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Considerations in Art E-therapy for Anxiety Disorders

Frances J. Morris*

Florida State University, USA

***Corresponding author:** Morris FJ, MS, Florida State University, USA, Tel: 843.345.8927; E-mail: frances.johanna.morris@gmail.com

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Abstract

Brief and online versions of cognitive behavioral therapy (CBT)—the favored treatment for severe anxiety disorders—have answered critiques that traditional CBT is too inaccessible and unaffordable. The integration of art into CBT protocols may address further critiques that the concepts of CBT can be too abstract and verbal by adding tangible components. Therefore, art e-therapy may offer a unique treatment option that is more financially and cognitively accessible. In a previously reported single-subject experiment, art e-therapy combined with a CBT protocol resulted in marginally significant decreases in the self-reported general anxiety of a participant with generalized anxiety disorder. Aspects of the case relating specifically to art e-therapy are discussed, including considerations for art e-therapy best practice. Taking the reported case and related literature into account, potential costs and benefits of using this treatment modality are discussed. Although art e-therapy can involve greater risks to confidentiality and reduced clarity of the art making process than in-person art therapy, it resulted in greater participant independence and convenience in this case.

Keywords: Art therapy; E-therapy; Cognitive behavioral therapy; Anxiety disorders; Generalized anxiety disorder

Introduction

Social technologies have altered the way relationships are formed and maintained, and the practitioner-client relationship is no exception. Web portals allow medical patients access to their records—laboratory and radiology reports, visit summaries, etc.—as well as a variety of interactive experiences. Clinical messaging is one of the most frequently used services of these web portals with high satisfaction ratings, suggesting the convenience of digital communication with providers [1,2]. Mental health practitioners, including art therapists, are also pursuing digital relationships and services, such as messaging as a supplement to self-directed online therapy [3], digital recordkeeping and image archiving [4], and distance supervision [5].

Art e-therapy delivered to clients at home may be especially useful for severe anxiety disorders. Many of the qualifying symptoms of these disorders present barriers to attending sessions outside the home or in unfamiliar places [6]. Agoraphobia—the fear of situations where escape is difficult—often presents with panic disorder and can result in confinement to the home in severe cases. Social or specific phobias can similarly result in the avoidance of certain activities or situations. Finally, generalized anxiety disorder is characterized by a variety of worries focusing on multiple areas of life—professional, social, medical, etc.—and can be exacerbated by stressful situations or life events. Cognitive behavioral therapy (CBT) is the preferred treatment method for anxiety disorders [7]. However, CBT may be underutilized due to costly sessions delivered in metropolitan areas [8] and the highly verbal nature of therapy concepts and tasks [9]. Therefore, art could be an especially effective adjunct to the more convenient option of online CBT. The visual and tactile nature of art can provide a tangible component to abstract CBT concepts [1], and the independent decision-making required by art could support the self-directed nature of e-therapy in general.

Art e-therapy was combined with CBT for a client with generalized anxiety disorder [1]. The intervention resulted in marginally significant decreases in her self-reported general anxiety. After a review of related literature, I will discuss ten considerations for best art e-therapy practice based on the reported case and potential costs and benefits of this treatment modality.

Related Literature

Art therapy can provide unique routes of expression to people with anxiety and other psychological disorders. Using the process and products of art making, art therapists engage clients with different art media at a hierarchy of expression levels (Lusebrink). For example, textured materials such as clay and fiber involve a kinesthetic and sensory experience. However, materials with a greater inherent reflective distance, such as pencils or pastels, require clients to engage perceptually, cognitively, or even symbolically as they plan and execute a composition. According to the American Art Therapy Association [AATA], these tools of art therapy can meet various psychosocial goals. Clients may "explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem."

