Art therapy & anxiety

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PART II

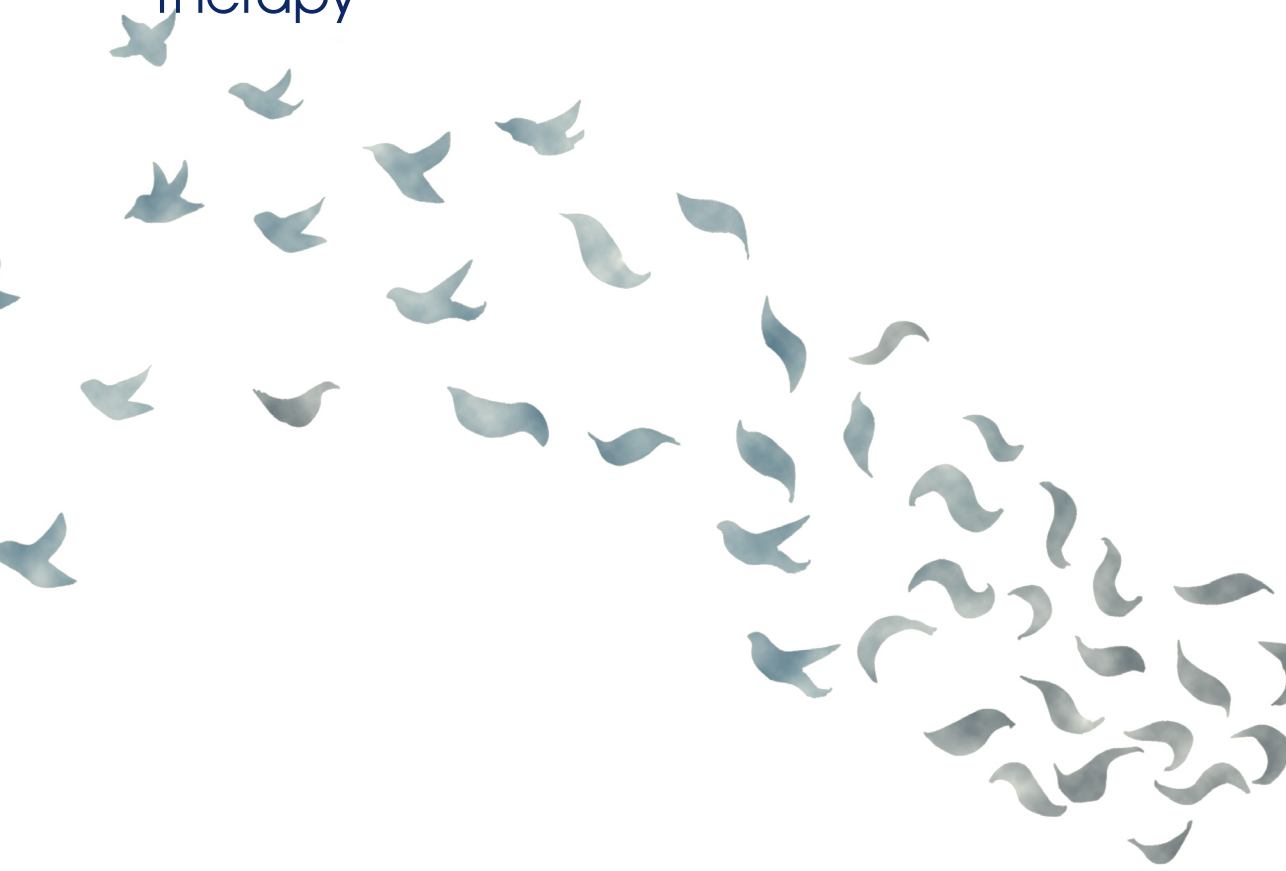
Towards further hypotheses on working mechanisms of anthroposophic art therapy: development of case report methodology

“The great thing is that the therapist somehow gave me the feeling, right from the start: you are more than your anxiety. I immediately felt that I could relax there, and that it would not matter if I could not relax.”

(Female participant, 32 years old)

Chapter 5

The CARE-AAT Guideline: Development and evaluation of a consensus-based guideline for Case Reports in Anthroposophic Art Therapy



Manuscript published as:
Abbing, A., Ponstein, A., Kienle, G., Gruber, H., Baars. E (2016).
The CARE-AAT Guideline: Development and testing of a consensus-based guideline for case reports in anthroposophic art therapy.
International Journal of Art Therapy,
DOI: 10.1080/17454832.2016.1170054.

