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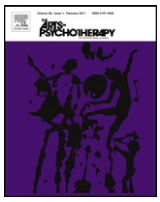

Highlights

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Conceptualizing international art therapy education standards

Jordan S. Potash PhD, ATR-BC, LCAT*, Heidi Bardot MA, ATR-BC, Rainbow T.H. Ho PhD, DMT-BC

► We review existing art therapy education standards. ► We propose standards that can serve to guide developing art therapy programs around the world. ► We offer four lenses (health, art, therapy, education) to ensure that international standards are country specific and culturally relevant. ► We offer Hong Kong and India as an example.

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The Arts in Psychotherapy

Conceptualizing international art therapy education standards☆

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ABSTRACT

Art therapy programs developing around the world need an educational framework to ensure that graduates have a knowledge base and set of skills consistent with peers in other countries. Currently there are many independent education standards offered by art therapy associations in the United Kingdom, United States, Canada, Australia and New Zealand, as well as, two international associations. Synthesizing these requirements reveals 12 content areas that may constitute the core of art therapy education. Even within these standards, programs developing around the world need to consider local values related to health, art, therapy and education in order to establish globally relevant and locally meaningful art therapy training programs—Hong Kong and India are offered as examples of how to adapt education standards to cultural expectations.

Art therapy education has taken on different forms throughout history and in various parts of the world. Early art therapist pioneers in the 1960s such as Adrian Hill, Edith Kramer, and many other artists, therapists, and art teachers discovered through experience the benefit of offering art materials to those in need of emotional healing and psychological growth (Hogan, 2001; Rubin, 1999). They were self taught, bringing together their previous experiences and skill sets for a new purpose. As others learned of their work, they began offering trainings where professionals would gather to discuss this new way of combining the arts and therapy. As art therapy evolved from a discovery to a profession, the training became more standardized. To ensure that those who call themselves art therapists had a common foundation, workshops became formal programs often hosted at universities and accredited by national organizations.

This progression that has been documented in the United Kingdom and the United States has also been noticed throughout the world. In Thailand, for example, Somjit Kraisiri has been working with mentally ill and mentally challenged individuals for over 20 years and calls herself an art therapist. She has no formal training in art therapy nor has she read any art therapy books. Reflecting on her art practice, Kraisiri discovered ways of working and in the process developed theories that resonate with those of Hill and Kramer. For some with excellent intuitive skills to enhance the healing aspects of art and with no access to training there are no other options. However, she now trains others to work alongside her.

Even though there are independent examples of individuals using art for therapy and healing around the globe, interconnectivity and globalization demand that we carefully examine our terminology. Training programs around the world have a common need to respond to the challenge of how to provide knowledge in a way that is accessible, adheres to professional standards, and promotes the field. Given that there is a profession called art therapy, practitioners need to be sensitive to what it means to call themselves art therapists or to call their practice art therapy. At this point in history, when the term art therapy is used, it is branded with an expectation of a certain educational background, theoretical paradigm, and ethical stance. For that reason, formal trainings and education standards are more than a way to consolidate knowledge and ensure its appropriate distribution; it is a way to mark oneself as a profession.

We were prompted to write this article when trying to conceptualize what format art therapy education should take in Hong Kong and India. In the United States, United Kingdom, Canada, Australia and New Zealand, educators can rely on the educational standards set by their national professional associations. In this process we asked ourselves many questions that perhaps others struggle with,

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as well. In parts of the world where there are no national associations or the ones that exist have not developed such standards, what course topics should be offered? Should we be beholden to standards set by associations beyond our borders? How do we integrate local cultural values?

A challenge to the global education of art therapists is to define standards to determine minimally expected content areas of knowledge. In addition to the standards, there is a need to create a curriculum that functions within these standards, but that is culturally applicable and relevant. In this paper, we define what seems to be an educational standard in art therapy and our recommendations for how to ensure its adoption in a manner that is culturally relevant. To illustrate our ideas, we offer case examples in Hong Kong and India.