Several studies and cases have demonstrated the effectiveness of art therapy for the qualifying symptoms and/or associated features of anxiety: panic disorder with agoraphobia [1,10,11], specific phobia [12], anxiety comorbid with other severe psychological disorders [13], in college students [14], and using mandalas [15,16]. Two of these studies [1,12] combined art therapy with a CBT protocol to effectively reduce symptoms of severe anxiety disorders in case examples. DeFrancisco [12] found that drawing images related to a specific phobia, e.g. blood-injection-injury type, could help desensitize the client to that phobia and reduce avoidance behaviors. Morris [1] similarly used drawing to desensitize clients to avoided situations triggering panic in panic disorder and anxiety in generalized anxiety

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disorder. Art making also provided a concrete component to learning abstract CBT skills, such as cognitive restructuring of anxious thoughts, and art products served as a tangible record of decreased anxiety over time.

Online and in-person CBT use a combination of cognitive therapy and behavior therapy to treat these symptoms of severe anxiety disorders. According to Craske, Barlow, and Meadows [17], the most effective treatments for panic, worry, and anxiety combine a series of components, including psychoeducation, breathing retraining, cognitive restructuring, and desensitization exercises. Therapist-assisted online CBT is comparable to in-person CBT in reducing the symptoms of panic disorder with agoraphobia [18] and generalized anxiety disorder [19]. Increased presence of clinicians—i.e. through email assistance—does not necessarily improve these distance treatments. According to Klein et al. [3], the frequency of therapist email contact in online CBT did not increase effectiveness of the treatment for panic disorder with agoraphobia. Similarly, Robinson, Titov, Andrews, McIntyre, Schwencke, and Solley [19], found no significant difference between clinician-assisted and technician-assisted versions of their online CBT program for generalized anxiety disorder.

Online treatments such as these, including art e-therapy, require specific ethical considerations. The Healthcare Insurance Portability and Accountability Act [HIPAA] requires privacy and confidentiality for all medical records, transactions, and interactions, including those in the field of mental health. Telehealth Resource Center [20] advised that agencies and providers using "telemedicine" should hire technical staff independent of medical personnel to ensure confidentiality of online communications. Therapists must protect both the paper and electronic documentation from sessions, and art therapists have the additional task of protecting image files of client artwork as well as the pieces themselves. Alders et al. [4] recommended password protection and data encryption of client files, especially when using personal computers. Similarly, any live online sessions must use a program with appropriate data encryption to ensure that the audio or video feed is not accessible. The client's comfort level with technology must also be considered. Alders et al. suggested informing clients who are comfortable with the Internet and social technologies about the costs and benefits of sharing their clinical information online, including image and video files. Whereas, clients who are wary of technology should be educated about the precautions taken to ensure the privacy of their medical records and online communications [20].

With appropriate informed consent and confidentiality practices, art e-therapy using a CBT protocol should be explored as a viable treatment modality for some people with severe anxiety disorders. In an aforementioned study [1], I reported that art e-therapy—using live video sessions—resulted in marginally significant reductions in the self-reported general anxiety of a client with generalized anxiety disorder using a diary instrument [21]. The A-B study included a two-week baseline period and seven-week treatment period, during which the client rated her feelings of general anxiety on a daily basis. This case was one of two reported pilot studies; the other was conducted in-person with a participant with panic disorder with agoraphobia. In both cases, I integrated art into the sessions, homework, and client manual of a brief CBT protocol developed by Marchand et al. [7] (Table 1) based on the 21-week Panic Control Treatment [PCT] developed by Craske et al. [17]. The following case vignette from the reported study using art e-therapy for generalized anxiety disorder includes descriptions of live online sessions.

Session	Focus	Art Experientials	Homework
1	Psychoeducation	"My Anxiety Cycle"	Anxiety diary
2	Identification of Support Systems	"My Support Systems"	Anxiety diary; Complete support systems chart
3	Cognitive restructuring	Depict "unlikely" cognition	Anxiety diary; Depict more "likely" version
4	Breathing retraining	Guided imagery; response pieces	Anxiety diary; At-home practice
5	Imaginal exposure	Guided imaginal exposure; fear hierarchy; least-feared situation piece	Anxiety diary; Moderately and most-feared situation pieces; Facing least-feared situation
6	In vivo exposure	Mastery of least-feared situation piece	Anxiety diary; Facing moderately to most-feared situations and mastery pieces
7	Relapse prevention	Bridge drawing	N/A

Table 1: Brief cognitive behavioral art therapy course of treatment for GAD [1]; reproduced with permission.

