Art Therapy: Journal of the American Art Therapy Association, 23(2) pp. 59-65 © AATA, Inc. 2006

Ethical Issues in School Art Therapy

Dafna Moriya, Ramat HaSharon, Israel

Abstract

School art therapists face numerous ethical dilemmas, from referrals to therapy, through privacy, safety and predictability in the art therapy room, to the need to balance cooperation with the educational staff and its expectations of shared information with loyalty to the patient. Breach of confidentiality also has legal implications. The ownership and exposure of treatment records and artwork likewise involve ethical considerations. System and patient needs sometimes conflict. The handling of ethical issues—often resolved technically or according to facility tradition—greatly impacts the therapy process. The author encourages art therapists in schools to plan and implement systematic work procedures; nevertheless, they should also make sure their methods comply with their moral and ethical standards.

Introduction

Art therapists in any setting try to provide their patients with a safe "container" in their art therapy sessions. Ethical standards are intended to help and guide them in this mission. Art therapists in school settings, however, often have to navigate in a very delicate situation, as the system's ethical standards tend to differ greatly from their own (Vandgrover, 1998). Despite a profusion of literature about ethical issues in art therapy (Blase, 2000; Haeseler, 1992; Hammond & Gantt, 1998; Moon, 2000; Spaniol, 1994), very little has been written specifically about ethics in the school setting. This paper raises questions regarding the applicability of the ethical standards of art therapy to practice in the school environment. However, many of the issues also are relevant to art therapy with children in other settings (such as private practice, clinical settings or hospitals).

Schools are increasingly employing art therapists. Upon starting out, they encounter a reality that many were not prepared for, as the tasks besides therapy are numerous. Art therapists must maintain ongoing contact with teachers, the school counselor, the student's parents, the school psychologist and others. The most problematic aspect is the system's educational orientation, meaning that the nature of art therapy often is not understood and may lead to unrealistic expectations. Some of the expectations and demands school art therapists face are contradictory to their professional ethics.

Editor's note: Dafna Moriya, PhD, ATR, is a graduate of Pratt Institute, Brooklyn, New York, and supervisor working in private and public schools and therapy centers for children in Ramat HaSharon, Israel. Correspondence concerning this article may be addressed to her at dafna@moriya.co.il.

Art Therapy in Schools by Moriya (2000) offers strategies for the effective integration of art therapy in schools based on work procedures tried in one particular school in Israel that are now used internationally. The book reviews theoretical and practical issues and presents systematic work procedures for art therapists in schools, with an emphasis on the need for collaboration with the educational staff. Art therapists in schools are encouraged to seek and create opportunities for staff involvement (Essex, Frostig & Hertz, 1996; Moriya, 2000). Balancing confidentiality and the expected sharing of information, however, is complicated by ethical considerations, legal implications and the question of the child's best interest. Treatment records pose another prevailing hazard to the ethical conduct of art therapists in schools, raising concerns in regard to the content, exposure and ownership of records (Hammond & Gantt, 1998), and different ideas about the inclusion of artwork as part of the records and the ownership of the artwork (Haeseler, 1992; Spaniol, 1994). This paper explores theoretical, legal and practical aspects of these and other complex issues.

Ethical Issues Concerning the Referral to Therapy

The moment an art therapist sets foot in a school, he or she faces numerous ethical stumbling blocks, beginning with the referral to therapy. In some schools the teachers approach the art therapist stating they have pupils who urgently need therapy. Other schools have an orderly procedure for referrals. Usually the therapist has many fewer available spots than candidates for therapy. Moriya (2000) suggests that, in cases where the therapist is responsible for sorting out the referrals, the therapist ask the teacher or counselor to fill in a referral form describing the child's background, academic situation, social and family situation, as well as state the reason for referral and their expectations from therapy. This compels the teacher to think carefully about each referral. Only after this is done can the therapy staff, usually the school counselor, school psychologist and art therapist and sometimes also the principal, sort out the referrals.

Important ethical questions that may emerge early in the process include:

1. Who refers the child to therapy? In most schools the school counselor or homeroom teacher refers the child to therapy. Sometimes parents request the therapy. Rarely does a child apply for therapy at his or her own initiative.

