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Competencies in arts therapies: A rating of importance, training and performance by practitioners and referring professionals in Switzerland

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Abstract

This survey was conducted in developing a final specialized examination for all arts therapists in Switzerland by the Council of Swiss Arts Therapy Associations (CSATA). Forty-eight generic key competencies (GKC) were sent to all 1235 arts therapists in five different disciplines in Switzerland (response 47.5%) and to 384 referring professionals and employers (RPE) listed by therapists (response 42%). The mean importance of GKC was rated high (4 points of 5) by practitioners and RPE. Different opinions on importance of GKC in disciplines included artistic ability and psychotherapeutic relative to medical orientation. The training of competencies was rated lower by practitioners (3.48 points) and different in the eight competence categories and five disciplines. Areas of weak training were identified. The performance of GKC was rated by referring professionals equally to its importance (mean +0.3 points) and showed a good understanding of competencies by RPE. Judging of performance was difficult for RPE in more than 20% of items. The results provide criteria for detailed outcome assessments and the advancement of a final examination for arts therapists in Switzerland.

Keywords: Arts therapy; Evaluation; Competencies; Training; Job-performance

Introduction and background

Creative arts therapies of various disciplines, including painting, sculpture, dance and movement, speech, drama, poetry, music and more recent techniques, like photography and video, are used widely in many settings of the health care systems in western and eastern countries (Naitove, 1981; Stoll, 2005). But the general acceptance of these disciplines, awareness of their competencies and professionalization vary considerably among disciplines and in different countries (Stoll, 2005). Referring health professionals and employers often find it difficult to conceptualize and classify indications for arts therapy (AT). A lack of definitions and standards regarding arts therapies has been criticized (Kunzmann, Aldridge, Gruber, Hamberger & Wichelhaus, 2005). This lack may be influenced by some arts therapists who feel that clearly defined standards contradict the holistic, individualistic and creative approach of arts therapy to health issues.

Nevertheless, if arts therapies are to survive in a field of increasing legal demands in health care systems, it is imperative that they further identify quality criteria, performance targets and competencies (Kunzmann et al., 2005; Olbrich, 2004).

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This situation applies to Switzerland, where no legally recognized titles and registration standards for arts therapists exist yet. Nine different associations represent the various disciplines and methods, and training ranges from post-graduate studies at universities for applied sciences to different institutes.

In this situation, the umbrella organisation of Swiss associations of arts therapists, the Council of Swiss Arts Therapy Associations (CSATA), aims at establishing a higher specialized examination for arts therapists and is appointed by the Swiss Federal Office for Professional Education and Technology (OPET) to develop this examination. This will lead to a recognized diploma at a tertiary level in Switzerland. The examination will focus on generic competencies and accept students of all arts therapy disciplines after completing a set of defined discipline-based competence modules in recognized arts therapy training and practise.

The generic competencies of Swiss arts therapists have been described recently in a job outline presented by the council and developed in conjunction with tutors of relevant Swiss arts therapy institutes (Berufsbild, 2004). This definition thus reflects a consensus of experts, but the opinion of Swiss arts therapy practitioners and of referring health professionals and employers has not been evaluated so far.

Evaluations of competencies in arts therapies have only been carried out sparsely. Two surveys in music therapy investigated the role and current functions of music therapists (Lathom, 1982) and required entry-level competencies (Taylor, 1987). These surveys aimed at answering questions similar to ours, but concentrated on one discipline only. A survey of generic competencies encompassing several AT disciplines has, to our knowledge, not been performed. In other allied health professions similar surveys focus on outcome assessments (e.g., Matuscak, 1983).

Richter and Ruebling (2003) proposed a model for developing outcome assessment surveys for allied health educational programs, which is suitable for arts therapies in many parts. However, valid outcome assessments have to be conducted at a discipline-based program level and are less meaningful at an interdisciplinary level.

This study represents one of the steps in developing a final examination for all arts therapists in Switzerland. It seemed vital to identify generic key competencies in all disciplines on which the main associations and disciplines involved agree, and to examine the opinions of referring professionals on these competencies. Furthermore, we wanted to collect initial informations about training and performance of the GKC.

We therefore performed a first survey among arts therapists who were members of one of the associations, and a second survey among referring health professionals, comprising the identical competencies. This report includes both surveys.