Standards for art therapy education

Perhaps a necessary starting place is to identify the necessity of an art therapy education standard. Lusebrink (1989) condensed the essential components of art therapy education into "(a) the methods and skills of counseling and psychotherapy, and (b) the applications of the creative arts in the different aspects of therapy" (p. 6). Within this broad conceptualization, Levick (1989) was concerned how the lack of a standardized approach to art therapy education would produce graduates with an inconsistent "sound basis" of what it means to be an art therapist (p. 59). This inconsistency can be problematic within a profession, as professionals may not be able to assume that others by the same name have the same knowledge, but it may also impact the perception of a field. In researching such perceptions of art therapy in Korea, Park and Hong (2010) found that the profession could gain more credibility if, among other factors, it had a unified curriculum.

Review of current educational standards

Currently, there are four art therapy organizations—British Association of Art Therapists (BAAT), American Art Therapy Association (AATA), Canadian Art Therapy Association (CATA) and Australia/New Zealand Arts Therapy Association (ANZATA)—that provide either accreditation or recommendations for what should be included in an art therapy training program. Graduates from programs that follow these standards are guaranteed to meet the educational requirements for registration as art therapists in these countries. Additionally, the International Expressive Arts Therapy Association (IEATA) and European Consortium for Arts Therapies Education (ECArTE) also detail educational standards that are more generally applicable than only visual art therapy. These two associations do not accredit programs or guarantee professional registration. The commonalities among these standards provide some guidance for what constitutes the core of art therapy education. The results are summarized in Table 1.

The reviewed standards place a great deal of importance in combining theoretical, experiential (class activities) and practical (internships) learning in art therapy. There is a strong emphasis on ensuring that students learn art therapy specific skills, while also gaining training in the more general areas of psychotherapy and counseling. On this point, AATA (2007), CATA (2009) and IEATA (2008–2011) specifically make distinctions between courses that are central to art therapy and those that are more generally related to mental health. These associations therefore allow non-art therapists to teach these courses. While there seems to be general consensus on what constitutes areas related to general mental health, ANZATA (2009) does not specify coursework in human development or psychopathology, but these two areas are implied in the description of "Applied Clinical Theory." Although most of the standards stipulate studio art requirements within the educational curriculum, BAAT (2009) does not. However, students seeking art therapy education in the United Kingdom are expected to have a strong arts foundation prior to entering the program, which is similar to required prerequisites as specified by other associations.

Most of the standards mandate that programs should be part of a postgraduate training in order to qualify as an art therapist (or a Registered Expressive Arts Therapist in the case of IEATA, which accepts a masters in art therapy to meet its educational requirements). BAAT and ANZATA require masters degrees, whereas CATA allows for both masters degrees and post-graduate diplomas, although the expected curriculum content and program duration are the same. As of current the two degrees are seen as equals; however, some employers and regulatory bodies display a preference for a masters degree (Esther Zeller, personal communication, 19 July 2011). AATA and IEATA allow for a post-masters training option to qualify as an art therapist for those students who already have a masters degree in a related field (such as counseling, social work, psychology, and in some cases special education or fine arts in the case of IEATA). For AATA the training must be part of a degree program, whereas for IEATA it can be a series of courses and workshops. In the case of AATA, the guidelines are also structured to ensure that students meet the minimum qualification to be an art therapist, but also possibly obtain licensure in a related health profession, such as counseling or marriage and family therapy. ECArTE (n.d.) allows for either postgraduate or a 4-year undergraduate program as the terminal degree.

There are some differences that are interesting to note. Of all the associations, AATA has the most specific guidelines on course content and also the broadest range of applications (including areas such as family therapy and career counseling). It also includes the greatest number of course requirements. While BAAT has educational standards, the art therapy training programs in the United Kingdom are regulated by the Health Professions Council (HPC) (2009), which is a regulatory body responsible for registering a number of professions including physical therapists, occupational therapists, psychologists, speech therapists, and others. As a result, BAAT provides suggested course content, although since they do not accredit programs, they are only recommendations (Val Huet, personal communication, 2 September 2010). Of the four national associations, ANZATA is the only one to recognize the range of creative and expressive art forms.