2. Is the patient (child) interested in therapy? Goodman states that children are prevented from voluntarily beginning or ending treatment since the parent is entitled to accept or refuse treatment for a child and only rarely may a child obtain treatment without parental consent. Thus, children may be denied access to therapy or forced to receive therapy they do not want (Agell & Goodman, 1995). In most cases, therapists cannot legally treat a child without parental consent, but what of a child's refusal to come to therapy? Does the therapist require the child's consent for therapy? This author failed to find a clause on this subject in the ethical codes. One way to resolve this dilemma is to offer a three-session trial. The therapist can suggest getting acquainted over three sessions and then check to see if the child wants to continue therapy.
3. Do the child and his parents understand that this is therapy? Many schools tell the child they have "art," "an art class," or even just "you have Dafna today." The term "therapy" often is concealed to avoid stigma and resistance. Most therapists explain to the child that this is a place where privacy and confidentiality are protected, a place to make art and express feelings. Is it important that the child understand? Children generally come to realize that the art therapy room is a place they enjoy, where they are accepted as they are and can explore their needs in a supportive environment. If children continue this "activity," regardless of what it is called, because they feel helped—that seems sufficient to this writer. The parents, on the other hand, can and should be informed about the type of therapy their child is receiving. Frequently, a letter is sent to the parents asking them to sign their approval for therapy. But parents may be accustomed to signing whatever is sent by the school and may assume that this is simply another educational activity. Ethics dictate that the therapist should invite the parents to a meeting and make sure they understand this is therapy and different from only another art class.
4. Finally, when the school staff (usually the teacher, counselor, principal, and art therapist) discuss the referrals, private information about the children and their families is very relevant. Does the therapist need a release form from the parents for this discussion? Usually there are far more candidates for therapy than available sessions. If the therapist asks the parents to sign a release form for the preliminary discussion, their expectations may be raised in vain. In one school, the school counselor resolved this dilemma as follows: In each interview she conducts with parents, she tells them that in order to help the child she will need to cooperate with the school psychologist, any outside therapist or social worker involved and the school staff, and she asks them to sign a very elaborate release form. That way, at the beginning of the school year, the staff are able to discuss all the children who are candidates for therapy. Only the parents of children who can receive therapy are invited for subsequent meetings.

Privacy, Safety and Predictability in the Art Therapy Room

After the candidates for therapy are chosen, the therapist begins to use the therapy room. The AATA Ethical Standards for Art Therapists state: "Art therapists shall treat patients in an environment that protects privacy and confidentiality" (2003, paragraph 2.1). As many schools have limited space, however, the physical conditions in art therapy rooms vary. If the room has a window where other students can peek in, the therapist can easily solve the problem by hanging up a curtain. But in many cases the situation is more complicated.

For example, in one school the space allocated for art therapy was a well-equipped, beautiful room that also provided the only access to the faculty bathroom. Staff members occasionally had to walk through the room, sometimes even commenting on the artwork or just greeting the patient during the sessions, thereby completely invading their privacy. There was no alternative space available in this school. Does this situation present a "red line" that the therapist should not be willing to cross? Should therapists risk losing their job and depriving the children of art therapy by insisting that these conditions do not protect the patient's privacy?

A more common occurrence is the art therapy room being situated close to a classroom so that sounds can be heard from both directions. Is this a "red line"? Should the therapist refuse to provide therapy? Moon (2000) states that it is the art therapist's responsibility to maintain aspects such as safety and predictability in the work place or studio environment: "The patient must believe that the art therapy milieu is a safe place in which to explore and express feelings" (p. 49). According to Moon (2000), it is the therapist's ethical responsibility to determine how to create a sense of safety in the art therapy room. He goes on to say that one of the cornerstones of safety is the predictability of the place:

> While the art therapists never know exactly what will happen artistically within the studio, they can be very clear about how they, as the keepers of the studio, will be. Art therapists can also be clear about how the studio space itself will be. (p. 49-52)

Yet it is not easy to maintain a predictable setting when other types of activity take place in the therapy room during the week. Most of the art therapists in school work part time and share the room with other teachers. When it is impossible to ensure the room's predictability, the art therapist can maintain a predictable setting by making sure that the same materials and tools are available each time, by setting up the art supplies consistently, by the way the child is greeted when entering the art therapy room and by how the session is ended (Moon, 2000; Moriya, 2003).