Arts therapies are represented in Switzerland (CSATA) in the following disciplines, of which each might consist of different methods: (1) art therapy, (2) artistic speech and drama therapy, (3) dance and movement therapy, (4) intermedial therapy (working with various artistic media) and (5) music therapy. Because the music therapy association has not joined the KSKV and dance and drama therapy are only starting to develop in Switzerland (Dulicai & Berger, 2005), those disciplines are not represented.

Our research questions were:

- How are the GKC rated by arts therapists?
- Are there differences in ratings among arts therapy disciplines?
- How are the GKC rated by referring professionals?
- Are the ratings of competencies associated by practitioners and by referring professionals?
- How are the GKC taught in arts therapy trainings, as rated by arts therapists?
- How are GKC performed by therapists, as assessed by referring professionals?

Methods

Study design and sampling

Arts therapies in Switzerland are multi-disciplined and at different stages of professional development. Trainings of therapists range from those with a master's and bachelor's degree to the majority with diploma to institutes, which emphasize applicable knowledge and skills rather than a scientific approach. The CSATA was founded in 2002 and therefore demographic information about the population of CSATA arts therapists, referring professionals and employers (RPE) was not yet available. The study was carried out in the winter and summer of 2004/2005 with two questionnaires, one for arts therapists and one for RPE (Fig. 1).

To get as many addresses of RPE as possible, all 1235 arts therapists in nine Swiss arts therapy associations were contacted. The mailing included a cover letter, the questionnaire number 1, a sheet for addresses of referring health professionals and two stamped envelopes, one for the questionnaire and one for the address sheet that also served as a response control. This procedure guaranteed anonymity. After 4 weeks, a follow-up mailing was sent to non-responders.

For access to the names and addresses of referring professionals and employers we used a sampling method suggested by Phillippi and Banta (1994), which we altered slightly. Enclosed with the questionnaire, the arts therapists received an address sheet asking them for permission to interview one to three referring health professionals or employers with whom they work.

The employers and referring professionals were sent a cover letter, the questionnaire number 2 and a copy of the signed permission of the therapist, as well as a stamped envelope and a postcard for response control. The assessment of more than one therapist (with another questionnaire) was permitted. After 4 weeks, a follow-up mailing containing all items was sent out.

Survey instruments

After a review of discipline-specific competence standards, 48 generic competencies from the following eight categories were selected and the survey items composed:

> *Artistic competence* (*AC*), *personal and professional growth* (*PPR*), *client-oriented competence* (*COC*), *professional skills and attitudes* (*PSA*), *professional knowledge* (*PK*), *medical orientation* (*MO*), *psychological orientation* (*PO*), *cooperation and representation* (*CR*).

Each of the eight categories was addressed with at least three items. The questionnaire number 1 for therapists consisted of two vertical columns with 48 competence statements each (see Appendix A). On the left (1a), practitioners were asked to rate the competence on a 5-point Likert scale from 5 (*very important*) to 1 (*not important*). The statements on the right (1b) always corresponded to the competence on the left and addressed the teaching of the competence in the training such as: *My arts therapy education prepared me well for performing this skill*. The training had to be rated on a similar scale. All rating scales offered the option not to answer.

Demographic questions were placed after the questionnaire and included discipline, membership in an association, gender, age, employment, income, referrals, patients a week, working experience and clients (Table 1).

Questionnaire number 2 for referring professionals and employers was designed similarly. The left-hand column (2a) contained the statements of questionnaire 1 regarding the importance of a competence. In the right-hand column (2b), the RPE were asked to assess the competence of one therapist they work with. At the end of the questionnaire, demographic information about the referring person was asked and questions about cooperation with the therapist: setting, contact time per week and situations in which they observed the professional behaviour of the therapist (Table 2).

The two questionnaires were pilot tested with 30 AT practitioners and RPE and revised accordingly.