Specific educational foci

In addition to the specified standards, there are three areas in particular that have been the focus of art therapy educators, which deserve to be addressed. The first one relates to professional identity. All of the standards place importance on ensuring a strong professional identity as an art therapist through mandating coursework on history and specifying who is qualified to teach. To this end, BAAT, CATA and ECArTE stipulate standards to ensure that graduates receive degrees which identify them as art (or arts) therapists, as opposed to another mental health profession with a specialization in art therapy. In the United Kingdom in particular, the HPC includes a provision on professional identity.

For AATA and IEATA, the matter of professional identity is more complex. Under these guidelines, art therapists may have to navigate the boundaries of several professional identities. Given both AATA's and IEATA's allowance of degrees that do not specifically reference art therapy and also to post-masters training, some practitioners may either view their art therapy as a modality or as only part of their identity that has to be reconciled with another

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Table 1
Comparison of art therapy education standards ("X" indicates art therapy curriculum requirement, "O" indicates related area requirement).

	BAAT	AATA	CATA	ANZATA	IEATA	ECArTE
Courses						
• Applications (populations and settings)	X	X	X	X	X	
• Assessment	X	X/O	X			
• Ethics	X	X	X	X	O	
• Family		X				
• Group Dynamics	X	X	X	X	X	
• History	X	X	X	X		
• Human development	X	O	O		O	
• Multicultural	X	X/O	X	X		
• Process (skills)	X	X	O	X	X	
• Professional practice	X	X	X	X		
• Psycho- pathology	X	O	O		O	
• Research	X	O	O			
• Studio		O	O	X	X	X
• Theory	X	X	X	X	X/O	X
Final project	Culminating clinical report	Culminating project	Thesis or major project	Dissertation	Not specified	Not specified
Practicum	Mandatory, but unspecified	900 h (masters) 700 h (post masters)	700 h	750 h	Mental health masters: 200 h Arts masters: 500 h	Required
Supervision	Mandatory, but unspecified	1:10 h individual (on-site) and 1.5:10 h group (at program) 1:8 persons in group	2:10 h (individual, group or combination)	1:10 h individual (on-site) and 1.5:10 hours group (at program)	Mental health masters: 25 h individual or 50 h group Arts masters: 50 h individual or 100 h group	Required
Terminal degree	Masters	Masters or post-masters	Masters or graduate diploma	Masters	Masters or post-masters	Postgraduate or bachelors
Length of program	2 years full-time (or equivalent)	2 years full-time (or equivalent)	2 years full-time (or equivalent)	2 years full-time (or equivalent)	100 h in specific content areas for post-masters	Not specified for postgraduate, but minimum of 4 years for other
Personal therapy	Required	Not required	Recommended	Recommended	Required	Not specified
Teacher requirements	Registered art therapists	Registered art therapists (for art therapy courses)	Registered art therapists (for art therapy courses)	Registered arts therapists supplemented by others	Registered art or expressive arts therapists	Not specified

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one (Dulicai, Hays, & Nolan, 1989; Lachman-Chapin, 2000). Sympathetic to the need to allow this duality, Moon (2003) emphatically states the need for programs to train students in a unique discipline that emphasizes both art and therapy without limiting training to a superficial understanding of either.

The second focus is on multiculturalism. Educators have demonstrated the importance of helping students to become aware of their own worldviews and biases to ensure the development of therapeutic relationships across cultural differences (George, Greene, & Blackwell, 2005). At the same time, they advocate for developing cultural competence in a range of theories and practices to ensure an ability to work with a diverse range of clients (Calisch, 2003; Hocoy, 2002).

The third focus is on research. Many art therapists have written about how limited research in art therapy affects its standing (Kaplan, 1998; Reynolds, Nabors, & Quinlan, 2000; Slayton, D'Archer, & Kaplan, 2010). The lack of evidenced-based research has also been an obstacle to the profession's credibility around the globe. Even though art therapists can point to the long-standing practice of art therapy, administrators and government officials often require scientific research to demonstrate efficacy that supports the claimed benefits of art therapy.

Framework for international art therapy education standards

Based on this review, existing education standards can be synthesized into a framework of what would generally be acceptable as a secure educational base by several associations (Table 2). There are 12 core areas that cover the major areas of agreement between the reviewed art therapy educational standards. These areas alone meet the minimum educational requirements of BAAT, CATA, and ANZATA, as well as, by IEATA and ECArTE. All of these areas are also required by AATA; however, the organization also specifies other courses that must be included in a program of study. While these areas are the minimum areas of agreement, educators may consider additional courses to allow for specialization in specific content areas.