This aspect is especially important when the child returns to the classroom after the therapy session. It is most important to announce when it is time to get ready to end the session, thus giving the child time to prepare for the

transition from art therapy's permissive atmosphere to the classroom's more disciplined environment. It is also essential to gather up and put away the artwork so that things are collected and protected, both physically and metaphorically, before the child has to face any peers and function appropriately in the classroom. Sending a child back to the classroom all worked up and vulnerable is unethical and may cause harm.

Cooperation and Confidentiality

Authors agree that it is vital for the school art therapist to maintain ongoing contact with the child's teachers (Essex, Frostig, & Hertz, 1996; Moriya, 2000). Moriya (2000) states the flow of information between therapists and educational staff is one of the greatest advantages of the integration of art therapy in schools. However, when art therapists cooperate with the educational staff, the latter tend to expect that, as partners, therapists will share information. In some schools, the principal and school counselor claim that since the homeroom teacher is responsible for the child while in school, he or she must be fully informed of anything that has taken place in therapy. In such an atmosphere, it is difficult and sometimes almost impossible to conduct art therapy and uphold ethical standards. In art therapy, therapists encourage self-exposure and exploration of the patient's inner world. If therapists do not protect the child's privacy and confidentiality, they may be harming more than they help.

For example, in a school for children with behavioral problems, this author had a child in art therapy who previously had been very violent. Since coming to the school, however, his behavior in class had been quite controlled; he was cooperative and did well academically. His teachers described him as a "good, responsible boy." Yet his drawings expressed terror and violence. The only subject in all of his drawings were creatures killing each other or being blown up. In the therapist's view, the child was making an appropriate effort to control himself in the school setting while expressing and dealing with his inner turmoil in the art therapy sessions. The school principal clearly stated that she expected information that came up in therapy to be shared with the educational staff. She was not satisfied with neutral reports such as "He cooperates," or "He is processing his inner world."

Should the therapist share this kind of information with the educational staff, in accordance with the school's expectations? What kind of impact would this information have on the teachers' perception of this child? Or, should the therapist protect the child's privacy, in this case allowing him to continue to perform and impress the educational staff as a calm and productive child?

Nothing can replace explanation, education and the therapist's sincere effort to create a dialogue with the educational staff (Moriya, 2000). However, these are long-term processes. Balancing confidentiality and the expected sharing of information is complicated by the question of the child's best interest, ethical considerations and legal implications (Agell & Goodman, 1995; Kessler,1993).

At a supervisors' conference for art therapists who supervise other therapists working in schools in Israel (Tel Aviv, Nov. 2001), participants shared that school art therapists often struggle with the following questions: How can we preserve confidentiality and at the same time create a productive partnership with the teachers? Where does our loyalty lie? Are we mostly loyal to the school system that hired us and to our partners on the school staff—and therefore obligated to compromise the child's privacy in order to cooperate with the system's demands? Or are we mainly loyal to our patients and therefore obliged to conceal information and compromise our partnership with the team?

The therapist must perform a very delicate balancing act here. When therapists share information it is imperative to check whose need is served by doing so. It is important to question whether the disclosure stems from the patient's best interest or from the therapist's needs. Therapists may tend to share information for various reasons besides the patient's best interest. When the job market is not very promising, the therapist who resists the principal's demand for information may be risking employment. In other cases the therapist understandably may seek the sense of belonging and thus be more loyal to the staff than to child patients who "come and go." Beginning therapists, wishing to prove their competence, may also be inclined to share more information than necessary. Research indicates that a counselor is more likely to breach confidentiality and discuss a patient with an outside party when the patient expresses strong sexual or aggressive feelings, or if the patient is particularly difficult. This happens more frequently to novice than experienced clinicians (Roback & Shelton, 1995, as cited in Hammond & Gantt, 1998).

Agell and Goodman (1995) suggest that information be released on a "need-to-know" basis and with consideration for its intended audience. Accordingly, if a child who was referred to treatment for a certain problem reveals additional issues during therapy, the therapist should carefully examine if sharing this new information with the educational team is in the child's best interest.

The therapist can and should discuss with the teachers issues relevant to an understanding of the child's behavior in the classroom. It is possible to discuss the process and general information without sharing specific details that come up in sessions. For example, the therapist may describe progress made with a child's self-confidence and discuss its manifestation in the classroom without sharing the specific imagery from the session.

