply aiding mainstream medicine by working alongside physicians and medical facilities. In so doing, they are giving medical patients a greater number of choices in their medical care, and in a way democratizing the concept of medical treatment.

So effective have these therapies been that many high profile hospitals are now taking serious notice of complementary and alternative medicines and integrating them into their medical programs. As Sheff (2001) writes:

> George Washington University in Washington, D.C., has a CAM clinic, and UCLA has had an affiliate physician-acupuncture education program for almost a decade. The integrative hospital programs at Columbia-New York Presbyterian utilize mind-body medicine in conjunction with acute surgical care and aftercare follow-up services. Memorial Sloan-Kettering Cancer Center in New York has developed an integrative medical service. Other academic medical centers that offer integrative clinics are the University of Arizona, Dartmouth, Duke, Harvard, the University of Maryland, the University of Minnesota, Stanford and Tufts. (p. 415)

Consequently, as these medical centers begin to incorporate complementary and alternative medicines into treatment programs, the general public becomes more aware of the benefits of this type of treatment. Thus, more people are realizing how much the face of medicine is changing. Many patients, who were previously unaware of the types of options afforded by complementary and alternative medicines, are becoming persuaded to use these types of treatment, although they are nontraditional. This is due in part to research that is showing that CAM can be effective. This conclusion was formed after "a 1994 survey of physicians from a wide array of medical specialties (in Washington State, New Mexico, and Israel) revealed that more than 60% recommended alternative

therapies to their patients at least once in the preceding year" (Astin, 1998, p. 1548). Of those physicians which were surveyed, "47% stated that they themselves had used alternative therapies. Additionally, 23% of those surveyed had also started integrating alternative medicine into their practice" (Astin,1998, p. 1549).

As CAM began to grow in popularity, questions concerning validity, efficacy, and patient safety began to emerge. Not surprisingly, these questions succeeded in garnering the attention of the United States Congress. Members of Congress then delegated this issue to the National Institute of Health (NIH). Jonas (1998) writes that in 1992, in order "to address the need for research in complementary, alternative, and unconventional medical practices, Congress created the Office of Alternative Medicine (OAM) at the NIH" (p. 709). Jonas states that OAM "works with NIH institutes and centers to identify and support CAM research applications and develops new programs in selected CAM-related areas. It supports 11 centers, conducting over 50 projects on CAM research at universities around the country" (p. 709).

The desire for more education in complementary and alternative medicines has been met with more medical schools offering courses centering on CAM. A recent report by the Institute of Medicine U.S. Committee on the Use of Complementary and Alternative Medicine, & American Public Board on Health Disease and Prevention (2005), stated:

> In 1995 the Alternative Medicine Interest Group of the Society of Teachers of Family Medicine surveyed U.S. medical school departments of family

> medicine and all family medicine residency programs to determine the extent to which CAM was being taught in medical schools. The results showed that in 1995 CAM was taught in 34 percent of U.S. medical schools and 28 percent of family practice residency programs. (p.226)

A survey taken three years later, in 1998, showed even more education about complementary and alternative medicines being offered. This survey showed that "over 40 medical schools in the United States offer introductory elective courses in CAM and almost one third of family practice residencies provide some type of instruction about CAM practices" (Jonas, 1998, p. 709).

There are difficulties, however, regarding offering courses in complementary medicine. One problem is that it is often difficult to find placement for these courses in an existing curriculum. Many degree programs simply do not have room in their curriculum to accommodate these additional classes. The matter of instruction is also of concern. Finding individuals qualified to teach classes in complementary medicine, which of course includes the arts therapies, is challenging (Institute of Medicine, 2005, p. 230).

But advocates of arts therapies continue to forge ahead, making their voices known. And it appears as if the public is supporting the fields of complementary and alternative medicines in a sizeable way. An example is the National Center for Complementary and Alternative Medicine. In 1998, the National Center for Complementary and Alternative Medicine (NCCAM) had a yearly operating budget of $40.5 million. In 2007, [NCCAM] showed a substantial increase in operating

costs, when it proposed a fiscal budget totaling $119.1 million (Cohen & Markman, 2008, p.5).

The advancement of complementary and alternative medicine was also supported by former President Bill Clinton, who, in March 2000, formed the White House Commission on Complementary and Alternative Medicine Policy. This Commission was given the task of studying and reporting on public policy issues concerning complementary and alternative medicine (Institute of Medicine, 2005, p.21).

The push for humanities in medicine as well as the promotion of complementary and alternative medicine, are a daunting task, as both fields encompass many subgroups. For example, several methods are included in the field of arts therapies alone. At a glance, it appears that the field of arts therapies is very different from other forms of complementary and alternative methods that are available. However, the connection of arts therapies with complementary and alternative medicines is much closer than it may seem.

Complementary Medicine and the Arts

During the 1960s and 1970s artists and art educators sought employment through what might be considered an unlikely employer. Believing that patients needed a creative outlet for self-expression, these artists sought jobs in hospitals and clinics, where they could teach patients drawing and painting (Edwards, 2004, p. 37).

However, the concept of implementing art in a hospital setting was not new.

For years, arts therapies have been used in medicine, but primarily in the field of psychiatry. Today, as the usage of complementary and alternative medicines becomes more prevalent, arts therapies are being implemented in other areas of medicine. As Wadeson, Durkin, and Perach (1989) note, "From [their] early roots in the traditional psychiatric settings of hospitals, clinics, and schools for the emotionally disturbed, [they have] branched out into rehabilitation, custodial, medical, educational, and other human services" (p.1).

One reason for the increased growth in the usage of arts therapies is that in today's society medical patients desire to be proactive in their treatment. McNiff (2004) states, "People today who suffer from illnesses want to be involved in their recovery, to contribute to the healing process, not just passively receive treatments administered by others" (p. 4). Medical patients believe that they can aid in their own recovery. McNiff addresses this perspective on therapy by writing, "When psychologically sound people experience life crises and medical traumas, they understand that recovery will be enhanced by their active and creative involvement" (p. 4).

The ability to be involved in one's treatment, rather than being an observer, is what makes the arts therapies unique. And it is this attribute of arts therapy that has filled a void that was lacking in traditional medicine. By engaging in arts therapy, patients feel that they are aiding in their healing by contributing what physical, mental, and emotional abilities they have available, and in doing so feel that their efforts are making a difference. In addition, not only do these therapies

require patient participation, they are also multi-faceted. They provide an active form of therapy that relies heavily on the importance of self expression – a feature to which Chisolm (2007) alluded when he stated that the arts therapies "provide a dynamic, action-oriented treatment utilizing symbolic expression and metaphor that embrace a wealth of meaning" (p.398). This method of artistic expression is what Cattanach (1999) defines as "action therapies in that they are not talking therapies, as such: instead, clients explore issues and experiences through the medium of an art form" (p. 7). This is not to say that verbal communication is discouraged. But the language that is used to communicate in standard conversation is expressed differently in arts therapies. As Knill, Levine, and Levine (2005) state, "there is a verbal conversation weaving through an entire session, though the extent to which it is the medium and substance of the relationship is always changing" (p. 96).