Case vignette

I will discuss considerations based on the reported case that relate specifically to the use of art e-therapy for anxiety disorders (Table 2). Although the aforementioned quantitative results and a description of this case were previously published [1], the modality of live e-therapy was not discussed in detail. For a more complete discussion of how art was integrated into CBT interventions, See Morris [1]. After the case vignette, I will expand on potential costs and benefits of using art e-therapy for anxiety disorders given the related literature and examples of issues arising in the case vignette.

In-person interview

I conducted the initial interview with the case participant, Aurelia, in-person rather than over live video feed. The appropriate number of times to meet in-person depended on my first consideration for art e-therapy (C1): what are the therapist's and client's comfort levels with technology? It may be advisable to meet several times with clients who are wary of e-therapy due to a lack of familiarity with digital communication. In-person meetings may help establish a sense of trust and rapport before a more distanced relationship is begun [20].

Conversely, clients who are comfortable with technology and/or cannot come in-person due to severe anxiety or remote locations may prefer to begin meeting online.

C1	What are the therapist's and client's comfort levels with technology?
C2	What are the new parameters and boundaries?
C3	How do I protect the client's confidentiality?
C4	How do I control the client's therapeutic setting?
C5	What are the modifications for collaborative activities?
C6	Does the client conceptualize my role differently and how?
C7	How do I facilitate art review and side-by-side comparisons?
C8	How is the client's artwork stored and protected?
C9	Does assigning homework in e-therapy create a "double distance?"
C10	How do I facilitate an appropriate termination?

Table 2: Considerations for art e-therapy.

Regardless of familiarity, it is important to disclose any other persons who will be present during live e-therapy or have access to digital files to decrease ambiguity of online communications. Due to Aurelia's comfort with technology, we met only once in-person for the initial interview (C1). Her familiarity with technology also led us to a discussion of my second consideration for art e-therapy (C2): what are the new parameters and boundaries? For example, we discussed the risks of downloading her image files to her computer or posting them to a web page [4]. We also decided on a convenient day of the week and time to conduct live e-therapy, and she indicated she was comfortable with the use of email as well as phone calls to communicate between sessions, upload manuals and homework assignments, etc. (C2).

With respect to the parameters and boundaries of future art e-therapy with Aurelia (C2), it was also important to determine Aurelia's case information and diagnosis in-person. Aurelia was a 22 year-old female student at a teaching zoo college at the time of the study. I confirmed Aurelia's diagnosis of generalized anxiety disorder using the Anxiety Disorders Interview Schedule IV [22]. She indicated that she met partial criteria for Attention Deficit Hyperactivity Disorder, but that her inattention related to her anxious thinking. Although many of Aurelia's anxieties were focused on social situations, generalized anxiety disorder was a better fit than social phobia due to the variety of life areas Aurelia worried about, i.e. school, work, health, etc. This information was relevant to her e-therapy, because, due to her social anxieties, Aurelia was not a good candidate for video observation by a third party, i.e. counseling intern or student, early in therapy (C2).

During the initial interview, we also discussed the merits of different live video software programs, which brought up my third consideration for art e-therapy (C3): how do I protect the client's confidentiality? There is a range of different live video meeting software, with greater data encryption often increasing with subscription price or fees. The HIPAA compliance, i.e. confidentiality through data encryption and "business associate" agreements by the companies, of several free programs like Skype™ has not been confirmed [23]. Other free and purchasable programs, however, such as VSee, claim to be HIPAA compliant [23]. Software that claims to be HIPAA compliant is preferable, but any option should be thoroughly researched by the therapist and all potential risks should be explained to the client. Therapists' personal emails should not be used for communication between e-therapy sessions. Their email should also not be accessed on personal laptops; the encrypted network of an agency or private practice using an at-work computer is preferable (C3). Alders et al. [4] discussed the likelihood that personal laptops may be stolen or lost, and therefore should not be used to store client information if possible.