Breaching Confidentiality

Sometimes private information about a patient must be shared despite the accord of confidentiality. The AATA Ethical Standards for Art Therapists (2003) state:

> Art therapists shall not disclose confidential information without the patient's explicit written consent unless there is reason to believe that the patient or others are in immediate, severe danger to health or life. Any such disclosure shall be

> consistent with state and federal laws that pertain to welfare of the patient, family and the general public. (paragraph 2.3)

Ahia and Martin (cited in Moon, 2000) maintain that confidentiality may be breached when a patient poses a danger to self or others; when a patient discloses an intention to commit a crime; when the therapist suspects abuse or neglect of a child, elderly person, resident of an institution or disabled adult; or when court ordered. In a school setting, there is no dilemma when the child clearly poses a danger to self or others. But many times, in an appropriate expression of rage during therapy, children say things like: "I'm going to kill him." Experienced therapists can judge if this is an actual intention. But can they ever be absolutely sure of their assessment?

When a patient discloses an actual intention to commit a crime, a dilemma ensues. If the child is about to commit a minor crime, for example to steal candy from a store, therapists often choose to maintain confidentiality and clinically probe the issue. But where should the therapist draw the line? What is the "crime level" that obliges disclosure?

Hass and Malouf (2002, p. 100) state that the therapist has options for dealing with situations in which information must be shared with colleagues, including statements about anticipated problems with giving consent for treatment or trying to get the patient's consent to share the information. Others add that when the therapist assures patients that "what they reveal will ordinarily be kept confidential, [the therapists] should point out that they have obligations to others besides their patients" (Corey, Corey, & Callahan, 1998, p. 161). Taylor and Aselman (1989, as cited in Agell & Goodman, 1995, p. 80) recommend a three-part approach to discussing confidentiality with children: First explain that most of what is talked about is private, then explain when exceptions must be made, and finally assure the child that he or she will be involved in any decision to break confidentiality.

Restrictions on therapeutic confidentiality may have a significant impact on the willingness of patients to disclose information to their therapists. The patient's right to privacy and respect, however, far outweigh the potential negative effects on the therapy stemming from a request for informed consent. "Patients should be treated as equals, multi-faceted human beings who have a right to make their own decisions about whether their struggles with life will be made public" (Blasé, 2000, p. 19).

Legal Implications

Kessler (1993) discusses the balancing act between the right of privacy and the right to know, citing Allan Westin's book *Privacy and Freedom* (1970), which traces the origins of our belief in the right to privacy through history and various cultures. The universal desire for privacy is valued in liberal democracies, as opposed to, for instance, totalitarian regimes which value surveillance and disclosure on the part of their citizens if not on their own part.

At the extreme, if we are called by the law to testify in regard to a child, the therapist may have to publicly expose private information about the patient. The legal implications vary from country to country. However, according to Grossman,

> The courts have generally held that access to all relevant information is imperative for them to properly function. Any embarrassment or harm to the individual resulting from disclosure was considered to be outweighed by society's need for unrestrained judicial inquiry. (1978, as cited in Kessler, 1993)

Therapists have to balance their obligation to codes of ethics, and to some state laws that require the protection of private information, with the obligation to reveal information under certain circumstances. Ethical standards for psychologists (American Psychological Association, 1992) state that intrusions on privacy should be minimized in written and oral reports by including only information germane to the purpose for which the communication is made.

One example of possible legal implications is demonstrated by the historic Tarasoff case. Until this case, physicians were held liable when their patients injured others due to the physician's negligence—a mistaken diagnosis, for example, or giving wrong information. With Tarasoff, for example, the courts went one step further, ruling that doctors are legally obligated to warn intended victims (Kessler, 1990). The Tarasoff case involved an international student who underwent a severe emotional crisis after the break-up with his girlfriend. He disclosed to his attending physician that he was going to kill an unnamed girl when she returned from a trip abroad. His doctor notified the campus police that the student suffered from acute and severe paranoid schizophrenic reaction, and was a danger to himself and others. The campus police took the student into custody but were satisfied that he was rational and would not harm anyone. A psychiatrist requested dismissal of the emergency detention order. When his girlfriend, Tanya Tarasoff, returned from abroad, the ex-boyfriend killed her and turned himself in to custody.

While a lower court held the campus police responsible, a 1976 decision by the California Supreme Court ruled that the therapist failed to detain his client and warn the victim's family of the danger. The psychiatrist who canceled the emergency detention was also accused. The court's ruling set the standard that to prevent liability, therapists need only to exercise a reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances (Buckner & Fillmore, 2000, p. 192-196). In regard to confidentiality, the court stated that "the protective privilege ends where the public peril begins" (p. 196).