Abstract

Background: Anthroposophic art therapists (AATs) report individual cases in narratives of poor scientific quality. Good quality case reports are an important factor in the development of EBP. A guideline for scientific case reports could contribute to this. However, the recently published guideline for medical case reports (the CARE Guidelines, covering diagnosis, treatment and outcomes) is not completely suitable for AAT.

Objective: The development of a guideline for AAT case reports.

Methods: The CARE Guidelines were adjusted following the recommended steps for health reporting guidelines. The proposed adjustments are based on AAT literature and expert opinions. The face validity of the new CARE-AAT Guideline was judged by an international group of 35 AATs and three experts on case-study methodology.

Results: Seven items of the CARE Guidelines needed specification or addition. One item (Treatment objectives and plan) had to be added and six items could be used without change. The face validity of the new guideline is good.

Discussion: The CARE-AAT Guideline is suitable for scientific case reporting of AAT practice. It is assumed to be suitable for AT case reporting as well. Future use of the guideline will show whether further optimization of the guideline is needed.

Introduction

Anthroposophic Art Therapy

Anthroposophic art therapy (AAT), a specific type of art therapy (AT), is developed by Dr. Margarethe Hauschka in the beginning of the 20th century as a part of anthroposophic medicine (AM) (Hauschka, 2004). AM is an integrative diagnostic and therapeutic concept, developed from 1921 onwards and practiced today in over 60 countries. It combines conventional medicine with Rudolf Steiner's spiritual science (anthroposophy). AM considers a human being as a whole entity of body, mind, soul, and individuality. AM consists of different disciplines, such as anthroposophic medicinal products, massage therapy and art therapy, in a 'whole-system-approach' (IVAA, 2014) and is also characterized by its individualized support of the patient and his[1] development (Kienle, Kiene & Albonico, 2006).

The AAT approach is used by visual art therapists, music therapists and speech/drama therapists. It is primarily an individual therapy, used in somatic and mental healthcare. In this form of art therapy, an expressive approach is combined with an '*im*-pressive' or inwardly oriented approach. The client is at first guided to (sub- or unconsciously) express inner feelings and life experiences. The therapist then provides artistic exercises with the therapeutic aim of improving the health and resilience of the patient or client[2]. The exercises provide *impressions*: profound experiences of colour and shape, or tone and harmony. The concept is, that these impressions work 'medicinally' and activate the self-healing ability of the client (Christeller et al., 2000; Hauschka, 2004; Rolff & Gruber, 2015). The difference with the BAAT art therapy model is that the BAAT approach is closely allied to psychotherapy, uses visual art only and the artwork is not used as a diagnostic tool (http://www.baat.org/About-Art-Therapy).

Developing Practice-Based Evidence in AAT

For any intervention or therapy, the present reality is that its value can only become clear as the interventions and practice methods are transparent and increasingly evidence-based (Nijhuis, 2009). This applies to AAT as well. With regard to designing and executing scientific

[1] Where 'he' is written, 'she' can also be read.
[2] In AAT the term *client* is used instead of patient, in order to emphasize the equal relationship between therapist and patient.

research to study the effectiveness of AAT, there is much to gain. The AAT field needs to describe its practices more explicit, monitor its therapeutic processes, test its quality, safety and (cost) effects and present these data to relevant stakeholders (Baars & Koster, 2008).
In art therapy practice, most of the knowledge and expertise of art therapists is implicit (Smeijsters, 2007). Because the experience is not documented, this tacit knowledge is difficult to transfer and transparency about the therapeutic process cannot be provided. Valuable experience and expert knowledge are often lost because of this. This expert knowledge needs to be explicated, in order to become a valuable source of information for scientific research and education.
Expert knowledge of therapists can be derived from professional reflection on individual cases in so-called case reports. Van der Laan (2004) explains that case studies transmute tacit knowledge into explicit knowledge that can be shared, further developed and applied. This contributes to the development of practice-based evidence (PBE). PBE can serve as the basis of randomized controlled trials (RCTs), the golden standard for studying the effects of interventions.