Even in cases where there is little chance of being cured, the hope for healing still exists. This is due in part to the fact that the ability to be healed of one's disease means that life, as experienced before diagnosis, has returned. Therefore, a feeling of normalcy is restored. As Tillman (2000) writes, "Healing is associated with a dynamic process of wellness, which is wider than the curing of individual illnesses. It encompasses the realization of the full potential of the self within the context of the prevailing value system" (p. 16).

It is through pursuing the arts in a quest for healing that medical patients engage in a cathartic experience when they search for a cure for their disease and

struggle to cope with their diagnosis. As Feder and Feder (1981) state, "The term *kathartic* is generally attributed to Aristotle, who said that 'art releases unconscious tensions and purges the soul.' The cathartic function, common to all the expressive therapies, is based on the finding that the expression of a problem or a concern provides relief" (p.68).

The ability to express oneself in an unrestricted and nonjudgmental environment also aids in the healing process. As Rogers (1993) explains, "It is an entirely different experience, for most people, to be offered an opportunity to explore and experiment with a wide variety of materials in a supportive, nonjudgmental space. Such a setting gives permission to be authentic, to delve deep, to be childlike" (p.18).

Unlike other artistic pursuits in which one can engage, such as serving as a member of an orchestra, or travelling in a dance troupe, arts therapies have no pre-requisites. No experience or prior training in the field of therapy in which the patients are interested is needed in order to participate. This opens up additional opportunities for patients to be creative and pursue their creativity even though they may never have participated in the arts before. Both the process of creating and the final product is correct, because the patient is expressing his or her personal feelings and emotions to outwardly illustrate his or her inner feelings. As Karkou and Sanderson (2006) state, "Within the arts therapies context, the wide definitions with which the arts have been used, [arts therapies]have allowed for a range of actions to be considered as 'artistic', while artistic/aesthetic value

judgments are removed and consequently pressure to create something 'good' [is] withdrawn" (p. 51).

This is important because it changes the artistic process completely. It also changes the definition of what can be perceived as "art." Karkou and Sanderson (2006) write, "With such an understanding of the meaning of the word 'arts', the level of skill becomes irrelevant – all can make music, draw, act or dance while the engagement in the artistic process is encouraged" (p. 51).

Medical patients also find that as they learn to live with their illness, their physical and psychological needs change. Arts therapies offer this type of flexibility. "At one point a visual medium may be the most conducive to an individual's need to express him or herself, whereas at another time, for the same individual, singing may be the essential outlet" (Warren, 2008, p.7).

Although arts therapies provide ample opportunities for freedom of self expression, that is not to say that boundaries do not exist within this field. Not every artistic endeavor is considered therapeutic and beneficial to the patient. Arts therapies do possess specific definitions and exist within certain structured parameters.

Arts Therapies Defined

As the field of arts therapies becomes more prevalent in American healthcare, there are various phrases and terms that have been used to define and describe them. There are individual creative arts therapies, such as drama therapy, music therapy, and dance/movement therapy. Each of these therapies is considered

to be a sub-group of arts therapy. However, therapies that comprise sub-groups are not limited to classification in one sub-group alone. For example, dance/movement therapy carries the label of a "creative arts" therapy and a "mind/body" therapy, yet it is also considered a branch of complementary and alternative therapy.

The challenge that exists regarding classifying and defining arts therapy, is due in part to the fact that "arts therapies definitions vary from those that regard the field as a type of applied arts with selected concepts borrowed from psychotherapy, to those that see it as a type of psychotherapy with the addition of the arts" (Karkou & Sanderson, 2006, p. 44).

As these therapies evolve, they are also expanding, encompassing varying areas of treatments and therapies. Therefore, it is often difficult to determine the proper term that should be used, and in what capacity. Phrases such as "creative arts therapies," "arts medicine," "healing art," and "expressive arts" are all phrases that have been used to describe the use of the arts in healthcare. "Some characterize expressive arts therapy as the inclusion of any of the arts therapies- art, music, dance/movement, drama, and poetry/writing. Thus, using one or more of these therapies in work with individuals or groups is defined as expressive arts therapy" (Malchiodi, 2003, p.107).

Other arts therapists, such as Atkins, provide a similar definition of expressive arts therapy. Atkins (2003) writes:

> Expressive arts therapy – also referred to as intermodal expressive therapy, or interdisciplinary arts therapy – is the practice of using imagery,

> storytelling, dance, music, drama, poetry, movement, dreamwork [sic] and visual arts together, in an integrated way to foster human growth, development, and healing. It is about reclaiming our innate capacity as human beings for creative expression of our individual and collective human experience in artistic form. Expressive arts therapy is also about experiencing natural capacity of creative expression and creative community for healing. (p. 4)

Another definition of expressive arts is given by Rogers (1993) who elaborates on the emotional aspects of this type of therapy:

> *Expressive art* refers to using the emotional, intuitive aspects of ourselves in various media. To use the arts expressively means going into our inner realms to discover feelings and to express them through visual art, movement, sound, writing, or dreams. Talking about our feelings is also an important way to express and discover ourselves meaningfully. (p. 2)

Goodill highlights another branch of the arts in healthcare, known as "arts medicine." Its definition closely parallels that of expressive arts therapy. Goodill (2005) notes:

> Another related emerging field is arts medicine. It has a close relationship in the arts therapies and to other practices in the mind/body intervention arena. Arts medicine is concerned with the various interrelationships between the arts and health care. These include the artistic lives of health care providers, the history of medicine through the study of arts, the esthetics of health care

> environments, works of art by people living with disease and arts-based services to patients and works of art by people living with disease and arts-based services to patients and their families, largely the creative arts therapies. (p. 29)

McNiff (2009) adds to these definitions in comparing and contrasting creative arts and expressive arts therapies when he writes:

> The term creative arts therapy has been used to designate the grouping of all of the individual arts therapy specializations and their professional associations. Expressive arts therapy describes a distinct discipline of integrated and multimodal arts practice which is a part of the larger creative arts therapies. (p.4)

Both creative arts therapy and expressive arts therapies can trace their American beginnings to Margaret Naumburg, a psychologist who would later become a psychoanalyst. She is also considered responsible for art therapy becoming a profession. Naumburg was also an advocate for art education, particularly in the 1950s & 1960s (Waller, 1991, p.5). However, it would be remiss not to acknowledge the work of Edith Kramer, who some consider to have pioneered art therapy in the States. Such a perspective is noted by Waller (1991): "Edith Kramer was a contemporary of Naumburg's and an art teacher by background. She is considered to be the founder of art therapy, or at least as essential to its development as Naumburg" (p. 5).