Live E-therapy sessions

The following six out of seven remaining sessions were scheduled for live e-therapy, which is distinct from online therapy where therapists email clients rather than speaking live. In the first e-therapy session, my fourth consideration for art e-therapy (C4) arose: how do I control the client's therapeutic setting? Unlike in-person therapy, the client is not coming into an office or studio decorated and stocked by the art therapist. I suggested to Aurelia that we schedule e-therapy sessions when her roommate was not at home, so she could speak more freely about her worries. Not all clients may be able to be alone in their home or have a device for live e-therapy (i.e. computer, tablet, or smartphone). The home of a trusted friend with a computer or a private room in a library are possible alternatives. It was also necessary that Aurelia have a comfortable, clean space to make artwork as well as all the necessary materials (C4). I chose to give Aurelia an assortment of art media, including drawing, painting, and three-dimensional materials, when we met in-person. I also allowed Aurelia to decide how she wanted to angle her computer's camera during sessions, but some art therapists may require that they see the entire art piece while it is being made (C4).

My first e-therapy session with Aurelia focused on psychoeducation. In-person, this session begins with a collaborative brainstorming activity where the client and I write the physiological, cognitive, and behavioral components of her anxiety on a large sheet of paper. My fifth consideration for art e-therapy (C5) was how to modify collaborative activities like these. Either the therapist and client can complete different artworks simultaneously, or one person can create the physical artwork while both participate verbally. Since this was Aurelia's first session, I elected to write the brainstorm words while we both suggested them (C5). I then asked her to complete the next art piece—"My Anxiety Cycle" magazine collage—on her own while looking at the brainstorm piece on her computer screen.

The second e-therapy session focused on the identification and development of support systems, an important goal for people with generalized anxiety disorder due to their preponderance of worries and the strain these place on them and their loved ones. I asked Aurelia to create a diagram of her support systems and/or coping skills from first to last resort (Figure 1). After discussing the relative effectiveness of these options, I asked her to create a chart with each member of her support system and their availability on certain weekdays (Figure 2). More than previously, this session brought up my sixth consideration for art e-therapy (C6): does the client conceptualize my role differently and how? Aurelia was away at college, so she had long distance relationships with most of her family and friends. In this way, the scheduled support of our distance relationship served as a model for appropriate boundaries and supports in her other distance relationships. The therapist's altered role in an e-therapy relationship may present different benefits and

challenges depending on the client; for example, a therapist is unable to engage in hands-on assistance during art making or therapeutic touch (C6).

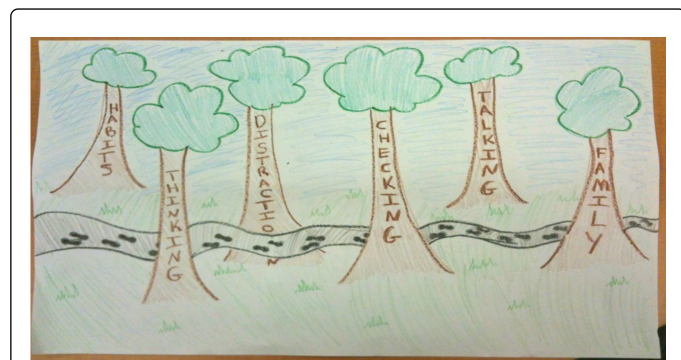

Figure 1: Aurelia's diagram of her support systems and coping skills. The figure is a photograph of Aurelia's visual diagram of her support systems and coping skills drawn with colored pencils.

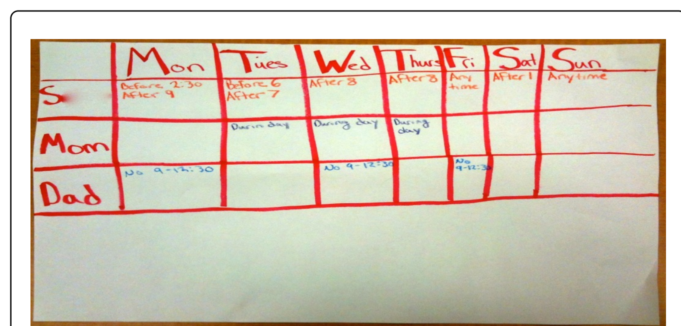

Figure 2: Aurelia's support systems chart. The figure is a photograph of Aurelia's support systems chart written with markers and colored pencils.