Data analysis

Data were analyzed using SPSS (Statistical Packages for Social Sciences Version 13) for Windows. Descriptive statistics were applied to obtain frequencies, cell and cumulative percentages for each item in the two parts of each questionnaire. Means, medians, standard deviations (S.D.), standard errors (S.E.), and confidence intervals were calculated for importance, training and performance across all competencies in both groups (therapists and RPE) as well as for

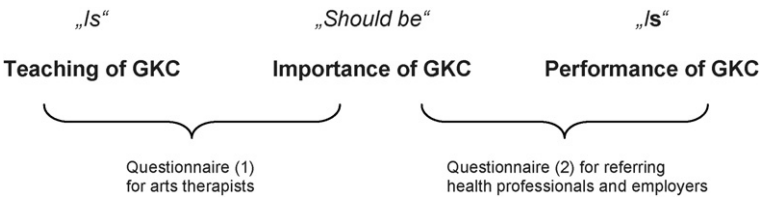

Fig. 1. Use of the two questionnaires for comparing the importance of GKC with its teaching and performance.

disciplines. The Kendall's tau (a non-parametric correlation coefficient) was used to estimate the association between importance and training of each competence (therapists) and importance and performance (RPE). To assess differences among disciplines with regard to rating of importance, training and performance, we used the Kruskal–Wallis test. A factor analysis was performed with part (a and b) in each of the two questionnaires.

Results

Arts therapists

Mean response was 47.5% (587 of 1235 therapists in nine associations), ranging from 30 to 70%. The distribution of age showed a strong majority being over 40 years old.

In Table 1 the category *disciplines* only shows therapy methods represented by more than 2% in our sample. The methods less frequently used, e.g., music therapy, are summarized in the category *other*. Almost half of the arts therapists in Switzerland are self-employed and 70% work with clients who referred themselves. On the other hand, the opinion of many Swiss arts therapists that colleagues work almost independent of the medical health care system is complemented by the fact that more than half of the therapists reported referrals by MD. The distribution of income shows that for many therapists arts therapy is not the only source of income.

Referring professionals and employers

Out of 384 referring professionals and employers listed by therapists, 162 returned a valid questionnaire (42%). Because some of the RPE cooperate with more than one arts therapist, the figures in Table 2 represent the percentages according to questionnaires (see Section Discussion).

The cooperation of RPE with arts therapists was characterized by long-term work relationships, with RPE only occasionally observing the arts therapist at work.

Table 1
Demographic characteristics of arts therapists[*]

Sex	Female, 88	Male, 12			
Age	<40 years, 13	41–50 years, 44	>51 years, 43		
Disciplines	Art therapy, 50	Speech/drama, 12	Dance/movement, 14	Intermedial, 6	Other, 18
Employment	Full time, 7	Combined, 28	Self-employed, 47		n.a., 18
Referrals by[**]	MD, 56	Institution, 49	Clients, 71		
Reimbursement	Clients, 40	Private insurance, 30	Institutions, 30		
Income (CHF), arts therapy only	<10,000.–, 31	10–29,000.–, 28	30–49,000.–, 22	50–69,000.–, 13	>70,000.–, 6

Note: Numbers represent percentages of therapists.
[*] $n = 587$.
[**] Multiple answers allowed.

Table 2
Demographic characteristics of referring professionals[*]

Sex	Female, 42	Male, 58			
Profession	MD, 56	Psychologist, 12	Other, 32		
Work in[**]	Acute care, 10	Psychiatric care, 22	Long-term care, 10	Remedial educ., 22	Private practice, 46
Relation to AT	Supervisor, 10	Employer, 26	Free cooperation, 64		
Cooperate with	Art therapy, 57	Dance/movement therapy, 17	Speech/drama therapy, 7	Others/missing, 19	
Duration of cooperation	<1 year, 5	<2 years, 15	2–5 years, 33	>5 years, 47	
Observation of therapist in[**]	Hospitation, 14	Case conference, 8	Function as employer, 12	Other, 82	
Intensity of observation	Selective, 71	<25% of week, 18	25–50% of week, 7	>50% of week, 4	

Note: Numbers represent percentages of referring professionals.
[*] $n = 384$.
[**] Multiple answers allowed.

Factor analysis for questionnaires 1 and 2

The Kaiser–Meyer–Olkin measure for both questionnaires ranged from 0.75 to 0.91. For questionnaire 1, eight factors were identified, which explained 45% (1a) and 53% (1b) of the total variance. Some categories of the questionnaires were reflected strongly in factors such as artistic competence and medical versus psychotherapeutic orientation. The Cronbach's alphas for questionnaire 1 (1a and 1b) ranged from 0.66 to 0.89 for all factors exept one (0.41), which might be described as sufficient since the questionnaires were designed to evaluate a spectrum of competencies rather than to test constructs.