Today, due to the pioneering efforts of these women and others, arts

therapies have developed to the point that professional organizations represent these therapies and those working in the field. “The American Art Therapy Association (AATA) is the national association of art therapists in the United States; it also has members in more than thirty other countries around the world” (Malchiodi, 2007, p. 249). Other organizations focus on specific creative arts therapies, such as: The National Association for Poetry, American Music Therapy Association, American Dance Therapy Association, and the National Association for Drama Therapy.

Because these organizations exist to increase awareness of the creative arts therapy they represent, as well as serving as a resource for therapists working in each genre, it has allowed those working in the individual arts therapies to develop a cohesive voice, as well as create a more professional image. Consequently, as the arts therapies become more established and receive more exposure, the role of the arts therapist becomes more defined.

The Role of the Therapist

Hospitals that implement arts therapies may use hospital staff, local artists and/or educators to provide their patients exposure to the arts. Other hospitals employ registered arts therapists to provide arts therapy and oversee humanities programs within the hospital. As the arts therapies branch out into medical care, the therapist may find that he/she is a professional pioneer in the institution where he/she is employed. This can prove challenging, requiring the therapist to have the ability to be flexible in technique and method. As Wadeson (1987) writes: “Few

treatment teams employ more than one art therapist, and it is not uncommon for the art therapist to find herself the facility's sole art therapy practitioner" (p. 14).

However, though the therapist may face challenging situations, this is not to say that this type of profession is not rewarding. Arts therapists have the opportunity to see the benefits of their career choice when working with their clients and consequently viewing firsthand the progress patients make during therapy. From a personal standpoint the therapist also experiences inner growth as he/she engages in the process of creating art. Thus, the practitioner and the client work together and engage in a journey of self fulfillment. As Scott (2000) states, "An important relationship between art and nursing or medicine is therefore one that enables the moral imagination of the practitioner to be stimulated and developed in such a manner that sensitive, compassionate, constructive care is the likely result" (p.5).

Therefore, it is beneficial to the hospital and its patients to employ a skilled therapist. It is by doing so that patients receive optimal care. More effort toward professionalization has been put forth to ensure that those working in arts therapies have professional experience in the field. This endeavor has proven to be a challenging and ongoing process. As Carroll & Snyder (2007) state, "Hospital and health care are struggling to develop guidelines for credentialing CAM practitioners" (p. 8).

As the arts therapies evolve, those working in the field are being required to meet certain qualifications. One organization that has, and continues to strive for

greater professionalization, is the American Art Therapy Association (AATA). Edwards (2004) writes that, "In 1993, the American Art Therapy Association officially determined that entry to the profession should be at Masters degree level" (p. 124).

It is through the efforts of an experienced arts therapist, that a patient can be guided through a proper treatment plan. As Malchiodi (2003) states:

> Although there are various theories and orientation in expressive arts therapy and intermodal work, all theorists who agree to employ them in treatment must possess a practical knowledge of how each of the art forms functions, how people respond to each art form, and how to guide the client from one art form to another. (p. 208)

Warren (2008) concurs with Malchiodi's views when he states that the arts therapist must remember three factors. "They should know themselves, their creative medium, and the members of their group both as individuals and as members of their group" (p. 6).

The ability to implement diversity in method is also important. Estrella (2005) gives insight to how this is accomplished when she writes, "Expressive therapists use a multimodal approach-at times working with the arts in sequence at other times using the arts simultaneously, and at still other times carefully transitioning from one art form to another within the therapeutic encounter" (p. 183).

Incorporating these skills can prove to be demanding both physically and

psychologically for the arts therapist. From a psychological standpoint, the role of an arts therapist differs from other professions in that the therapist is required to form both a personal and professional relationship with each client in order for the treatment to be successful. It is this personal relationship that is essential to effective art therapy. As Wadeson (1987) explains, "Some therapists have been known to view their clients as through a microscope, putting themselves in the role of observer without recognition of their own strong influence on the therapeutic process" (p. 9). Flint (2004) also notes the importance of developing a more personal relationship with the client. He describes the uniqueness of this relationship, highlighting two forms of arts therapy as an example. He states, "In an art or poetry therapy session the relationship between the therapist and the patient is loaded with both their experiences of life – memories, knowledge, emotions, sensations – and their inner lives where the consciousness of imagination is interleaved with the unconscious, with its whorls of dreams and archetypes, primal drives and collective memory" (p. 146).

It is this type of relationship that can prove effective in the patient's healing. "Using expressive arts becomes a healing *process* [emphasis in the original] as well as a new language that speaks to both client and therapist" (Rogers, 1993, p. 3). From the beginning however, both therapist and client realize that the relationship that is being formed will be short term. Edwards (2004) notes, "From the very beginning of therapy both the client and the arts therapist are inexorably moving towards ending and parting. It is towards the making of a satisfactory ending in

order to make a new beginning that the process of therapy is directed" (p. 90).

In arts therapy, other relationships exist somewhat apart from the patient-therapist relationship, yet each relationship is somewhat dependent on the others. Moon (2008) explains: "In the art therapy milieu, many relationships co-exist: client to therapist, materials, tools, images, and artworks, and therapist to client materials, tools, images, and artworks" (p.116).

The relationship that is formed between the therapist and materials is one that it is influenced by the therapist's views concerning the creative process. Arts therapists are of the opinion that we have the ability to make art before we learn how to communicate verbally. Our experiences with art are stored as preverbal recollections that we remember throughout our adulthood (Karkou & Sanderson, 2006, p. 51).

In order to encourage the client to expound on these experiences and express himself/herself both visually and audibly, a combination of art forms are implemented. As Buchalter (2004) explains:

> Poetry and music, for example, in combination with fine art enhance sensory stimulation and the expression of feelings and ideas. Dance/movement combined with drawing and/or painting provides a rich forum for clients to share issues and concerns. They may move their bodies in a certain way and then draw that movement. In this way clients can explore symbolism represented through both their movements and their drawings. They may look for similarities and/or discrepancies in the way they represent

themselves using these creative approaches. (p.110)

Though the role of the arts therapist is essential to facilitate therapy, she cannot succeed without the participation of the patient. “In a therapy relationship, the artist/patient brings her own meaning to the image from her own ‘culture’ to the ‘culture’ of the therapy room where it is viewed with the subsequent impact and resonance in both patient and therapist” (Case & Dalley, 1992, p.50).