The Advantages of Case Reports for Art Therapy Research

Case reports are increasingly recognized in medicine (Kienle, 2012) since 'information from case reports provide feedback on clinical practice guidelines and offer a framework for early signals of effectiveness, adverse events, and cost. They can be shared for medical, scientific, or educational purposes' (www.care-statement.org). In addition, they allow for describing clinical reasoning, individual decision-making and individual therapeutic effects (Kienle, Anderson, Baars, Hamre & Murphy, 2010; Vanderbrouke, 2001). Case studies leave the complexity of the therapeutic setting intact (Kienle et al, 2010) and can point out details that are difficult to catch in a RCT. For example, RCTs do not provide therapists with all details needed to benefit from experiences of colleagues (Huet & Springham, personal communication, Art Therapy Practice Research Network, April 2014). Therefore, case reports are an essential complementation for other types of research.
Normally in medicine, a treatment has been manufactured before and is generally available. But in art therapy, the intervention is not only based on external knowledge, but also on a creative process. The art therapist is part of the intervention: the professional attitude of the therapist influences the therapeutic process as well and the therapy is created within the

actual treatment session, based on knowledge of the personal characteristics and the life situation of the client. This can be captured by case reports.

To conclude: case reporting is a type of research that will provide a starting point for explicating knowledge and experiences of art therapists.

Quality of AAT Case Reports

Up to now, case reports about anthroposophic art therapy are published in books (e.g. Uitgeest, 2010; Ponstein, 2009; Uitgeest, 2016), anthroposophic journals (e.g., Der Merkurstab and the journal of the professional association of Dutch Anthroposophic Art Therapists (Reliëf)). There are no guidelines for these case reports and they are often a form of storytelling (e.g. Ratcliffe, 2015; Solheim, 2002a; Solheim, 2002b). This has the advantage that 'through storytelling, meaning is created and shared inside and outside the clinical setting' (Edwards, 1999). The disadvantage is that reflecting on a case (in retrospect) usually coincides several holes in the information gathered: for example the starting point of the therapeutic process is usually poorly documented and possible effects of the therapy are usually not visible because of a lack of repeated measures. This implies that the interpretation of the therapeutic process by the therapist is prone to subjectivity.

Within the current development of evidence-based medicine, medical science does not value stories, but demands good quality evidence, based on the application of good research methods (Kienle et al, 2010). The narrative case report needs to provide more (systematically gathered) information than usually provided by AATs. Therefore, it is important to improve the quality of case reports by developing reporting guidelines.

Aim of the Study

The aim of the present study was to develop a case report guideline for AAT. In 2013, the CARE (CAse REport) Guidelines, were developed (Gagnier et al, 2013) and accepted in medicine worldwide. These case report guidelines provide a scientific framework for publication of a transparent case report. However, these guidelines are developed for medical practice and cannot be applied directly to art therapy practice, including AAT practice. The guidelines require therapy-specific adjustments. Therefore we carried out a study that aimed at developing a case report guideline for AAT, based on the CARE Guidelines, AAT literature and AAT expertise.

Research Questions

In order to develop a case report guideline for AAT, we designed a study with the following research questions:

1. What are the specific adaptations (additions, specifications and modifications) that must be made to the CARE Guidelines, in order to be useful for publishing good quality case reports on anthroposophic art therapy?
2. What is the face validity of the case report guideline for AAT according to international AAT experts and methodologists?

Methods

The case report guidelines for AAT were developed according to the core items of the recommended steps for developing a health reporting guideline (Moher, Schulz, Simera & Altman, 2010), namely: (1) Initial steps (discussing the need for a guideline, extending of existing guideline, reviewing the literature, acquiring funding for the project), (2) Pre-meeting activities (identifying participants, Delphi method, preparing consensus meeting, preparing a list of items for consideration), (3) Consensus meeting (presenting pre-meeting activities, determining final version) and (4) Post-meeting activities (seeking and dealing with feedback and criticism, encouraging guideline endorsement).

For the development of the AAT case report guideline, the concrete activities within each of the steps, were:

1. Initial steps

1.a Discussing the need and purpose of the guideline

In several meetings with the Dutch professional association for anthroposophic art therapists (NVKT: www.kunstzinnigetherapie.nl), the educational program for AATs at the University of Applied Sciences Leiden, The Netherlands and the European Academy of AAT (in 2012 and 2014) the need for a guideline was discussed. A guideline was broadly seen as necessary for the improvement of case report quality. Hence, a research group (further referred to as the CARE-AAT Group; CAse REport Anthroposophic Art Therapy) was formed to execute this

specific task. The group consisted of three art therapists/researchers (two visual art therapists and one musical art therapist) and two experts in case-study methodology. During a kick-off meeting, the purpose of the guideline was discussed with the members of this research group.