In questionnaire 2 for RPE six factors were identified, explaining 0.46% (2a) and 0.49% (2b) of the total variance. An interesting factor (2b–3) got loadings both from items emphasizing artistic competence and competence in somatic medicine, which indicates that the same RPE who rated artistic competence to be high also considered competence in somatic medicine well performed (and the converse). The Cronbach's alphas in questionnaire 2 (2a and 2b) ranged from 0.69 to 0.91 for all factors.

In clarifying associations among items the factor analysis will be used for reevaluation of items and competence categories. A subsequent analysis will be based on the structures found and dealt with elsewhere.

Rating of competencies by arts therapists

The rating of importance of the 48 arts therapists competencies by practitioners (mean rating 4.07, S.D. 0.36) was high (Fig. 2).

If ranked according to importance, the mean rating of 75% of the competencies exceeded 3.6 points. Only two competence statements were rated less than 3 points: *Bases his therapeutic treatment on arts therapy diagnoses only* and *A basic knowledge of somatic medicine is more important for art therapists than knowledge of psychology/psychopathology* (see Fig. 3). Both positions represent extremes in different ways. The first statement describes an arts therapist not paying attention to medical opinions and the second statement contradicts the psychotherapeutic orientation of many arts therapy disciplines.

Twelve statements showed differences in opinion among disciplines of more than 1 point (Kruskal–Wallis test $p < 0.00001$). These included items in the categories of artistic ability, somatic and psychological orientation and items regarding the independence of referring health professionals.

Whereas all disciplines agreed that arts therapists should have artistic ability at least in one art (rating more than 4 points), only artistic speech/drama therapy and dance/movement therapy supported the stronger statement: *The arts therapist is a trained artist* (mean rating over 4 points). Mean rating of this item in art therapy – the largest group of therapists – was much lower (2.75 points).

In somatic relative to psychological orientation, the disciplines of intermedial therapy and dance/movement represented the extreme positions. The former strongly supported the statement: *Is mainly competent to treat psychological*

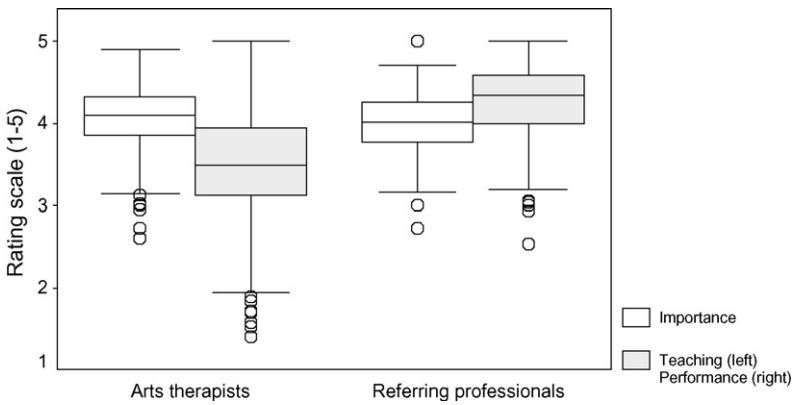

Fig. 2. Mean ratings of importance and teaching of competencies by arts therapists (left) and mean ratings of importance and performance by referring professionals/employers (right). Therapists, $n = 587$, referring professionals/employers, $n = 162$.