Throughout the sessions, it is important for the patient to feel as though he/she can engage in self expression freely without the pressure to master the art form in which she engages. Rogers also emphasizes the need to focus on the artistic process rather than the final product. Rogers (1993) states that, “We use the arts to let go, to express, and to release. Also, we can gain insight by studying the symbolic and metaphoric messages. Our art speaks back to us if we take the time to let in those messages” (p. 2).

Every work that is produced by a patient has some form of meaning, since it reflects the patient’s innermost thoughts and feelings. “Even when a person has produced simple stick figures or nondescript smears, these should be received with as much interest and respect as a fully elaborated drawing or painting” (Rubin, 2005, p.75).

With so many arts therapies available to medical patients, it is important for patients to have an understanding of what arts therapies are offered. Thus, a skilled therapist can direct the patient in the most appropriate form of therapy. Certain therapies are more popular than others. This is due in part to availability,

patient preference, and the hospital's financial abilities.

The Most Popular Forms of Arts Therapies

The following is a description of some of the most popular forms of arts therapies. These arts therapies include: dance/movement therapy, music therapy, poetry therapy, drama therapy, and (visual) art therapy. Each therapy differs in the types of materials and methods used, but the goal of each therapy is the same: to provide an open environment for healing through self expression.

Dance/Movement Therapy

Dance/Movement therapy (DMT) is one of the most popular forms of expressive arts therapies. It originated in the 1940s primarily through the work of Marian Chace, a dance therapist. Chace "brought elements of her earlier dance career into working with psychiatric patients from the 1940's [sic] through the 1960's [sic]" (Bradshaw & Lowenstein, 2011, p. 90). This type of therapy allows for a patient's physical movements to become strengthened in an environment that is welcoming. Any patient can participate, regardless of whether or not she has had prior dance experience.

Dance/Movement Therapy is also one of the most physical of the arts therapies, incorporating elements of dance while also addressing the patient's mental and emotional needs. As Loman (2005) writes, "In dance/movement therapy the therapist works toward expanding the individual's movement repertoire to further develop coping skills and strengths" (p.76).

Although the patient may not realize it, in dance/movement therapy, each

patient's "expressive initiations become the content of the session, and unfold in an interactive and improvisational manner. Usually, the dance/movement therapist follows the patient into whatever themes or issues emerge as most salient" (Goodill, 2005, p. 36).

While the patient learns to enjoy this type of therapeutic process, the therapist is proactive as well. He/she does not simply observe. This allows for a strengthening of the patient/client relationship. "The main method in initiating trusting and meaningful contact with patients is mirroring, or joining them in movement" (Loman, 2005, p.72).

As the therapist works with each client, an individual treatment program is developed. "The ability to analyze and interpret nonverbal behavior and assess the individual's body attitude and psychophysical characteristics is essential in dance/movement therapy" (Loman, 2005, p. 74).

As with other arts therapies, dance/movement therapy "does not set as a goal to elaborate a work of art as product nor to expose it in public; neither does it demand any formal or technical capacity for the person to be able to benefit from this type of therapy" (Chaiklin, & Wengrower, 2009, p.15).

Thus, the final result of successful dance/movement therapy reflects its foundation. As Loman (2005) writes, "The field of dance/movement therapy is based on the belief that healthy functioning depends on the integration of the mind, the body, and the spirit. When there is a lack of such integration, an individual, group, or family may suffer from a variety of psychophysical disorders" (p.70).

Dance/Movement Therapy also allows patients to work in groups. As Chaiklin and Wengrower (2009) write, "There is shared energy and strength when being with others. It enables us to go beyond our personal limitations or concerns. Within the joy of moving together, we also appreciate validation of our own worth and recognition of our personal struggles" (p.5).

Dance/Movement Therapy offers an advantage over other "treatment modalities like therapeutic touch or massage therapy. Like many other CAM, mind/body and psychotherapeutic approaches with medically ill patients, DMT [Dance/Movement Therapy] and the other creative arts therapies employ imagery" (Goodill, 2005, p. 31). This is important as "imagery is the foundation of mind-body medicine and is the essential and activating element in the clinical use of relaxation therapy, meditation, biofeedback, and hypnosis" (Freeman, 2004, p.575).

Music Therapy

Forinash (2005) defines music therapy in a medical setting as a form of therapy that "focuses on helping clients to improve, restore, or maintain physical well-being and on the emotional issues that accompany medical treatment" (p.53).

When observing arts therapies that are being used in hospitals, it would appear that music therapy is the most popular. As Warren (2008) writes, "Of all the art forms used in hospitals, music seems to have the broadest reach. Music can be used with all ages of individuals under almost any circumstances" (p. 191).

Music therapy was first implemented in American hospitals after World War II. Musicians, who were performing in veterans hospitals, "found that patients

suffering both physically and emotionally were often responsive to music while unresponsive to other forms of engagement. The first training program for music therapy began in the United States in 1944" (Forinash, 2005, p. 46). Six years later, the American Music Therapy Association was formed. "As of 2004 there are approximately 4,000 music therapists in the United States" (Forinash, 2005, p. 46).

Today, patients are still using this type of therapy. One reason for its enduring appeal was observed by Miell, McDonald, & Hargreaves (2005) when they wrote, "Music seems to have the capacity to communicate, hinting, alluding, connoting, and referring not only beyond itself but to itself" (p. 34). Bunt (1994) adds to this theory when he states, "Music is the human institution in which individuals create meaning and beauty through sound, using the arts of composition, improvisation, performance and listening" (p.1).

The beauty and meaning one gleans when listening to music is personal. This personal interpretation varies for each individual listener. Bruscia (1998) writes, "Meaning and beauty are derived from the intrinsic relationships created between the sounds themselves and from the extrinsic relationships created between the sounds and other forms of human experience" (p. 1). In reference to the appeal that music has to the medical patient, Bruscia (1998) states, "Music engages all of the senses. Though we typically think of music as an 'auditory' art form, it also provides visual, tactile and kinesthetic stimulation, and it affords us opportunities to respond through these sensory channels" (p. 102). The type of personal response is elaborated on by Boyce-Tillman & Robertson (2000) when they wrote, "Music is

both a private and public medium, where each listener decodes the meaning in his or her own way and is unlikely to come up with specific details of events and happenings" (p. 44).

When used clinically, the first priority in selecting music should be that it is relevant and useful. The client should also find the selection(s) appealing, yet traditional artistic values should also be taken into consideration. Through all of these factors working together, the client's musical potential can be achieved. (Bruscia,1998, p.96)

As with other therapists working in arts therapies, music therapists work with the patient to create a personal program that meets the client's needs. Therefore, "music therapists frequently find that their approach and treatment objectives are directed towards improving the general health of the patient, working with specific pathological problems and disorders" (Wigram, Nygaard, & Bonde, 2002, 33).