1b Extending of existing guideline

The CARE Guidelines was selected as a basis, because this guideline was developed by a group of international scientists according to the highest standards of guideline development, comparable to for example the STROBE (for observational studies) ((http://www.strobe-statement.org/) and CONSORT (for randomized trials) guidelines (http://www.consort-statement.org/) and is accepted as a guideline for medical case reports.

The existing CARE Guidelines provides 13 items with definitions (www.care-statement.org). These items are: Title, Keywords, Abstract, Introduction, Client or Patient Information, Clinical Findings, Timeline, Diagnostic Assessment, Therapeutic Intervention, Follow-up and Outcomes, Discussion, Client or Patient Perspective, Informed Consent.

1c Item selection for the guideline

The existing CARE Guidelines were extended by means of items that were selected from the AAT literature and AAT expertise:

1. *Literature search:* by means of a literature review, items for case reports about AAT were collected. The searched databases were Pubmed/medline, Google Scholar, Arthedata and the database of Der Merkurstab. The following search terms were used: case report OR case study AND anthroposophic art therapy. The search was also performed in German and Dutch. In addition, the journal of the professional association of Dutch Anthroposophic Art Therapists (Reliëf) was searched for case reports. Articles were selected by the following criteria: reports are in Dutch, English or German; published after 2005; about a *single* case; only about anthroposophic art therapy (and no other therapies). Based on the assumption that an author uses the same standards and style for each care report, only the most recent case report per author was chosen. The selected case reports were read and the described items were extracted. Then, these items were categorized and finally compared to the CARE Guidelines.
2. *Explicating AAT expertise:* a survey, an online questionnaire, was held among all AATs registered at the Dutch Professional Association (NVKToag). AATs were asked what

information they routinely document. Based on this survey, documentation items were collected and clustered separately by two art therapists/ researchers (both member of the CARE-AAT group).

The selected case report items from the literature search and the survey were judged on quality, according to the concept mapping method (Nederlands Centrum Geestelijke Volksgezondheid, 1995): overlap with other items, ambiguity (an item has more than one meaning), singularity (an item is not a compound of more than one content), and concreteness (an item is specific, not vague or general). Then, the selected high-quality items were content-wise clustered by the same two art therapists/researchers that analysed the survey results.
After clustering the items were categorized according to four therapy phases: intake, diagnostic phase, therapeutic phase, and evaluation. As a result, a list of items per therapy phase was constructed.

2. Pre-meeting activities

2a Draft version

The list of items of the CARE Guidelines was extended with the acquired items, resulting in a first draft version of the AAT case report guideline.

2b Participants

The CARE-AAT group consisted of three art therapists/researchers and two experts on case-study methodology.

2c Delphi method

The CARE-AAT group performed a Delphi method to discuss the draft version, and discussed which items from the CARE Guidelines:

- could be applied directly to AAT cases;
- matched the CARE Guidelines items,
- required adjustments;
- were missing.

2d List items for consideration

The result of the Delphi method was a list of items for consideration, in preparation for the consensus meeting with other AAT experts.

3. The Consensus Meeting

During the consensus meeting with members of the CARE-AAT group, complemented with other expert AATs, all pre-meeting activities were presented, including the list of items for consideration. The final version was determined, following the method of the CODM Model (Hartnett, 2011) with a focus on open discussion and synthesizing a final proposal.

Ten expert AATs were invited for this meeting. They were selected by the following inclusion criteria: (1) educated as an AAT, (2) over five years working experience in clinical practice and/or AAT research or AAT teaching or in an executive function in AAT education.

4. Post-meeting Activities

Presenting the guideline and judgement of face validity

For the judgement of the face validity of the constructed guideline, expert AATs (different from the AATs that participated in the consensus meeting) were selected by the following inclusion criteria: minimum of five years experience with AAT research or AAT teaching or with an executive function in AAT education.

During the annual meeting (January 2015) of the European Academy for AAT in Dornach, Switzerland, all present AAT experts that fulfilled the inclusion criteria were asked to answer two questions about the case report guideline: Do the items cover all necessary information, needed for a case report on AAT? Can the case report guideline provide a framework for good quality case reports on AAT?

Three experts on case study methodology and AM research were separately asked to provide their professional opinion about the case report guideline and the methodology of the development of this guideline.

Results

1a Kick-off meeting: discussion of the purpose of the guideline

The CARE-AAT group stated that the guideline should improve the quality of case reports in the light of education (transferability of experience) and from a scientific point of view (publishing about AAT and executing the first steps in demonstrating effects).