It is important to note that while all of these areas are required, they do not necessarily need to be addressed in specific courses, but can be combined or integrated. For example, many of the standards cite multiculturalism, but not necessarily as its own course. Doby-Copeland (2006) makes the case that multiculturalism can be taught either on its own or infused into other courses. Since AATA is the only association to specify a number of study hours for each content area, educators may be free to design training programs as they see fit, so long, as these 12 core areas are addressed. However, the associations reviewed here stipulate minimum numbers that should be considered in designing the length of the program and duration of the courses.

In addition to academic courses, students must also engage in practicum experience and supervision. Although a culminating project or thesis is not universally required, four of the six associations do require one. While there is a great diversity in what form the project should take, we agree with Johnson's (1989) suggestion for a research based project, but Lusebrink's (1989) recommendations for it to be infused with personal reflection. In this way, students gain personal benefit while contributing to an overall body of knowledge that will inform the local area and expand global knowledge. Lastly, four out of the six associations either recommend or require students to participate in personal art therapy to allow for self-development, experiential understanding of being a client, and self-awareness in those areas that could affect therapeutic relationships. Although we are not in a position to mandate that all art therapy training programs follow these standards, we see them as providing a secure foundation in becoming an art therapist.

Challenges in curriculum design

The 12 core areas represent educational standards that dictate the structure of an art therapy training program, but there is still a need to determine the specific curriculum content in each area. While the standards may be universal, the actual teaching content is specific to educators' and students' philosophy, culture, and residence.

One choice in meeting the standards involves choosing specific theories and practices, whether psychoanalytic or humanistic, clinical or studio, for example. As part of art therapy being a respected profession, Levick (2009) commands that among other factors, we need "to teach our students the principles put forth by our pioneers" (p. 139). In contrast, Riley (1996) writes that we must remain cognizant of the need for various theories and approaches as they pertain to different settings and populations. These two positions reveal a necessary tension in how to transmit education to students that is both rooted in the origin of the profession, but adaptable for changing times and circumstances.

Another choice is one based on cultural values. Many art therapists have written on the prevalence of ethnocentrism in art therapy education given embedded and unchallenged values related to Western discourse, rhetoric and practice (Hocoy, 2002; Lewis, 1997; Talwar, 2010; Talwar, Iyer, & Doby-Copeland, 2004). In adopting educational standards for structural continuity across programs, we need to be careful that we do not impose theories and practices that are alien to students and the clients they will ultimately serve in their cultural context. This point is particularly true for programs developing outside of the Western world, but whose faculty were trained in the west or solely exposed to Western art therapy resources.

Additionally, we need to consider country specific necessities and requirements in terms of program length and particularly the terminal degree. Although a masters degree is or is becoming the norm among allied health professions in Western countries, some places allow for practitioners at the bachelors or diploma levels. As has been noted in a creative art therapy training program in Nicaragua, demanding a masters degree would make receiving education difficult, if not impossible (Kapitan, Litell, & Torres, 2011). While the reviewed educational standards strive towards a post-graduate education—and a masters degree specifically—this choice should be determined by country specific expectations. No matter what form the education takes, educators can still base their curriculum on the proposed areas.

Lastly, while we looked for a compromise among the existing standards, all of them were largely created by associations based in or influenced by Western art therapy practice. We should consider the implications and assumptions entailed in asking countries around the world to adopt these Western standards and expectations. In importing the standards and structure, we should remain aware that we do not also import theories and practices that are inconsistent with the host culture. In order to assure that training programs remain true to their cultural and country contexts we now consider a strategy to meet this aim.

Applying international educational standards in specific countries

Several art therapists have commented on the difficulty and ethics of standardizing art therapy training programs across international borders due to diverse expectations within individual countries for what constitutes as art and what qualifies as therapy (Arrington, 2005; Kalmanowitz & Potash, 2010; Stoll, 2005). In order to ensure acceptance for art therapy in various places, the international standards for education we proposed can only serve

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Table 2
Proposed international educational standards.