How should the school art therapist deal with the legal implications when an adolescent with behavior problems rages about a wish to kill his teacher? Although an experienced professional can usually assess if this is an actual intention or a legitimate expression of anger in the context of therapy, it is questionable if he or she can always know it with certainty (Buckner & Fillmore, 2000, p. 196-198). Should the therapist warn the teacher "just in case," and

thus help avoid endangerment and provide legal cover at the price of sabotaging the therapy? Buckner and Fillmore (2000) state that the risk is lowered if the therapist views potential violent behavior as a therapeutic issue, and therefore helps the patient process the feelings, plans and results were the violence to be acted upon. They further claim that patients accept therapists' legal and ethical obligations to society. The cornerstone of psychotherapy is therefore trust and not absolute confidentiality.

Documentation of School Art Therapy

Treatment records pose another prevailing hazard to the ethical conduct of the art therapists in schools. School art therapists often raise questions in regard to the content, exposure and ownership of the records. The documentation of treatment is of great importance for the therapist's follow-up, for the transfer of information to other treatment frameworks and even for the legal system.

Moon (2000) suggests that the art therapy progress notes should include: identifying information on the patient; the session date and duration; a description of what the patient did during the session, the art materials used and the images created; a summary of things the patient said; specific quotes from the session if relevant; a reference to the current treatment goals and actions the art therapist took in addressing them; and a brief summary of the session.

A therapist in the Untied States also has to bear in mind that the federal Freedom of Information Act entitles parents to request and review materials in a child's record (Agell & Goodman, 1995). Blase (2000) states that the therapist must maintain ethical boundaries ensuring that the needs of the child patient are served. Hass and Malouf (2002) suggest that therapists should consider potential audiences when deciding what should be included in records. They differentiate cases where the information is a resource either for the therapist or for other clinicians. Additionally, patients may need referrals to other clinicians for various reasons and, furthermore, may return to therapy in the future. In these cases good records will help future treatment planning.

Child art therapy patients or their parents may wish to review the chart. Hass and Malouf (2002) suggest that notes be worded in such a way that the therapist would not be troubled if family members were to read them. Finally, the legal system may require reviewing the records in cases of malpractice, criminal actions, or civil actions like divorce or a custody suit. For malpractice suits it is important that the records show the therapist was responsible for devising a treatment plan (Hass & Malouf, 2002) and assessing for suicide risk, potential for violence, and any medical component. The authors also remind therapists that once something is included in the chart it becomes archival and may be assigned more importance than it merits. Therefore, the therapist must be careful when writing speculations and clearly show that they are not facts (Hass & Malouf, 2002, p. 122-125).

The art therapist in a school is faced with a dilemma: On one hand, responsible professional conduct requires elaborate notes for the therapist's use and for future treatment. They will also be useful in the case of a malpractice suit. On the other hand, the records may be exposed to the child's parents, the educational staff and others who are not trained clinicians. If the therapist bears the audience in mind, he or she may tend to be very brief in writing progress reports.

Including Artwork in Treatment Records

Moon (2000) is satisfied with a description rather than placing actual artwork in the patient records. However, even many written pages do not encompass what may be gleaned from viewing a picture. Art therapists debate whether artwork should be included in the records, with some choosing to include photographs of the artwork. Artwork should not automatically be included; according to Hammond and Gantt (1998), some artwork, which may reveal primitive emotions, could violate the patient's right to privacy. Lowental (1974) states that patients assume the therapist will keep confidential all contents "from harmless childhood memories and 'innocent' dreams to the most bizarre sexual or aggressive contents of his psychic experiences" (1974, p. 235). Because artwork often expresses such contents, the therapist must be prudent when deciding whether to share it even with those who are part of the treatment staff. Spaniol (1994) suggests that, like the verbal therapist who does not present recordings of the sessions but rather paraphrases sessions, the art therapist describe artwork verbally.

Hammond and Gantt (1998), in contrast, believe that sometimes showing a particular artwork to the treatment team may be vital to make the art therapist's point more convincing. But they strongly suggest that not all the artwork be included in the records. The main criteria in deciding what should be included are the audience and the exposure. However, it is very helpful for the therapist to maintain records (and not just a verbal description) of the imagery throughout therapy either by keeping all the artwork for the duration of treatment, by photographing it, or by sketching a facsimile of it. Keeping is necessary because it is unlikely that the therapist will have perfect recall of all relevant themes and issues. Images, forms and shapes may recur, change and develop over time in the course of therapy and it is important to keep track of such processes.