1b Existing guideline

The existing CARE Guidelines (www.care-statement.org) with 13 items were used as a starting document.

1c Item selection

i Literature review

The results of the review of the literature in the databases: Pubmed contained three results, but none of these matched the inclusion criteria; Google Scholar: no matching results (only cohort studies or conventional art therapy); Der Merkurstab: one matching item (Hamre, Glockman & Kiene, 2004); Arthedata: no papers in peer reviewed journals, only book contributions.

Criteria for case reports were discussed in the book on scientific foundations of (anthroposophic) art therapy (Sinapius & Ganss, 2007). These criteria contain a list of items that should be included in a therapeutical oncological single case report (Kienle, 2007). These criteria are not directly applicable for AAT or diseases other than cancer.

From the journal Reliëf, five case reports were selected. Complemented with a book, six case reports matched the criteria and were selected (Gooijer – du Buf, 2008; Farshi & Rümke, 2009; Pels, 2010; Ponstein, 2009; Twisk, 2009; Uitgeest, 2010).

All described parts in these case reports were compared and categorized. These case reports describe all together items in 18 different categories: Title, Abstract, Introduction, Client history, Diagnostics, Indication, Treatment request, Treatment goals, Contra indications, Course of treatment, Interventions, Therapist attitude, Results/conclusion, Methods/material, Duration of the therapy, Evaluation of the treatment, Clients consent,

Visual material. The case reports differed with respect to the number of the above items that were covered.

A comparison with the CARE Guidelines, showed that the following items are missing in these case reports: (*routine) outcome measures* (except for Ponstein (2009)), and/or *client experiences*; the *use of (scientific) literature* to substantiated the treatment plan; *patient perspective* on the results of the therapy and *follow up information*. An important finding was, that effects and results are mostly descriptive and from therapist point of view. However, the use of outcome measures is desirable from EBP perspective.

Because we expected to find more AAT case reports, we strongly believe that there are more case reports published, but these were not found with the used search words. We encountered the following problems in finding case reports: first, the word 'case report' is not present in the title, which makes case reports on AAT hard to find. Second, case reports are often not solely about AAT, but about a combination of therapies. These findings prompted us to follow the CARE Guidelines in explicitly stating the words 'case report' in the title.

ii Survey

Of the 350 registered AATs, 77 completed the online survey (22%). These therapists provided 1,162 entries for documentation of the therapeutic process.

Item selection for the case report guideline

The 1,162 entries from the survey were put in an Excel sheet. After a process of concept mapping, a final list of 113 items was constructed based on consensus building between the two art therapists/researchers. These items were content-wise clustered into a small group of 11 items with description.

Second, these AAT items were placed under nine of the in total 13 items of the CARE Guidelines by the two researchers. (Table I, the right column, in regular font (not bold)).

2.a-d Draft version

This list was discussed in a Delphi method process, to form the draft version of the CARE-AAT Guideline. There were three participants in this process.

The draft version of the CARE-AAT Guideline was presented to the other members of the CARE-AAT group and they were asked to provide their additions. The following specifications and additions were made:

- Introduction: use of *literature* was specified because AATs need to link their professional insights to explanation models from scientific literature and established evidence, to explain their professional practice. This contributes to providing mechanistic evidence of AAT. The use of literature needs more attention, since AATs tend not to use literature to underpin the treatment goals/plan in their case reports, according to the results from the foregoing survey and literature search.
- Client or patient information: *biographical history* (e.g. childhood, life events, diseases, crises) was added, because this is an important part of the diagnostic information in AM, based on the assumption that i.e. diseases and crises may have a place and meaning in the life course of an individual (Heusser, Scheffer, Neumann, Tauschel & Edelhaüser, 2012).
- The *client's treatment request* is an important issue in AAT. In AM, clients are given and (many) want to take responsibility for their healing process (Kienle et al., 2006) and from that perspective they are asked what treatment needs they have: what problems are they facing, on which issues do they want to work on and/or what would they want to develop? A side note must be made: for mentally disabled patients, small children or dementia patients, this item is not applicable.
- Clinical findings: *outcome measures* were specified for this item, because in AAT case reports, effects and results are usually only descriptive in nature and only judged by the therapist, hence principally subjective from a scientific point of view. From the literature review and survey, we concluded that in practice, AATs do not routinely use measuring instruments to monitor effects of the therapy. However, from a scientific point of view, this is necessary.
- Diagnostic assessment: this was modified according to the general procedure of AAT, that is built up from *observations* of the client (on the appearance, the behaviour/attitude and the way of working) and a *medium specific diagnosis.* This diagnosis is made on the free work that the client makes during the first session(s). The therapist observes the features of the artwork and gives meaning to these features and

the total art work, following a four step method, based on Goethe's phenomenological science (Bie, van der, 2012; Uitgeest, 2010; Verhoogh, 2006).