Components	Topics	Description
Courses	History	Global and local history of art therapy with specific references to various professional influences
	Theory	Defining essential theories within a culturally sensitive model
	Studio	Experience with creative process and spontaneous art making with a range of materials and art forms
	Human development	Expectations of clients at different ages in terms of emotional development and art making potential
	Research	Qualitative, quantitative and arts-based methods of research
	Assessment	Making culturally-competent appraisals of clients to determine appropriate art therapy goals
	Individual process	Conducting individual art therapy, knowing the stages of art therapy, and interpretation skills
	Group process	Facilitating group dynamics, how group members influence and affect each other
	Applications	Offering art therapy in a range of settings and with diverse groups of client populations
	Multiculturalism	Helping students become aware of their biases and worldviews, learning skills to work with clients from diverse social and cultural backgrounds
	Diagnosis	Distinguishing among categories of illness based on symptoms, behaviors, and art indicators
	Ethics and professional practice	Identifying professional standards, relevant laws, ethical decision-making
Practicum	500–750 h	Clinical, educational or community settings with regular supervision – including direct contact hours and general practicum requirements (consultations, meetings, note taking) 1 h individual supervision:10 h practicum (on-site) and 1.5 h group supervision:10 h practicum (at program)
Final project or thesis	Research-focus	Integration of personal experience and case report with strong research backing

as a general framework. The actual curriculum content will have to be adapted according to local values. We propose filtering the standards through four specific lenses.

Country specific ideas of health

Western health is largely based in and influenced by the mainstream medical model with an emphasis on the self, duality conceptions of the body-mind, and focused on specifics without attention to the whole. Several other parts of the world adopt a more holistic framework of health that looks at the overall system, embraces suffering, and focuses on spiritual and emotional healing over physical curing (Armstrong et al., 2011; Lee, Ng, Leung, & Chan, 2009; Moodley & West, 2005). In deciding on specific theories and practices, educators will need to honor the dominant health beliefs in the country.

Country specific conceptions of Art

Dissanayake (1995) demonstrated that often the arts accompany rituals, meaning-making, and community development. Particularly in the West, the arts have become increasingly distanced from community ritual and more focused on art and art therapy as individual and personal expression. Around the world, art may also serve to beautify an environment or express community concerns (Moon, 2010). Still others may engage art making as a form of meditation and spiritual connection (Bonan, 1995). In some countries, the creation of art is striving for perfection and the resultant art must look beautiful rather than be emotionally expressive. Further, art may not be artificially divided into specialties, but may be integrated into the combined arts. Given local traditions on how the arts are used in health, there may need to be an expanded focus to provide exposure and comfort with the range of art forms, rather than limit a program to only visual art (Lusebrink, 1989).

Country specific expectations of therapy

Closely connected, but still separate from conceptions of health, are country and cultural conceptions of what constitutes therapy and who practices it. Although in the West therapy may be limited to conversation and psychopharmacology, in other parts of the world it may involve meditation, exercise, prayers, and prevention (Hwang & Chang, 2009; Kar, 2008) and may be utilized by a variety of practitioners. Of importance in these considerations is the role that stigma plays in providing and accessing different types of therapy or helping services. This point can guide practitioners in how they conceptualize and offer services, as well as, in guiding their theoretical constructs. In terms of qualifications, educators will need to carefully review the expectation for a terminal degree whether in the form of a higher education degree or a series of trainings and workshops. For a training to be both accessible and marketable, the program of study will have to mirror the expected timeframe and costs of like programs in related fields.

Country specific style of education

Simultaneous to ensuring that the curriculum content is culturally appropriate and regionally specific, the educational philosophy and delivery also needs to match. Art therapy programs frequently emphasize experiential learning and group discussion. These methods of education reflect a bias towards individualism in that they rely on personal experience, as opposed to emphasizing collectivist ideas (Watkins & Biggs, 2001). For example, while reliance on memorization has become an over generalized stereotype in Asian education, there are studies to demonstrate how it serves as an effective pathway to understanding, particularly for mastering core theoretical concepts (Marton, Dall'Alba, & Tse, 1996). Still, experiential learning is becoming an expectation throughout Asia, but educators point out simply importing Western experiential strategies may be ineffective and ill advised (Kennedy, 2002). Educators need to be attuned to how to introduce the concepts behind experiential learning, while being mindful of expectations for didactic learning.