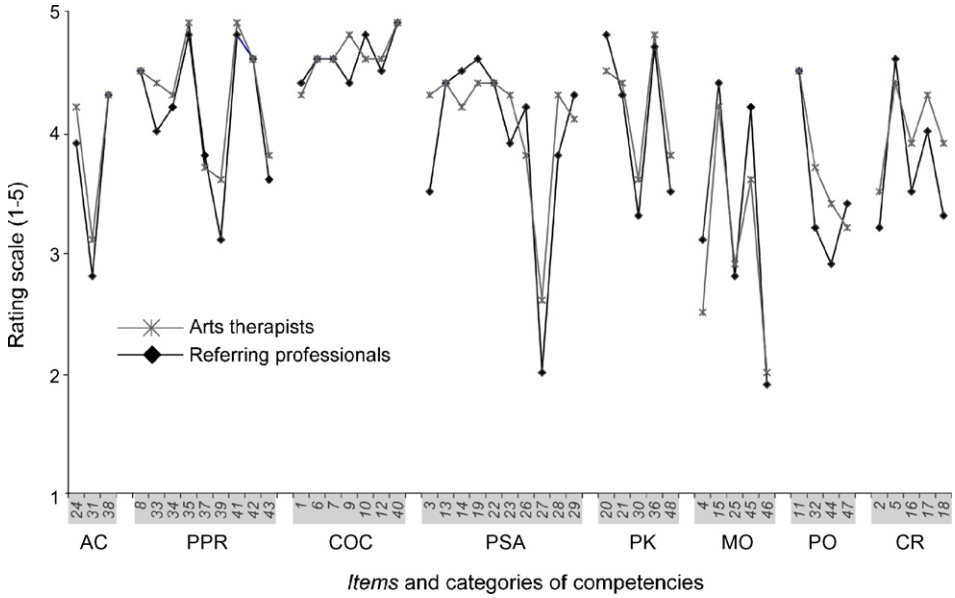

Fig. 3. Comparison of importance ratings by referring professionals/employers and by arts therapists in the eight competence categories. *Abbreviations*: (AC) artistic competence; (PPR) personal and professional growth; (COC) client-oriented competence; (PSA) professional skills and attitudes; (PK) professional knowledge; (MO) medical orientation; (PO) psychological orientation; (CR) cooperation and representation.

disorders (average rating over 4 points), whereas the latter only rated this competence 2.5 points. The same holds for this item: *For arts therapists a basic knowledge of psychology/psychopathology is more important than knowledge of somatic medicine* (average rating 3.8 versus 2).

The judgement of *Should work under supervision of a doctor only* points in the opposite direction. This statement was rejected by intermedial and art therapy (average rating 1.9 and 2.1) and supported by dance/movement therapy (average rating 4.2) showing the somatic orientation of the best represented method (eurythmy therapy) of this discipline in Switzerland. Correspondingly, *Is able to treat patients independent of referring professionals* was rated lower by dance/movement therapy (average rating 3.5) and higher (over 4) by the other disciplines.

Rating of competencies by referring health professionals and its association with arts therapists ratings

Besides the opinion of therapists on generic competencies in AT, we assessed the view of referring professionals and employers in direct cooperation with AT on the same competencies. As Fig. 2 shows, the overall ratings of importance of competencies by RPE were at the level of the ratings of therapists (mean rating 3.99, S.D. 0.35).

To assess the association among opinions of RPE and practitioners, the Kendall's tau correlation was calculated across all disciplines (0.74) and for each discipline (dance/movement therapy 0.71, intermedial therapy 0.53, art therapy 0.71, and speech/drama therapy 0.57). The vicinity of practitioners and RPE's ratings is visualized for all items in Fig. 3, which shows the average ratings in the eight competence categories.

In the following paragraph we describe the rating of selected items by RPE and by therapists. Not surprisingly the statement *Is able to treat patients independent of referring professionals* was rated lower (−0.8 points) by RPE than by therapists and the opposite statement *Should work under the supervision of a doctor only* was rated higher (0.6 points). Another difference in opinion concerns *Competence is in the treatment of psychological and somatic disorders*, a statement, which was supported stronger by RPE than by therapists (4.2 points versus 3.6 points). Concerning disciplines this competence was given a rating of 4–5 points by more than 80% of RPE regarding dance/movement and speech/drama therapy and still by 62% regarding art therapy. This finding complements the perception prevalent in Switzerland of arts therapy comprising solely psychotherapeutic methods.