Music therapy is similar to the other arts therapies in that it is the process of creating, not the final product, that is the focus of the sessions. This is not to say that the patient is not capable of producing a fine work. "Often the music for therapy is of exceptional artistic quality and aesthetic merit, not only when judged according to conventional standards of professional musicians and critics, but also based on the broader criteria of artistry embraced in music therapy" (Bruscia, 1998, p. 97).

Poetry Therapy

According to Chisolm (2007), "Poetry therapy began in the United States when Pennsylvania Hospital instituted creative writing as a treatment modality over 200 years ago" (p.404). However, it was not until the 1970s through the work of Dr. Jack Leedy that the Association for Poetry Therapy was founded. Shortly thereafter, the term "bibliotherapy" began to be used to describe the benefits of using poetry and prose, as well as nonfiction, in a therapeutic treatment (Wengell, Gabriel, & Perlman, 2008, p. 225).

There are many reasons why poetry therapy and/or bibliotherapy has continued to be appealing to patients. Like the other arts therapies, poetry therapy offers the freedom of personal expression and creativity that results in a feeling of empowerment for the patient. "All persons are potentially capable of responding to the creativity of others with their own creativity. All can be moved and soothed by beauty. All have the capacity to be creators in their own lives, to assume more authority" (Gorelick, 2005, p.126). Mazza (2003) states, "Poetry writing can also be a very helpful therapeutic tool in providing a vehicle for individuals to express themselves and gain control over fragmented thoughts or feelings" (p.26).

Gorelick (2005) defines poetry therapy as the "intentional application of the written and the spoken word to growth and healing" (p.117). This is a process that enhances the therapy itself but can prove to be challenging and stimulating for the client and therapist. The poetry therapist must make an effort to "contextualize the client and his or her problem: Where in the life cycle is the client? How did he or she get here? What is the next step?" (Gorelick, 2005, p. 117). Therefore, the

therapist begins the process of assessing the most beneficial forms of therapy for the patient by using various tools such as having the patient keep a diary or journal. (Mazza, 2003, p. 20).

Poetry therapy can also serve as a means of personal organization. "By beginning to write down personal feelings, the individual begins to identify those feelings in a more coherent fashion, thereby promoting a sense of control" (Mazza, 2003, p. 26).

Part of the appeal of poetry therapy in healthcare settings is that it "reflects the classic issues in literary analysis and psychological practice: the romantic aspects of empathy and subjectivity vs. reason and observation" (Mazza, 2003. p. 4).

Drama Therapy

Like other arts therapies, drama therapy can trace its roots to psychology, and has been practiced for several decades. Jones (1996) states:

> The emergence of Dramatherapy [sic] as a specific discipline and as a profession has taken place since the 1930's. [sic] The nature of Dramatherapy's [sic] emergence can be said to be parallel in countries such as the United States, the Netherlands and Great Britain: the main countries which mark its origin as a distinct field and profession. (p. 71)

Although England and the United States practice this form of therapy, there are differences that exist. One difference is in spelling. In England in the 1950s, Peter Slade began referring to this form of therapy as "dramatherapy", combining both words together (Landy, 2005). In the United States, the term is written as two

words: drama therapy.

One reason why drama therapy is attractive to medical patients is that drama therapy allows the patient to view themselves in the third person; to disassociate from their present physical state. Thus, patients have the opportunity to temporarily step back from the stressors of their disease and view their circumstances more objectively. Landy (2005) elaborates on this concept when he states, "In many ways the genesis of drama mimics the genesis of consciousness in that through both developing human beings are able to stand outside themselves and view themselves as a separate entity" (p. 90).

Therefore, as patients are allowed to act out their feelings, they are also able to control their disease through dramatic interpretation, and the patients feel empowered. At any time during treatment, a patient may change her performance or method, tailoring her therapy to the current condition or situation. Jones (1996) elaborates on this aspect of drama therapy when he writes that drama therapy "facilitates change through drama processes. It uses the potential of drama to reflect and transform life experiences to enable clients to express and work through problems they are encountering or to maintain a client's well-being and health" (p. 6).

Though drama therapy allows for creativity, it is also structured. Regardless of whether the patient is performing alone, or in a group setting, certain standards must be set in order for the therapy to prove effective. Cattanach (1999) states:

Theatre is both creative and structured; the actor is given permission to show

> anger, sadness, joy and love through roles and characters and above all to play with others in a social group motivated by the same sense of purpose, within the structure of the text and the theatre process of audition, rehearsal, performance and ending. (p. 36)

Pitruzella (2004) elaborates on what should be the goals of drama therapy: "Dramatherapy's [sic] objectives are clearly defined: first of all the improvement of people's self identity, with the expansion, both in a quantitative and qualitative sense of the repertoire of available roles along with the growth of imagination, interpersonal abilities and communication" (p.116).

As with the other arts therapies, effectiveness comes when the patient perceives this form of therapy as fun and welcoming. That is not to say that drama therapy should not be challenging. There should be opportunity to experience challenge and tension, but the patient should feel freedom to do so in a safe and positive therapeutic environment. Art therapy is considered next.

Art Therapy

Malchiodi (2003) defines medical art therapy "as the clinical application of art expression and imagery with individuals who are physically ill, experiencing bodily trauma, or undergoing invasive or aggressive medical procedures such as surgery or chemotherapy, and is considered a form of complementary or integrative medicine" (p. 352).

The integration of art therapy in hospitals is currently being achieved through a variety of venues. Art galleries, art exhibits, and patient art classes are

just a few of the ways patients are given exposure to the visual arts. Integration of the visual arts in medicine supports the theory that a visual image can have a profound effect on the human mind. As Leavy (2009) states, "Visual images are unique and can evoke particular kinds of emotional and visceral responses from their perceivers; they are typically filed in the subconscious without the same conscious interpretive process people engage in when confronted with at written text" (pp. 215-216). Such images are invaluable when assessing a medical patient's thoughts and feeling in art therapy. Malchiodi (2003) writes of the importance of the image, whether mental or drawn, when she states that, "through art making clients are invited to reframe how they feel, respond to an event or experience, and work on emotional and behavioral change" (p. 19).

As with other forms of arts therapy, the patient is not required to follow specific artistic methods to create what could be deemed an acceptable work of art. Even the most simplistic art engagements are acceptable in this type of therapeutic process. "The details of what is created are not important, only the bodily expression of movement through the art form" (Malchiodi, 2003, p.109).

Art therapy is based on knowledge of human developmental and psychological theories. Chisolm (2007) states:

> It encompasses the full spectrum of current models of assessment and treatment, including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems,

reducing anxiety, aiding reality orientation, and increasing self-esteem (p. 399).