Example art therapy education in two countries

All countries have to find the appropriate type of art therapy training for them. We will now turn to the development of art therapy in both Hong Kong and India, two places in which the development of art therapy education is being actively discussed, to provide examples for how to adapt the proposed international educational standards given local culture and values.

Brief overview of art therapy education in Hong Kong and India

Over the past 20 years Hong Kong has had artists engaged in healing, therapists who use the arts and art therapists (Potash, 2010). Currently, there are three trainings that relate to art therapy. Since 1997, Hong Kong University School of Professional and Continuing Education has offered a certificate course in Foundations of

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Art Therapy. In 2005, the Hong Kong Association of Art Therapists taught Art Facilitation to train healthcare, education, and community professionals to incorporate art in their work. The training includes a 6-month period of supervision following the didactic and experiential learning. Natalie Roger's Person-Centered Expressive Arts Therapy training began in 2011 with practicum and supervision components, which will meet the educational requirements as either a Registered Expressive Arts Therapist or Registered Expressive Arts Consultant/Educator through IEATA. This one is the first in Hong Kong to provide an education that matches others around the world. In addition to these formal trainings, there are also workshops, short course trainings and elective courses in counseling and social work programs provided by local and visiting art therapists.

Art therapy has also been in India for approximately 20 years; however, the field remains in the initial stages though the need, interest, and potential are great. There are no formal art therapy education programs at this time and trainings have consisted of workshops and short certificate programs offered by Indian and Western art therapists. Therefore, Indian art therapists are trained in other countries and then some return to start programs or offer workshops. Many have the intention of returning permanently to India but for a variety of reasons never do. This has left India with no art therapy association, leadership, or connections between those interested in art therapy, essential aspects of growing the field. Recently, The George Washington University from Washington, DC and the Prasad Family Foundation have conducted workshops, month-long trainings and summer abroad programs to introduce art therapy to a variety of organizations in Chennai, southern India. Additionally, as of 2012, there are two short-term expressive arts certificate programs offered, one in central India, Pune (Art Becomes Therapy), and the other in Chennai (East West Counseling Expressive Arts Therapy); both are run by non-art therapists. The programs offer drama, storytelling, art, drumming, movement, and counseling skills and ethics specific to southeast Asia.

Although all of these trainings provide invaluable education in skills and techniques, their curricula are largely individually determined by the educators, rather then adhering to a common standard or organized in a cohesive manner to build upon previous coursework and knowledge offered. As a result, they give an inconsistent message as to what training and foundational knowledge is necessary to be considered an art therapist, leading to confusion among practitioners, employers and the public.

Applying the four filters

As art therapy training in Hong Kong and India develops and evolves, we can consider how to build a program that incorporates international educational standards, but is mindful of local values. By adopting the proposed standards and filters, students would receive a culturally relevant education within a more unified and consistent structure. Applying the four filters to these very different countries reveals the following.

Health

Hong Kong is a truly international city due to over 150 years of colonial influence from the British and its current place as a world financial city. Ideas of health mirror this history. There are many doctors trained in Western style medicine, but also many practitioners of Traditional Chinese Medicine. As a result, many Hong Kong Chinese people may seek out both Western doctors and Traditional Chinese Medicine practitioners, depending on the particular problem (Lam, 2001) and both kinds of services are accessible through the Hospital Authority, a government regulatory body.

Similarly, India has a strong foundation of traditional healing, Ayurvedic Medicine, a belief that health is related to the connectedness of the body, mind and spirit. Though there is subsidized health care, many do not seek any form of treatment due to extensive and pervasive poverty. There are huge variations in health care services, from the best possible care for those who can afford to pay (India has become a medical tourism site) to basic, essential medical services lacking for those who are poor and/or living in rural communities and unable to access services (Reddy et al., 2011). Additionally, there is an integral family involvement in health care. Much of the day to day care (feeding, bathing, washing) in hospitals, cancer centers, and clinics is provided by family members who deliver around the clock care.