The AATA ethical standards as well as insurance companies require that art therapists keep treatment records for at least seven years. Physical conditions usually do not allow therapists in schools to store all the artwork over such a duration. Both for seven-year recordkeeping and to allow patients to take some artwork home with them while keeping full records of the work, some therapists keep photographs of the artwork. Photos also fit more easily into a file.

Hammond and Gantt (1998) warn therapists who photograph patient artwork that doing so could violate confidentiality. The artwork created in therapy differs from art made in art classes that is intended for public display. This is especially true in schools, where the educational staff, which is not clinically trained, may have access to the

records. Does photographing a patient's artwork require informed consent? Hammond and Gantt believe it does. The patient's awareness of the fact that his or her work is being photographed may impact the therapeutic relationship. Whereas some patients feel it gives recognition and respect for their work, others may feel like guinea pigs in the therapist's follow-up procedures.

Ownership of Artwork

Spaniol (1994) describes three common approaches to the question of who owns the artwork: Some claim that artwork belongs to the treatment facility, others believe that it belongs to the treatment staff. A third approach is that artwork belongs to the person who made it, as is the case with artists. Agell and Goodman (1995) speculate that the fact that patients who know the artwork will be kept by the therapist may produce "poor" artwork in the sessions. Spaniol (1994) states that releases are one-sided, albeit well-intended documents that protect the art therapist without offering any control to the patient. She recommends negotiating the conditions of artwork use with the patients, writing a two-sided contract, and even selecting with patients the artwork they consent to have shown at staff meetings.

The question of ownership of artwork is even more complicated in group work. Haeseler (1992) keeps her groups' mural artwork, which contains much personal material, unless all group members provide written permission to give it away. She informs group members that she keeps the murals for a while and then destroys them to protect confidentiality.

At a forum for supervisors of school art therapists (Tel Aviv, Nov. 2001), the supervisors tried to concur on the matter of ownership in order to make recommendations to the school board. While some therapists insist that artwork is part of the therapy and giving it to patients is inappropriate, others strongly believe that art belongs to its creator. Therapists' approaches to this matter depend on their orientation and the way they view the place of artwork in art therapy. In any case, therapists are ethically required to clearly inform patients about the eventual fate of their artwork before, and not after, it is created.

Displaying Artwork

Hammond and Gantt (1998) point out that while art created for therapeutic purposes is not created for an audience, in some facilities such as adult day programs and rehabilitation centers in which a trained art therapist conducts an art program without emphasizing a psychotherapeutic approach, participants may benefit from a public display of their work. However, the authors stress that in setting up any display the goal must be carefully thought out and diagnostic or personal information must be omitted. The art should be selected for its aesthetic qualities. According to AATA, "under no circumstance may any student's products of art therapy be displayed without the written consent of the student's parent(s) or legal guardian(s). Consent must be in the form of specific use of the product, date, place and purpose of the display (2003, p. 14).

What about the child's consent? Moreover, it is valid to ask who benefits from patients' art shows; do such shows support the patient's recovery or the art therapist's employment? This author strongly recommends avoiding any display of artwork from therapy sessions in order to maintain clear boundaries between the discreet, non-judgmental therapy atmosphere and the achievement-oriented school environment.

System Needs versus Patient Needs

Many of the school art therapist's ethical dilemmas have to do with the following question: Do we fully protect the needs of our patients or should we make compromises to comply with the school's expectations and demands? For example, the school principal is often concerned with "reaching" as many students as possible. Therapists are frequently asked to take students in groups or to provide short-term individual therapy. But in many cases the students referred to therapy in school are those with long-lasting difficulties requiring extensive individual therapy.

Hass and Malouf (2002) discuss the question of loyalty to the patient versus loyalty to one's organization. They note that the code of ethics in psychology demands that when in conflict, the therapist should "clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, seek to resolve the conflict in a way that permits the fullest adherence" (Hass & Malouf, 2002, p. 98). The National Association of Social Workers Ethical Code holds that their practitioners should not allow an employer's policies, procedures, or administrative orders to interfere with the ethical practice of their profession. They should take reasonable steps to ensure that such practices are consistent with their professional code of ethics (1999, as cited in Hass & Malouf, 2002, p. 99).