Although its origins are based in psychology, art therapy is also physical in nature. Malchiodi (2003) writes, "Art therapy is an active form of therapy. Clients are engaged in physical manipulation of materials and in thinking about their problems in new ways. Representing a conflict or feeling in a pencil drawing, collage, or clay sculpture allows clients literally to see their problems from all sides" (p.73).

The role of the therapist in art therapy is essential to the success of this type of therapy. Feder and Feder (1981) write, "By means of pictorial projection, the art therapist encourages patients to come out of themselves, to communicate with others, to deal with the world outside" (p.70).

Medical patients can also benefit from group sessions that focus on art therapy. "Although many practitioners view art therapy as a way to understand the psychosocial impact of illness on the individual, for those who participate in medical art therapy groups it has additional benefits: personal empowerment, stress reduction, social support, and the opportunity to re-author one's life story" (Malchiodi, 2003, p. 352). The disadvantages of using expressive arts therapy is considered next.

The Disadvantages of Using Expressive Arts Therapy

To state that there are not disadvantages to using expressive arts therapies would be untrue, as there are positive and negative aspects of any type of

therapeutic treatment. However, in regard to arts therapies, certain disadvantages exist that are unique to the field. One disadvantage is that when offering arts treatments in a group setting, clients are able to "hide" from addressing the core of their problems. Also in group settings, it becomes more difficult to maintain confidentiality, as working in a public setting allows others in the group to observe all the work that is being done. This may also hinder the patient's ability to engage in true self expression, as seeing the work of others may cause her to feel self-conscious about her creative abilities. For the therapist and patient, conducting group sessions can result in being able to spend less individual time with each client, which also works as a disadvantage.

The disadvantages of using arts therapies lie not only in the usage of the therapies themselves, but also the fact that they are a branch of complementary and alternative medicines. While complementary and alternative medicines are becoming more prevalent, they still battle the negative stigma of the past. Rather than being perceived as complementary, this branch of medicine has been seen as conflicting and obtrusive, a hindrance to standard forms of treatment and conventional medicine. "Mind-body therapies stand in opposition to the long held, beliefs that underlie Western biomedicine in which the body and mind are examined separately" (Snyder & Lyndquist, 2006, p. 57).

However, differences in ideology regarding treatment are only a small fraction of the problem. Physicians are hesitant to endorse alternative treatments whose efficacy has not been firmly established, as recommending therapies which

have not been thoroughly studied puts both the physician and patient in potential jeopardy. “Although the body of knowledge on some complementary therapies is increasing, few have been studied extensively using the gold standard of Western medicine, the double-blind clinical trial” (Snyder & Lindquist, 2006, p. 12).

Therefore, without solid clinical evidence to support their usage, arts therapies and other forms of complementary and alternative medicines will continue to struggle with credibility. Therefore, the burden lies upon advocates of complementary and alternative medicines to provide evidence of their validity. This can prove challenging. “At present, too little is known about the potential risks and benefits of CAM. Proponents of CAM have to demonstrate beyond a reasonable doubt that these therapies do more good than harm. The only way of achieving this is through rigorous research using the best methodology for the problem under the investigation” (Kelner,Wellman, Pescosolido, & Saks, 2000, p. 172).

However, researching complementary and alternative medicine is much more difficult than it may seem because they are not easily measurable or easy to define. It is difficult to determine effectiveness when they are being measured through feelings. For example, it is hard to measure “centeredness” “energy balance” and “harmony” (Institute of Medicine, 2005, p.110).

Consequently, when the process of choosing therapies for investigation begins, who is to determine which methods should be tested? “Here the challenge for CAM research will be to select for investigation those therapies that have the greatest social or scientific significance” (Institute of Medicine, 2005, p.175).

But there are also other disadvantages facing users of complementary and alternative medicines, besides a lack of cohesive research. Another disadvantage that patients often encounter is that they are not properly guided in choosing the best form of complementary therapy. Thus, they are left to determine which form of therapy is best for them. This can lead to making wrong decisions, which can lead to disappointment if the therapy proves ineffective. Patients rely on their physician to help them make such choices, but often choosing the correct form of therapy for a patient is difficult for the physicians, if they are willing to do so. This is because of the plethora of alternatives available. Even physicians who are aware of alternative therapies find it challenging if not impossible to keep abreast of the many treatment options available.

Patients who choose complementary and alternative medicines also face the obstacle of not knowing whether they are experiencing true healing. As Kelner et al (2000) write, "A more difficult, yet ultimately more relevant, issue is whether CAM is superior to placebo, or to 'sham', or other treatment options such as conventional medical therapies" (p.165). Thus, patients who chose to use complementary and alternative medicines have to acknowledge the possibility of the placebo effect. "Critics using biomedical approaches to health often argue that the placebo effect is often the reason for CAM working and also its weak point. They say that healing in CAM is often the result of the powerful effects of the therapeutic encounter and users' and practitioner's belief that it will work" (Heller, Treweek, Kantz, Stone, and Spurr, 2006, p.232). And there is validity in this argument. Because of the

difficulty in measuring progress, it is hard to determine if patients are truly experiencing healing, or if their healing is simply a matter of perception. Thus, this branch of medicine is often determined to heal only because the patient wants it to even when therapeutic healing does not occur at all. There are times, though, when the placebo effect can work to the patient's advantage. "In many CAM modalities (and in some conventional modalities as well), however, the placebo effect is an inherent part of the mechanism of treatment efficacy. That is, the benefit obtained by the patient is at least partially due to his or her own sense of hope, positive expectation, and activation of self-healing processes" (Institute of Medicine, 2005, p.110).

But perhaps the biggest disadvantage that medical patients face, and a main determinant in whether or not complementary and alternative medicines are chosen for treatment, is the cost of using this type of medicine. The price for using choosing these types of therapies is often high, with the majority of patients paying for these treatments out of pocket. Insurance companies are reluctant to pay for this form of medicine. As Cohen (2000) writes:

> The law provides no standard definition of the term '*complementary and alternative medicine'*. No court or legislature has defined the practice of complementary and alternative medicine or set its legal parameters and boundaries generally. Rather, individual groups of providers are subject to different licensing laws, and providers and practices fall within several interlocking areas of law. (p.10)

Because complementary and alternative medicines lack legal definition, this creates more opportunities for legal liabilities on the part of the physician, medical facility, and the employer offering CAM benefits. "Health plans considering offering a CAM benefit are in a bit of a Catch-22 situation. Reliable data to use in pricing such benefits will not be available until the benefits are insured, but the lack of useful data discourages health plans from offering such coverage" (Snook, 2001, p. 148).

Those who support complementary and alternative medicines propose that using these forms of medicines can possibly prevent more serious medical conditions from occurring; while other supporters who argue for the inclusion of CAM into insurance coverage highlight the benefits of CAM for employers. They state that, "In highly competitive job markets, employers may be more attractive to job seekers if they offer health plans that include CAM as part of the benefits package" (Kittner & Faass, 2001, p. 348).