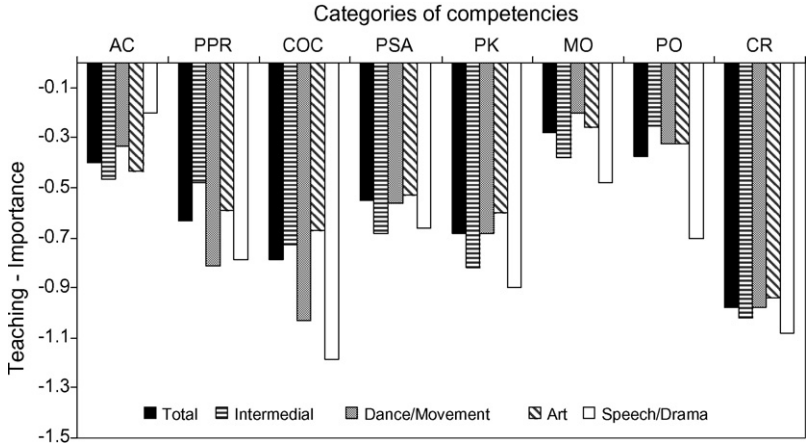

Fig. 4. Differences between the teaching of competence categories and its importance (1b–1a) as rated by arts therapists in four disciplines. Abbreviations as in Fig. 3 caption.

Teaching of competencies in arts therapy trainings

Therapists rated the teaching of competencies in all disciplines lower than its importance (see Fig. 2; mean rating 3.48 points, S.D. 0.60). The correlation of importance and teaching of a competence was moderate to low for all items (less than 0.46).

Fig. 4 shows the differences between the ratings of training quality in competence categories and its importance. The most consistent shortcomings in training across all disciplines concerned the items cooperation and representation with an emphasis on representation.

Among those 17 items rated very important (average 4–5 points) three were rated poorly prepared in the training by all disciplines. (1) *Knows the limits of his/her health*. (2) *Compares the results of the therapy with the objectives set at the beginning*. (3) *Is aware of and can deal with psychological/psychosomatic repercussions of his/her work with clients*.

Performance of competencies

The average performance of therapists was rated by RPE 0.3 points above the importance of the competencies (mean rating 4.27, S.D. 0.47). And the moderate to low correlation (all items less than 0.47) between importance and performance indicated a differentiated judgement of the performance by RPE.

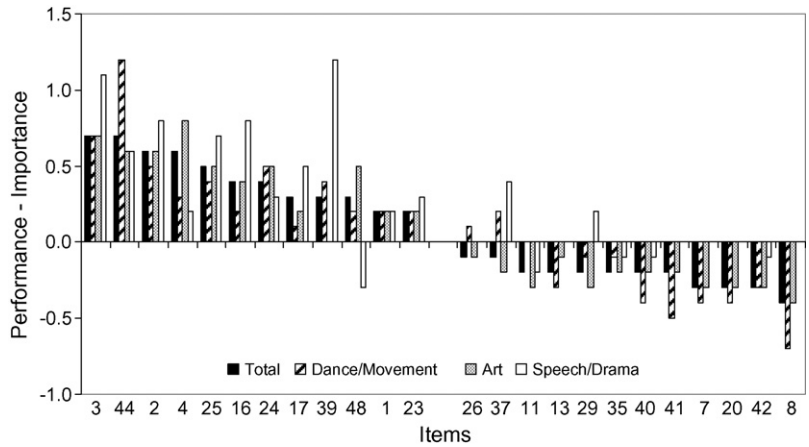

Fig. 5. Differences between the performance of competencies by arts therapists and its importance as assessed by referring professionals/employers (2b–2a). The figure shows those competencies with the most positive (left) and those with the most negative (right) differences.

Fig. 5 shows the differences in ratings between performance and importance for the top and the bottom 12 items (see Appendix A for items). Of the other items, performance and importance were rated as equal.

The ability to treat clients independent of RPE is rated higher in performance than in importance, as well as willingness to assume responsibility in the organisation, ability to represent the profession in public, availability of artistic skills in one art and understanding of Latin medical terms. This competence was addressed insufficiently in many trainings (65% 1–2 points), which indicates that therapists acquire these skills in practice.

Items rated less well performed than their importance by RPE included the awareness of therapists about the limits of their own health and of repercussions of patients on their health. Practitioners criticized the same items regarding training efficiency. Furthermore, the ability to handle conflicts as well as the knowledge of indications and contraindications of ones method received a moderately negative assessment by RPE too.

Due to the small number of therapists assessed, intermediate therapy was excluded from a detailed analysis in questionnaire 2, as well as those 11 items rated "I don't know" by more than 25% of referring professionals. The relatively high number of such items in 2b is a consequence of the decision to use the same competence items for therapists and for RPE, making it difficult for RPE to rate the performance of some of the competencies.