Art

As a city focused on finance, Hong Kong is not generally know for arts appreciation. There are relatively few museums and few opportunities to pursue formal fine arts education. However, there are a growing number of contemporary art galleries, recent government investment in a proposed new art museum and cultural district, as well as, increased public support for the arts (Ng, 2011). In addition, there are engaged community artists and a rich tradition of Chinese traditional arts in painting, music, and dance that focus on form, expression, and wellness. Many people have some level of training and experience with them.

India is a country with a long artistic heritage influenced by many cultures and primarily focused on their religious beliefs—in Southern India chalk designs (known as rangoli or kolams) are drawn each morning on the threshold of many homes to protect and bless its inhabitants, and there are numerous shrines and temples almost on every corner adorned with plaster, stone and bronze statues and colorful designs. Many children are introduced to art in school; however, it widely ranges between an art curriculum and merely being introduced to craft projects (Prasad, 2008).

Therapy

According to traditional Chinese values, it is considered improper to discuss negative or painful emotions, especially with someone outside of the family (So, 2005). There is also a degree of stigma attached to mental illness (Lam et al., 2010). In addition, in the Traditional Chinese Medicine, emotional concerns are generally understood and treated somatically through herbs, body manipulation and exercise (such as qigong). The profession of social work is approximately 60 years old and psychology has been in Hong Kong for about 30 years, but there is only a government registration process for social workers. This credential is granted on the basis of a bachelor's degree, although many practitioners obtain a masters degree to work clinically. As for other mental health professions, there is no legal definition or criteria for who is considered a mental health therapist, counselor or psychologist resulting in a wide spectrum of individuals using the terms "therapist" or "counselor" in an unregulated manner. As a way to offer some semblance of qualification, local mental health associations often check the credentials of those who wish to be full members; however joining these associations is optional. The Hong Kong Association of Art Therapists maintains a list of Full Members, who have completed a masters degree in art therapy in another country.

Mental health illness still has much stigma and dishonor attached to it in India. Most mental illnesses are unrecognized and inadequately treated, especially in rural populations and poorer communities (Armstrong et al., 2011; Carson, Jain, & Ramirez, 2009; Reddy et al., 2011). Ninety percent of people with mental disorders do not receive even basic mental health care and often patients are "co-morbid with communicable and non-communicable diseases" (Armstrong et al., 2011, p. 1). There is still a strong belief that mental illness is connected to evil spirits or curses and it has been found that this belief in supernatural causes of mental illness is not associated with a certain age, gender, or level of education of a person (Carson et al., 2009; Kar, 2008). Therefore many people turn to the

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temples and shrines for faith healing rather than seeking professional help, finding it supportive, reassuring, and more acceptable in their communities. Therefore, sensitivity to these belief systems is important to remember (Kar, 2008). Many patients seek both medical and faith healing simultaneously. Masters and doctoral level clinical psychologists can receive a national registration number from the Rehabilitation Council of India (RCI), but licensing is not given or required for clinical psychology, counseling psychology or social work (Carson et al., 2009).

Education

For many years undergraduate education was completed in three years, in accordance with the British model. Recently it changed to the four-year system in order to provide a broader base of knowledge with the inclusion of a common core or liberal arts aspect. With the exception of the master of social work degree, many masters in mental health are offered as one year full-time or two-year part-time programs. Generally, this amount of time allows for 10–12 courses of 36 h each. Typically courses are taught in a lecture format, but there is a growing use of experiential learning. Many programs related to mental health focus on cognitive-behavioral therapy and involve practicum work, although with various requirements for placement hours. Some require dissertations, but sometimes this requirement can be substituted for additional coursework. Additionally, a program that results in an international qualification is seen as desirable and of a higher standard.

In India social work training has been available for over 70 years and is based on the Western model of the two-year masters of social work with specialization in a variety of areas (i.e., social service administration, labor welfare) and practicum work or field training. This has brought about the division between theory and practice as many of the Western theories taught are not practical in the actual work in the community (Ejaz, 1991). There are also short term graduate certificates in family therapy and rehabilitation counseling, specializing in community-based services. In recent years, counselors, therapists, and psychologists have been trained mostly within a cognitive-behavioral framework and a broader array of training and perspectives is needed (Carson et al., 2009).