However, even though arts therapies and other fields of complementary and alternative medicines continue to gain acceptance with the general public, it may be a long time before those wishing to use arts therapies can afford this type of treatment.

Conclusion

The field of arts therapies is one that has faced, and currently faces, many obstacles and misconceptions since its introduction to medicine. It is hopeful that these challenges will soon be a part of arts therapies' history rather than its future.

Warren (2008) writes,

> Over the last ten to fifteen years, an understanding of the benefits gained from the use of the arts in healing and for health has been growing. This has occurred as more and more specialists work in this area, as more administrators are willing to experiment using the arts in their institutions and as methodological research is interwoven with anecdotal reports of the effects of this work. (p. 3)

As their integration into American mainstream medicine continues, arts therapies are thriving because they are acknowledging the patient's wishes and allowing them to be heard. "An emerging appreciation for the *subjective* [emphasis in the original] voice-that is, the voice of the patient, the family member, or someone other than the health care professional's detached orientation – has become important" (Paola, Walker, & Nixon, 2009, p.391).

Medical patients also desire to be able to heal without fear of rejection or exposure. As Boyce-Tillman & Robertson (2000) state, "The model of treating illness in Western society is to remove the sick person from the surrounding society into hospitals or institutions where healing can take place away from the main society" (p. 43). Arts therapies allow the patient a healing environment that is secluded and set apart, yet open to the patient's feelings and emotions.

However, when seeking this type of therapy, patients still highly value, and trust, their physician's opinion. They also desire their physician to approve of their alternative choices. How the physician determines which therapy a patient should

choose is based on the physician's perceptions. Because patients assume their physician will make a recommendation that is best suited to their individual needs, it is important that they can trust their physician to make a knowledgeable, objective opinion. "Given that CAM is widely used by the U.S. population, health care professionals need to be informed about CAM and knowledgeable enough to discuss the CAM therapies that the patient is using or thinking of using to more effectively communicate with their patients" (Institute of Medicine, 2005, p. 228).

However, Udani (1998) states, "Even while keeping an open mind toward these therapies, physicians must demand that alternative therapies meet the same rigorous scientific standards as western medicine. Physicians should review the literature on alternative therapies, which is scarce but growing" (p. 1620). Additionally, the number of therapies that are offered is rather daunting. This can prove challenging for the physician who is researching a therapy, about which little information is available. Nonetheless, "physicians need to know both the CAM practices that have the potential to harm or be ineffective and knowledge of which CAM practices that, when critically and intelligently integrated into health care, could be of benefit to patients" (Institute of Medicine, 2005, p. 228).

As the field of arts therapies continues to expand, advocates are learning that there is a downside to its success. This involves many factors other than art therapy. As Stone (2000) writes:

> CAM is political because health and health care is political. The ethics of CAM cannot be divorced from the politics of CAM. Practitioners might want

> to reflect on whether the factors which have permitted CAM to flourish in recent years indicate a radical redefinition of health or a passing trend. Ironically, CAM might now be considered a victim of its own success. By virtue of its size it can no longer be considered as "fringe" or "marginal". CAM is now big business, providing many patients with a viable alternative to conventional medicine. (p.26)

How much the field of arts therapies grows remains to be seen. Arts therapies, as well as other forms of complementary and alternative medicines, are "customarily tailored to the individual patient rather than standardized for a specific condition" (Kelner, et. al, 2000, p. 10). This factor may prove problematic when adapting these therapies to the general public.

However, in generations to come, arts therapies may very well be able to overcome such hurdles and have more of an impact in medicine. This is already being achieved, by beginning at the basic level – medical education. Gordon (2008) states**:**

> In the United States, the Accreditation Council for Graduate Medical Education has identified compassionate patient care and professionalism among six required competencies for residents, which training programs must assess. It has been suggested that the humanities, and specifically bioethics, could contribute to resident education. However, it has been argued that time and effort would be better spent in humanising the US health care system itself" (p. 420).

So what does the future hold for arts therapies in American medicine? While steps have been taken, mainstream integration appears to be a goal that will be years in the making. Perhaps it is time for those practicing medicine, and others in the medical field, to realize that the nature of medicine should be one that exists solely for the meeting best interests of the patient. Then, a true form of "healing" can occur.

References

Astin, J. (1998). Why patients use alternative medicine. . *The Journal of the American Medical Association*, *279* (19), 1548-1553.

Atkins, S.S. (2003). *Expressive arts therapy: creative process in art and life*. Boone: Appalachian State Arts Collective/Appalachian State University.

Boyce-Tillman, J., & Robertson, P. (2000). *Constructing musical healing: The wounds that heal.* Philadelphia: Jessica Kingsley Publishers.

Bradshaw, M., & Lowenstein, A. (2010). *Innovative teaching strategies in nursing and related health professions, fifth edition*. Sudbury: Jones and Bartlett Publishers .

Bruscia, K. (1998). *Defining music therapy*. Gilsum: Barcelona Publishers.

Buchalter, S.I. (2004). *A practical art therapy*. Philadelphia: Jessica Kingsley Publishers.

Bunt, L. (1994). *Music therapy: An art beyond words*. New York: Routledge.

Carroll, R.J., & Snyder, L. (Eds.). (2007). *Complementary and alternative medicine: Ethics, the patient, and the physician.* Totowa: Humana Press, Inc.

Case, C., & Dalley, T. (1992). *The Handbook of art therapy*. New York: Routledge.

Cattanach, A. (1999). *Process in the arts therapies*. Philadelphia: Jessica Kingsley

Publishers.

Chaiklin, S., & Wengrower, H. (2009). *The art and science of dance/movement therapy: Life is dance*. New York: Routledge.

Chisolm, S. (2007). *The health professions: Trends and opportunities in U.S. health care*. New York: Routledge.

Cohen, M.H. (2000). *Beyond complementary medicine: Legal and ethical perspectives on health care and human evolution*. Ann Arbor: The University of Michigan Press.

Cohen, L., & Markman, M. (2008). *Integrative oncology: Incorporating complementary medicine into conventional cancer care*. Houston: Humana Press.

Edwards, D. (2004). *Art therapy*. London: Sage Publications, Ltd.

Estrella, K. (2005). *Expressive therapy: an integrated arts approach.* In C.A. Malchiodi (Ed.), *Expressive Therapies*. (pp. 183-209). New York: The Guilford Press.

Feder, E., & Feder, B. (1981). *Expressive arts therapies: Arts, music and dance as psychotherapy*. Upper Saddle River: Prentice Hall, Inc.