When a conflict arises in regard to therapy, (for example, if an organization allots six therapy sessions for a particular child but the clinician determines that the patient needs long-term therapy), Hass and Malouf (2002) stress that, despite the therapist's obligation to promote the patient's welfare, he or she should not openly disagree with policy in a way that will harm the organization and may also be counter-therapeutic for the patient. They advocate handling the situation "to the extent feasible"; seeking to resolve the conflict, take "reasonable steps" and use diplomacy. Sometimes the therapist must take a stand and insist on his or her ethical standards, even if this necessitates some debate with the system.

Conclusion

The AATA Ethical Standards for Art Therapists state that art therapists shall advance the welfare of all patients, respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately. This paper raises the question of

what is a reasonable effort in a school setting. This author believes that despite the inherent pitfalls, it is nonetheless ethically possible to conduct art therapy in schools and protect the patient's privacy and confidentiality.

Schools and educational systems differ from the clinical settings for which most art therapy students have been prepared. In order to work responsibly in schools, art therapists must educate themselves specifically for this challenging setting. Agell and Goodman (1995) state that therapists should only do what they have been trained to do. Rubin (1992) contends that even "natural clinicians" have a responsibility to develop as much skill as they can. This author would go as far as to claim it is unethical for art therapists to work in a school without proper preparation. Part of a school art therapist's preparation should be awareness of the job's ethical aspects and dilemmas, such as those raised in this paper, despite the impossibility of easy, unequivocal answers.

Moriya (2000) calls for art therapists in schools to adopt well-thought-out, orderly and systematic work procedures. Nevertheless, as discussed in this paper, one cannot emphasize enough how imperative it is for art therapists to step back once in a while to check if the solutions and compromises they developed in order to integrate into the school environment obey their own professional, ethical standards.

References

American Art Therapy Association. (2003). *Art therapy in the schools resource packet for school art therapists.* Retrieved May 14, 2003, from http://www.arttherapy.org/resources/arttherapy intheschools.pdf

Agell, G., & Goodman, R. (1995). The professional relationship: Ethics. *American Journal of Art Therapy, 33*(4), 99-110.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. Retrieved on May 13, 2006 from *APA Online:* http://www.apa.org/ethics/code2002.html.

Blase, C. (2000). Candace Blase—South Africa. *American Journal of Art Therapy, 39*(1), 15-23.

Buckner, F. (2000). Where the public peril begins: 25 years after Tarasoff. *Journal of Legal Medicine 21*(2), 187-223.

Corey, G., Corey M., & Callahan, P. (1994). *Issues and ethics in the helping professions.* Belmont, CA: Brooks/Cole.

Essex, M., Frostig, K., & Hertz, J. (1996). In the service of children: Art and expressive therapies in public schools. *Art Therapy: Journal of the American Art Therapy Association, 13*(3), 23-27.

Haeseler, M. (1992). Ethical considerations for the group therapist. *American Journal of Art Therapy, 31*(1), 2-9.

Hammond, L., & Gantt, L. (1998). Using art in counseling: Ethical considerations. *Journal of Counseling & Development, 76*(3), 271-277.

Hass, L. J., & Malouf, J. L. (Eds.). (2002). *Keeping up the good work: A practitioner's guide to mental health ethics.* Sarasota, FL: Professional Resource Press.

Kessler, M. (1993). Privacy, right of source. *American Journal of Art Therapy, 31*(4), 106-109.

Lowental, U. (1974). The vicissitudes of discretion in psychotherapy. *American Journal of Psychotherapy, 28,* 235-242.

Moon, B. (2000). *Ethical issues in art therapy.* Springfield, IL: Charles C Thomas.

Moriya, D. (2000). *Art therapy in schools: Effective integration of art therapists in schools.* Ramat HaSharon, Israel: www.art-therapy.co.il.

Rubin, J. (1994). Commencement address at Vermont College of Norwich University. *American Journal of Art Therapy, 33*(3), 66-69.

Spaniol, S. (1994). Confidentiality reexamined: Negotiating use of art by clients. *American Journal of Art Therapy, 32*(3), 69-75.

Vandgrover, H. (1998). Dancing together, at a different pace with the same partner: Teachers and art therapists in schools. *Special Issues in Special Education and Rehabilitation, 13*(2), 22-31.