- Therapeutic Intervention: this item was substantially expanded. In the CARE Guidelines, it is sufficient to only mention the choice of treatment, since the users (medical doctors) don't have to underpin or substantiate this choice, because working mechanisms, effects and side effects are, generally speaking, already explicated, studied and published. This is not the case with AAT, where scientific research explaining and proofing the rationale of the non-verbal therapy is commonly lacking. Therefore, the *intervention* (exercises and adjustments given during therapy and therapeutic attitude) should be well described and substantiated in the AAT case report guideline.
- Also, *consultation with others* was added to this item. Because this can provide extra information about the client and may lead to changes in the treatment approach or intervention. The same applies to *reflection* and *evaluation during the course of treatment*. These can lead to changes in the approach and substantiate these choices.
- Follow-up and Outcomes: the use of *outcome measures* was specified for this item, because in AAT cases, as mentioned earlier, effects and results are usually only descriptive and from the therapist point of view.
- Also *patient perspective on the evaluation* is included here. Usually, an evaluation between patient and therapist is held at the end of the therapy process. There is no standardized form for this evaluation, notes are not always made and it is not clear whether patients can provide their opinions freely.
- Discussion: the use of *literature* was specified because AATs don't often use literature in case reports.

With the above information, the first version of the AAT case report guideline was created, with the working title 'CARE-AAT Guideline' (CAse REport Anthroposophic Art Therapy Guideline).

3. Consensus meeting

The first version of the CARE-AAT Guideline was discussed in a consensus meeting. In addition to the CARE-AAT group, three other experts participated (two art therapists/researchers, one

Dutch and one German, and one epidemiologist). The list was discussed per item during this meeting, after which full consensus was achieved.

One item was added as a separate item: *Treatment Objectives and Plan*. Experts stated that this should be a separate item, because this is an important step in the art therapy process that precedes the Therapeutic Intervention.

The additions to Therapeutic Intervention were found to be too extensive and were shortened. Nevertheless, all experts agreed that the intervention should be well described and substantiated. *The underpinning of the treatment plan* was found an important addition, because in case reports, AATs do not make clear why they choose a specific treatment direction and where these choices are based on.

Therapist self-reflection (e.g., observations of own actions and own attitude, reflection on the interaction with the client, intuitive moments) was not present in the draft version of the guideline. Since it is an important item in AAT practice, the expert group suggested this to be incorporated in the CARE-AAT guideline. Reflection is done after each session and also on the therapeutic process as a whole. The therapeutic relationship is an important factor in healthcare (Born, 2006). Reflection on these aspects is essential in the ongoing professionalization of the therapist. It is important to include the reflection item in this guideline, because this can provide more insight in the clinical reasoning of the therapist, in the decision moments and the way AATs work. This can provide explicit information about the therapy. The therapist's self-reflection was classified under the item Discussion, because in this item, one can reflect on the case and can point out strengths and weaknesses of professional intervention.

The items that remained unchanged are: Title, Keywords, Abstract, Timeline, Client or Patient Perspective and Informed Consent (Table I).

Final version

After the changes made during the meeting, the CARE-AAT Guideline was accepted with minor revisions, through e-mail contact with the participants of the consensus meeting. The CARE-AAT Guideline is presented in Table I.