Discussion and conclusion

The survey presented is one of several steps in developing a specialized examination for arts therapists in Switzerland. Our aim was to assess the opinion of therapists and RPE on the importance of competencies presented by the umbrella association of Swiss arts therapists, CSATA. Another intention was to get first information with regard to training and performance of these competencies. The survey included all relevant Swiss arts therapy associations except the association of music therapists, which has not joined the CSATA.

To assess the return rate we compared our data with that of two surveys on functions and competencies of music therapists in the USA (Lathom, 1982; Taylor, 1987). Their studies addressed populations of a similar size (1200 and 1900 members of the NAMT); return rates were 41 and 34%. Our response rate of 48% thus seems reasonable.

It has been reported that responders, as compared with non-responders, have a higher educational and occupational status, more interest in the subject matter and have a better relation to the examiner (Binder, Sieber & Angst, 1979). These characteristics might apply to our sample too, thus limiting the generalizability of the results. However, since this study is one step in the process of preparing a future certification examination, the opinion of therapists with a stronger interest in professional matters could be regarded as more relevant. Those therapists will be more likely to accept the strain of a future post-graduate examination than are non-responders.

Because many AT practitioners in Switzerland are self-employed and many do not work frequently with referrals, we expected the number of referring professionals to be small. This we tried to counterbalance (a) by contacting all practitioners and (b) by using a survey method known to get as much response as possible without using a "broadside approach" (Phillippi & Banta, 1994).

A limitation of the method used is the fact that the opinion of those RPE working with several therapists is overrepresented, because RPE had to complete one questionnaire for each therapist assessed (22% of responding RPE work with more than one therapist). Secondly, since in theory three assessments of performance could be assigned to one therapist, the performance of this one practitioner may be overrated.

What has to be mentioned as well is the fact that the opinion of referring professionals associated with therapists who did not give permission to interview those RPE may differ from the opinion of those who did. We thus recommend further individual and group interviews with RPE to complete our findings. Nevertheless, the method applied to get in touch with the population of those RPE linked with arts therapists seemed to be the most feasible in the situation given.

The strong association in ratings of importance by practitioners and by RPE indicates a good understanding of arts therapy by the respondents, and supports our decision to use the same set of competence items both for therapists and referring professionals. Whether this understanding entails more, e.g., a knowledge of indications for different AT methods, remains to be shown.

In Germany, a representative survey in psychosomatic rehabilitation clinics reported the presence of arts therapies in most of these institutions (the use of different methods ranging from 73 to 34%). Clinic directors rated its importance high (8.9 of 10 points). On the other hand, reimbursement was inhomogeneous and far from satisfactory (Olbrich, 2004). In Switzerland a non-representative survey by one of the AT-associations (Fähndrich Campiche, 1997) in 43 psychiatric clinics (response 49%) found arts therapists of different levels of qualification working in 76% of these

institutes. The relation between one bed and the employment percentages assigned to therapy staff ranged from 1 to 9% for all those potentially working with the arts (art therapy, occupational therapy, activation therapy). Many arts therapists were employed as occupational therapists because there is no clear profile for arts therapies in Switzerland.

The typical Swiss arts therapist in our study is female, fully self-employed (47%) or part-time employed; only a few work in clinics. This does not mean that cooperation with referring professional is not taking place, since 56% of all practitioners reported referrals by MD.

There is a clear distinction between more medicine-oriented disciplines and methods (dance/movement therapy and speech/drama therapy) and psychotherapy-oriented methods (intermedial therapy and art therapy). This methodological orientation is associated with a different emphasis on artistic skills, and has to be considered in the further development of modules and a final examination.

An area of concern of both RPE and therapists was the awareness of therapists about the limits of their own health and of repercussions of patients conditions on their own health, thus making it necessary to give more importance to this significant issue in the training and further education of therapists. Nevertheless, more than 60% of Swiss arts therapists have been working for more than 5 years and the amount of RPE cooperating with a therapist for this length of time is nearly 50%.