Implications for international art therapy education

From this information, a formal art therapy education that adopts the proposed standards will require modifications to make it acceptable in each country. Due to an overlap between the areas covered by the four lenses in both Hong Kong and India, these two regions have similar considerations for art therapy education. The curriculum content will need to mirror dual health systems with an emphasis on the holistic and preventative aspects of art therapy, while still providing the necessary assessment and therapy skills and honoring cultural beliefs and traditions. The dual health systems will need to be emphasized in all areas, but especially such areas as theory, assessment and diagnosis. While adherence to the dual systems is important, educators in each region will have to pay particular attention to the unique features of either Traditional Chinese Medicine or Ayurvedic philosophies as well as other religious or belief systems and to what extent these practices are followed by potential clients.

In order to honor the traditional arts in both Hong Kong and India, an art therapy program will need to take into consideration the spiritual and health applications of the arts, not simply the expressive or arts for art's sake dimensions. In India specifically, the close connection between the traditional arts and spirituality may provide a way in which to position art therapy within an overall healing intervention. Given the overlap and integration of many art forms, a program may need to include exposure to music, dance, drama and poetry. Even in this scenario, we must recognize that there are separate fields of therapy in all of these areas. Given limited fine arts education and the application of the arts for creative and expressive process, the studio course may take on heightened importance, as students may not have the expected studio art prerequisites required in other countries.

Given that the dominant model of psychotherapy in these two countries is based in a cognitive-behavioral framework, educators may have to adapt their theories and practices. However, knowing the tradition of body-based preventative and healing treatments may serve as a useful entry point for introducing art therapy. Topics such as individual and group process and applications will need to include engaging with clients who do not readily discuss feelings, but also make use of art for expression and relaxation. Family work should be emphasized in coursework as often the family or community are essential participants in the caretaking and treatment of patients. It may be possible to support the families by helping combat the stigma of mental health treatment by focusing on how art is associated with the traditional health systems.

In terms of training type and duration, although 500–750 h of practicum, 12 taught courses, culminating project and two years full-time or three years part-time are quite extensive for a postgraduate or masters programs in Hong Kong and India, it is close to the requirements for a master of social work offered in both regions and is therefore reasonable for a professional training. Since a program with this structure could qualify graduates to receive an international credential through IEATA and possibly CATA and ANZATA, they may be willing to undertake the requirements of this program. However, in both countries it is essential to first receive training in a foundational field (i.e., social work, education, nursing) before pursuing additional training. Therefore the financial and time commitments of a masters in art therapy may not be fully feasible, especially since it is possible to practice in some fields with only a bachelors level education. Still other related fields are adopting or have adopted a masters degree expectation, which implies that art therapy may have to move in that direction, as well.

Although this analysis details the process to determine how to create a masters level equivalent program specific to two countries, we offer it as a case study for educators in other countries who have similar goals. Hong Kong and India's seeming readiness for a masters degree should not be taken as the expectation for programs developing in other parts of the world. We want to reiterate that a formal degree is not necessarily desirable or necessary in all parts of the world. Whether as a degree or an otherwise structured training, it is quite possible to ensure an educational program that adheres to international educational standards, while still honoring and infusing local values without displacing either.

Conclusion

Although it may be impractical, unenforceable and culturally insensitive to demand one international standard for art therapy education, arriving at common ideas as to what should be included in art therapy training are important for the profession to grow on a global scale. In order to ensure world-wide sustainable art therapy training programs, we will need to find the careful balance between globalization of standards and the unique value of local traditions. A truly international standard cannot simply be a Western one imposed on the rest of the world, but rather one that has input from many different cultures. Given that the currently available standards are from the west, educators will need to reconsider the standards proposed in this article as art therapy takes shape across borders. It is important, however, for developing programs to examine existing programs and standards so that their graduates receive a comparable education. By learning from art therapy programs around the world, understanding the challenges

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to designing new programs and developing the profession, we can enhance the overall quality of art therapy education, which will ultimately benefit clients and professionals in every country.

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