Table I. CARE Guidelines Items and AAT Specific Adaptations: CARE-AAT Guideline

CARE ITEM	CARE GUIDELINESS SECTION DESCRIPTION	ANTHROPOSOPHIC ART THERAPY SPECIFIC ADAPTATION*
TITLE	The words case report (or case study) should appear in the title along with phenomenon of greatest interest (e.g., symptom, diagnosis, test, intervention)	No change
KEYWORDS	The key elements of this case in 2 to 5 words	No change
ABSTRACT	1) Introduction—What is unique about this case? What does it add to the literature? Why is this important? 2) Case Presentation: a. main symptoms of the patient and main clinical findings b. main diagnoses, interventions and outcomes 3) Conclusion—What were the main takeaway lessons from this case?	No change
INTRODUCTION	One or two paragraphs summarizing why this case is unique with reference to the relevant medical literature	Specify: **Literature (profession specific (AAT as well as AT), disease/condition specific, research on natural course, other treatments and side effects)**
CLIENT OR PATIENT INFORMATION	Include all of the following details about the client/patient: 1) Demographic information (e.g., age, gender, ethnicity, occupation) 2) Main symptoms and concerns of the patient 3) Medical, family, and psychosocial history—including diet, lifestyle, and genetic information whenever possible and details about relevant comorbidities including past interventions and their outcomes	3) Add: - Clients treatment request - Short biographical description 4) Referral data (if applicable): - Position of the referrer - Referral question and/or therapy objective
CLINICAL FINDINGS	Describe the relevant physical examination and other significant clinical findings	Modify: **Describe physical and psychological state of health, preferably based on results from a generic questionnaire.** **Describe specific characteristics of the condition, if possible by a classification system (DSM, ICD, ICF,…) and/or based on results from a specific questionnaire (aimed at the specific condition of the patient).**
TIMELINE	Relevant data from the patient's history organized as a timeline	No change

DIAGNOSTIC ASSESSMENT	Diagnostic methods (e.g., PE, laboratory testing, imaging, questionnaires) Diagnostic challenges (e.g., financial, language/cultural) Diagnostic reasoning including other diagnoses considered Prognostic characteristics (e.g., staging) where applicable	Modify: Diagnostic Assessment: - Observation of the client, attitude, way of working and the art works - Medium specific diagnosis
ADD: TREATMENT OBJECTIVES AND PLAN		Treatment goals / objectives: - Main objective (general) - Sub-objectives (behavioural and medium specific) Treatment plan: - Treatment direction, phases and themes (if applicable) - Medium specific (material, techniques) - Therapist attitude - **Reasoning/rationale for the above** **Evaluation plan:** - **Observation criteria (core observations for this specific patient in this case)** - **Evaluation criteria**
THERAPEUTIC INTERVENTION	Types of intervention (eg, pharmacologic, surgical, preventive, self-care) Administration of intervention (eg, dosage, strength, duration) Changes in intervention (with rationale)	Each session: - Artistic exercises (medium and technique), with rationale - Therapists attitude, with reasoning - Observations: on the execution / way of working of the client / on the art work / and related to observation criteria, including pictures of the art works - Interventions and reactions on interventions - **Reflection on the session** - **Other remarkable events** Add: **Consultation with others (reasons and conclusions)** (if applicable) Add: Evaluation during the course of treatment: - Therapist reflection on the therapeutic process (changes in symptoms, behaviour and art work). - Clients opinion and client-assessed outcomes - **Adjustment of the therapy, with specification and reasoning**
FOLLOW-UP AND OUTCOMES	Summarize the clinical course of all follow-up visits, including	Specify:

	• Clinician- and patient-assessed outcomes Important follow-up test results (positive or negative) • Intervention adherence and tolerability (and how this was assessed) • Adverse and unanticipated events	• **Results (quantitative/measurable): questionnaires or other measurement instruments** • Results (descriptive): evaluation of the effects: – judgement by the therapist (summarize the developments in art work, behaviour and social interaction) – judgement by the client – **judgement by third parties (parents, family, partner, co-treating professionals and/or referrer)** Add: • Conclusions • Comparison of the conclusions with the main therapy objectives.
DISCUSSION	Strengths and limitations of the management of this case Relevant medical literature Rationale for conclusions (including assessments of cause and effect) Main takeaway lessons of this case report.	Add: reflection on own acts, therapeutic relationship, interaction with the client and intuitive moments. Specify: **Literature (profession specific (AAT as well as AT), disease/condition specific, research on natural course, other treatments and side effects)**
CLIENT OR PATIENT PERSPECTIVE	The patient should share his or her perspective or experience whenever possible.	No change
INFORMED CONSENT	Did the patient give informed consent? Please provide if requested	No change

*__In bold font:__ items *not* mentioned by AATs

4. Post-Meeting Activities

Face validity of the CARE-AAT guideline

During the annual meeting of the European Academy of AAT in January 2015, the AATs present participated in a discussion about the quality of the CARE-AAT Guideline. The guideline was presented and the 35 included AATs (visual, musical and speech art therapists, from different working areas and all involved in AAT education) were asked questions about the CARE-AAT Guideline (covering all necessary information, needed for a case report on AAT; adequacy as

a framework for good quality case reports on AAT). All experts responded positively to the two questions.