Flint, R. (2004). *Fragile space: Therapeutic relationship and the word.* In F. Sampson (Ed.), *Creative Writing in Health and Social Care.* Psychoanalytic Psychotherapy with Victim/Perpetrators of Sexual Abuse (pp. 138-153). Philadelphia: Jessica Kingsley Publishers.

Forinash, M. (2005). *Music therapy*. In C.A. Malchiodi (Ed.), *Expressive Therapies*.

(pp.46-67). New York: The Guilford Press.

Freeman, L. (2004). *Mosby's complementary and alternative medicine*. St. Louis: Mosby, Inc.

Goodill, S.W. (2005). *An Introduction to medical dance/movement therapy*: *Health care in motion*. Philadelphia: Jessica Kingsley Publishers.

Gordon, J.J. (2008). Humanising doctors: What can the medical humanities offer? *Medical Journal of Australia*, *189*(8), 420-421.

Gorelick, K. (2005). *Poetry therapy*. In C.A. Malchiodi (Ed.), *Expressive Therapies.* (pp.117-140). NewYork: The Guilford Press.

Heller, T., Treweek, G.L., Kantz, J., Stone, J., & Spurr, S. (2006). *Perspectives on complementary and alternative medicine.* Abingdon: Routledge, Taylor & Francis.

Institute of Medicine U.S. Committee on the Use of Complementary and Alternative Medicine, & American Public Board on Health Disease and Prevention. (2005). *Complementary and alternative medicine in the United States*. Washington, D.C.: National Academies Press.

Jonas, W. (1998). Alternative medicine and the conventional practitioner. *Jounal of the American Medical Association*, *279*, 708-709.

Jones, P. (1996). *Drama as therapy*: *Theatre as living*. New York: Routledge.

Karkou, V., & Sanderson, P. (2006). *Arts therapies: A research-based map of the field*. Edinburgh: Elsevier Publishers.

Kelner, M.J., Wellman, B., Pescosolido, B., & Saks, M. (2000). *Complementary and*

alternative medicine: *Challenge and change*. New York: Routledge.

Kilhorn, S., & Gamlin, R. (2001). *Palliative nursing*: *Bringing comfort and hope*. Harcourt Publishers Ltd.: London.

Kittner, A., & Faass, N. (Eds.). (2001). *Integrating alternative complementary medicine into health systems*. Gaithersburg: Aspen Publishers.

Knill, P., Levine, E., & Levine, S. (2005). *Principles and practice of arts therapies*: *Toward a therapeutic aesthetics*. Philadelphia: Jessica Kingsley Publishers.

Landy, R.J. (2005). *Drama therapy and psychodrama*. In C.A. Malchiodi (Ed.), *Expressive Therapies.* (pp.90-116). NewYork: The Guilford Press.

Leavy, P. (2009). *Method meets art*: *Arts-based research practice*. New York: The Guilford Press.

Loman, S.T. (2005). *Dance/movement therapy*. In C.A. Malchiodi (Ed.), *Expressive Therapies.* (pp.68-89). NewYork: The Guilford Press.

Malchiodi, C. (2003). *Art therapy handbook*. New York: Guilford Press.

Malchiodi, C. (2007). *The art therapy sourcebook*. New York: McGraw-Hill.

Mazza, N. (2003). *Poetry therapy: theory and practice*. New York: Brunner-Routledge.

McNiff, S. (2004). *Art heals: How creativity heals the soul*. Boston: Shambhala Publications, Inc..

McNiff, S. (2009). *Integrating the arts in therapy*: *History, theory, and practice.* Springfield: Charles C. Thomas Publishers Ltd.

Miell, D., McDonald, R., & Hargreaves, D. (2005). *Musical communication*. New

York: Oxford University Press.

Moon, B. (2008). *Introduction to art therapy: Faith in the product.* Springfield: Charles C. Thomas Publisher, Ltd.

Paola, F.A., Walker, R., & Nixon, L.L. (2010). *Medical ethics and humanities*. Sudbury: Jones & Bartlett Publishers, Ltd.

Pitruzella, S. (2004). *Introduction to dramatherapy: Personal and threshold*. New York: Brunner-Routledge.

Rogers, N. (1993). *The Creative connection: Creative arts as healing*. Palo Alta: Science and Behavior Books, Inc.

Rubin, J.A. (2005). *Artful therapies.* Hoboken: John Wiley & Sons, Inc.

Scott, P.A. (2000). The Relationship between the arts and medicine. *Medical Humanities*, *26*, 3-8.

Sheff, R.(2001). *The potential of integrative medicine in disease management.* In N. Faass (Ed.),*Integrating Alternative Complementary Medicine into Health Systems.* (pp. 411-415) Gaithersburg: Aspen Publishers.

Shi, L., & Singh, D. (2008). *Delivering health care in America: a systems approach*. Sudbury: Jones and Bartlett Publishers.

Snook, Jr., D.I. (2004). *Hospitals: What they are and how they work*. Sudbury: Jones & Bartlett Publishers.

Snook, T. (2001) *Consideration in the design and pricing of a complementary and alternative medicine benefit.* In Nancy Faass (Ed.), *Expressive Therapies Integrating Alternative Complementary Medicine Into Health Systems.*

(pp.141-148). Gaithersburg: Aspen Publishers.

Snyder, L. (2007). *Complementary and alternative medicine: Ethics, the patient, and the physician*. Totowa: Humana Press, Inc.

Snyder, M., & Lindquist, R. (2006). *Complementary/alternative therapies in nursing*. New York: Springer Publishing Company, Inc.

Stone, J. (2000). *An Ethical framework for complementary and alternative therapists*. New York: Routledge.

Tillman, J. (2000). *Constructing musical healing: the wounds that heal*. Philadelphia: Jessica Kingsley Publishers.

Udani, J. (1998). Integrating alternative medicine into practice. *Journal of the American Medical Association*, *280*, 1620.

Vinent, C., & Furnham, A. (1997). *Complementary medicine: a research perspective*. Sussex: John Wiley & Sons, Inc..

Wadeson, H. (1987). *The Dynamics of art psychotherapy*. New York: John Wiley & Sons, Inc.

Wadeson, H., Durkin, J., & Perach, D. (1989). *Advances in art therapy*. Hoboken: John Wiley & Sons, Inc.

Waller, D. (1991). *Becoming a profession: The history of art therapy in Britain, 1940- 1982*. London: Routledge.

Warren, B. (2008). *Using the creative arts in therapy and healthcare: A practical introduction*. New York: Routledge.

Wengell, D., Gabriel, N., & Perlman, A. (2008). *Educational opportunities in*

integrative medicine: *The a-z healing arts guide and professional resource directory*. Atlanta: The Hunter Press.

Wigram, T., Nygaard, I., & Bonde, L. (2002). *A Comprehensive guide to music therapy*. Philadelphia: Jessica Kingsley Publishers.