All in all the performance of Swiss therapists seems to be better than the credit they give their training. This is not surprising, considering that most respondents were not new to the job. It has been reported (Phillippi & Banta, 1994) that employers tend to rate most employee attributes as important and most employees performance as good or very good, concluding that employer surveys show little variance. We cannot confirm this for our sample of referring professionals and employers. The assessment of competencies by RPE proved to be as differentiated as by practitioners. On the other hand, the performance assessment did not show overoptimistic ratings by RPE. This suggests a true gain in competence on the job after training and a need to continue improving competencies in certain areas.

Our method of evaluating the same set of generic key competencies with therapists and RPE proved meaningful for assessing both the importance and the teaching of competencies. The assessment of the performance of arts therapists by RPE with the same set of competencies resulted in many items that were difficult to answer for RPE. Therefore, outcome assessment surveys in the individual AT disciplines in Switzerland are recommended.

The future qualifying examination for arts therapists in Switzerland requires to develop guidelines for competence modules by the CSATA in accordance with the OPET. This includes defining generic competencies and identifying final assessment tasks for the examination.

Following this, the individual arts therapy institutes will be able to adapt their present curricula to the requirements of the competencies defined. This process should be accompanied by research on quality criteria and on performance targets.

Acknowledgements

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Appendix A. Appendix A

Competence statements (translated from German) in the questionnaires for arts therapists (1a) and for referring professionals/employers (2a)

Item	Statement
1	Is able to perceive the client/patient in his/her social background
2	Assumes responsibilities in the organisation
3	Is able to treat client/patients independent of referring professionals
4	Should work under the supervision of a doctor only
5	Coordinates his/her work in institutions with the team
6	Has learned to deal with power in the therapeutic relationship consciously
7	Has learned to handle conflicts
8	Knows the limits of his/her health

Appendix A (*Continued*)

Item	Statement
9	Makes clear agreements with client/patient about the financial aspect of the therapy
10	Treats client/patients confidently because he/she knows his/her therapy method well
11	Is familiar with the concept of projection and counter-projection
12	Supports the client/patient in integrating therapeutic experiences into his/her everyday life
13	Has clear therapeutic objectives
14	Is familiar with drawing up method-specific case histories and making diagnoses in his/her discipline
15	Is able to translate a medical diagnosis into correct AT treatment
16	Is able to represent his/her profession in the public (in lectures, in the press)
17	Is able to talk or write about his/her work to professional colleagues
18	Is able to write an article about professional subjects
19	Compares the results of the therapy with the objectives set at the beginning
20	Knows the indication and contraindication of his/her therapeutic measures
21	Is familiar with therapeutic counselling
22	Applies means and methods purposefully in accord with his/her AT diagnoses
23	Applies means and methods intuitively in the moment
24	Has developed artistic skills in at least one field of arts
25	Can understand Latin medical terms, such as otitis media, hysterectomy, dysthymia, etc.
26	Bases his/her therapeutic treatment on AT and medical/psychopathological diagnoses
27	Bases his/her therapeutic treatment on AT diagnoses only
28	Takes notes of every therapy session
29	Documents treatment on conclusion of every therapy
30	Is familiar with the foundations of history of his/her specific art
31	Is a trained artist
32	Has undergone psychotherapy him-/herself
33	Has gone through a learning process in AT of >100 h to work on their own weaknesses and deficits
34	Is in continual professional supervision/intervision
35	Is aware of the limits of his/her competence and refers cases outside these limitations on
36	Is familiar with the ethical guidelines of his/her therapy method and follows them in his/her work
37	Brings his/her medical knowledge (medicine/psychopathology) regularly up to date
38	Brings his/her specific artistic skills regularly up to date
39	Regularly reads one to two professional journals
40	Knows how to keep his/her boundaries in the therapeutic relation
41	Has self-perception and self-reflection
42	Is aware of and can deal with psychological/psychosomatic repercussions of his/her work with clients
43	Constantly increases his/her repertoire of new therapeutic methods
44	Is mainly competent to treat psychological disorders
45	Competence is in the treatment of psychological and somatic disorders
46	For arts therapists a basic knowledge of somatic medicine is more important than of psychology/psychopathology
47	For arts therapists a basic knowledge of psychology/psychopathology is more important than of somatic medicine
48	For arts therapists a basic knowledge of somatic medicine and psychology/psychopathology are equally important

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