There were two remarks: first, the AAT experts doubted if AATs would be able to provide all necessary information for a case report according to this guideline. Not all items are momentarily well documented in practice by AATs. Therapists indicated that they need more support with obtaining the necessary information for writing a case report. This requires detailed instructions.

Second, AATs indicated that some might not be possible to be addressed in all working areas of art therapists (e.g. intellectual disabled clients might not be able to mention their own treatment request, or demented elderly might not be able to fill in a questionnaire or provide their opinion about the therapy progress). Hence, it was strengthened that the guideline reflects the ideal situation and alterations, if explained, to the suggested data collection can be made.

Endorsement

Since the guideline is developed with and judged by representatives from international AAT schools, the guideline is already endorsed by AAT education throughout Europe. The CARE-AAT group encourages AAT schools to educate students in the use of the guideline.

Conclusions

Based on the results of the study the following conclusions can be drawn:

1. For the development of a case report guideline for AAT, specific adaptations (additions, specifications and modifications) were made to seven of the thirteen items of the CARE Guidelines (see Table I). The adaptations concern the items: Introduction, Client or patient information, Clinical findings, Diagnostic assessment, Therapeutic Intervention, Follow-up and Outcomes, Discussion. One item was added, because it did not fit in one of the CARE Guidelines items: Treatment Objectives and Plan. Six items remained unchanged: Title, Keywords, Abstract, Timeline, Client or Patient Perspective and Informed Consent.

2. The face validity of the CARE-AAT guideline is good according to a group of 35 international expert AATs and methodologists. The guideline covers all necessary information, needed for a case report about AAT. However, the guideline might not be used in all domains of art therapists (e.g., in the treatment of intellectual disabled or demented clients).

Discussion

The demand for evidence in art therapy is not easily met as anthroposophic art therapists (AAT) report individual cases in narratives of poor scientific quality. In this study, a guideline for case reports by anthroposophic art therapists (AATs) was developed and tested on face validity. The CARE Guidelines, for the medical profession, were successfully adapted for AAT. The developed guideline (Table I) was positively judged on face validity by experienced international AATs and methodologists.

The importance of the CARE-AAT Guideline for AAT practice is that therapists can use it for scientific publication of individual therapy processes, and by doing that, contribute to education (Ponstein, 2009), professionalization and building the body of evidence of AAT. The guideline provides the scientific instrument to design and conduct case studies in the field of AAT. The case reports that will be published according to the guideline, can provide an insight into best practices and serve as a fundament for clinical trials. Finally, the results of the study can contribute to the development of case-report guidelines for other paramedical professions.

A limitation of the study is that it focuses on AAT only. Although the problems, mentioned in the introduction, pertain to both art therapy (AT) and the AAT field, for the sake of the viability and because all researchers had an AM/AAT background, we restricted ourselves in the study to the field of AAT. The research group is of the opinion that many of the adaptations are applicable to art therapy in general and that the guideline can be used in the art therapy field with limited adjustments. Because the guideline is not medium specific, and is judged by AATs from all different media, it can be used by visual art therapists, as well as music therapists and speech/drama therapists.

The development of the case report guideline is not completed yet. The CARE-AAT Guideline describes how a case report should be written and published, but prior to this, an art therapist needs to provide the right input: complete and good quality information. The therapists indicated that for this, more guidance is needed, preferably by means of a documentation method. The CARE-AAT group is currently developing a documentation format that can be used for collecting the data for a prospective case study. This documentation format (CARE-AAT Documentation Method) is created for facilitating case reporting and will be content-wise in line with the case report guideline. In this format, the items that should be documented, will be described in chronological order. This can support the therapist to track daily AAT practice (diagnosis, treatment plan, interventions, outcomes) in a structured manner. To generate client-assessed outcomes, therapists can use a monitoring tool, e.g. a client questionnaire can generate basic information about the (client experienced) effects of art therapy. This will also be included in the documentation method.

Future research will focus on the use of the CARE-AAT Guideline and Documentation Method in clinical practice in three countries (the Netherlands, the UK and Germany) and the testing of its usability and validity in clinical practice, in art therapy education and in scientific case studies. We will assess whether the guideline has helped to improve the quality of case reports. Finally, the CARE-AAT Guideline and documentation method will be optimized, based on testing and users' experiences.

A logical next step for conventional art therapy (as provided by BAAT therapists) could be to test and discuss the guideline in AT practice.

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“I encountered my fear. I am often still very anxious, but I have less problems with it. I let it come and it goes again”

(Female participany, 54 years old)