The foci of the third e-therapy session—cognitive restructuring—led to my seventh consideration (C7): how do I facilitate art review and side-by-side comparison? I asked Aurelia to list cognitions she experienced during especially anxious times and rate their likelihood on a scale from 1 to 10. She then drew one of her thoughts, "Everyone is judging me," as a huge eye with a tiny person next to it. We then discussed techniques, such as using previous evidence, to scale down the extremity of cognitions. She stated a more "likely" version of the previous thought, "Everyone is thinking about themselves and their own concerns," and painted it for homework. The image was a variety of people surrounding her with the word "Me" painted on their heads. The side-by-side comparison of these two images was essential to give Aurelia concrete evidence of her ability to alter anxious thoughts, but I was unable to hang the two pieces side-by-side as I would have in-person. Using e-therapy, I had to ask Aurelia to bring her previous drawing and her homework to the next video session and hang them up side-by-side in her room for comparison.

Another consideration from this third e-therapy session came up again in the fourth session: how is the client's artwork stored and protected (C8)? I used watercolor brushstrokes to teach Aurelia techniques for slow, abdominal breathing and I led her in progressive muscle relaxation (M. Rosal, personal communication, May 24, 2013). After a guided imagery exercise focused on relaxation, I asked her to create a response piece using watercolors or air-dry clay. Aurelia selected clay and sculpted a detailed sailboat floating on small waves. Unfortunately, the sailboat cracked and fell apart by the next video session. Although I may not have prevented this happening if I had kept the boat, I was unable to store or protect any of Aurelia's artwork during our e-therapy sessions. Debriefing after she accidentally broke her boat was somewhat different than if I had broken it—Aurelia had to accept that the accident happened, forgive herself, and move on. Storing and protecting artwork is one of many facets of e-therapy that requires an anxious client to take greater responsibility and act independently, a goal in common with CBT (C8).

In the fifth e-therapy session focusing on imaginal exposure, my first consideration (C1) reemerged: What are the therapist's and client's comfort levels with technology? Technical difficulties can be expected in the first few sessions, but they may arise later due to Internet connectivity. Aurelia and I began to frequently lose connection during our fifth e-therapy session. Connectivity can be improved (e.g. rebooting wireless routers or connecting directly to a cable modem), but the therapist must decide at what point the technical difficulties are adding undue stress or time (C1). Possible solutions include switching to a phone conversation or rescheduling the e-therapy session to another time when connectivity can be guaranteed. Aurelia and I elected to speak over the phone, and I was able to guide her verbally through an imaginary situation she had been avoiding in real life: talking to a stranger in class. Aurelia then created an image of facing this situation, although I was unable to see it until our next video session. Similar to damaged artwork, minor technical difficulties that arise during e-therapy can be used as practice in dealing with stressful situations for people with severe anxiety (C1).

The sixth and final e-therapy session included more exposure exercises—I asked Aurelia to create two more imaginal artworks based on other avoided situations for homework and to face the first situation in real life. At the beginning of this session, my ninth consideration for art e-therapy came up (C9): does assigning homework in e-therapy create a "double distance?" Aurelia was able to talk to someone in class during the past week as well as create another imaginal desensitization drawing about being introduced to someone new, but she was unable to complete her third imaginal desensitization drawing based on talking to a stranger in a public place. Many therapists encounter resistance to homework whether or not they conduct sessions in-person, but I felt a "double distance" when Aurelia returned to my computer screen. Art e-therapy requires more independence than art therapy or e-therapy alone, because both types of therapy demand their own self-direction: art therapy through the independent decision-making of the creative process and e-therapy through the physical distance from the therapist. Art e-therapy homework is completed and processed at a distance (C9). Although Aurelia finished her incomplete homework in session, drawing her third imaginal desensitization drawing (Figure 3), this "double distance" left me feeling vulnerable to respond to future resistance.

Aurelia was again unable to complete her homework for the seventh in-person termination session. I asked her to face the two remaining avoided situations in real life and create mastery images based on her accomplishments while facing them, but she was only able to face one of the two situations—being introduced to someone new—and no mastery images.

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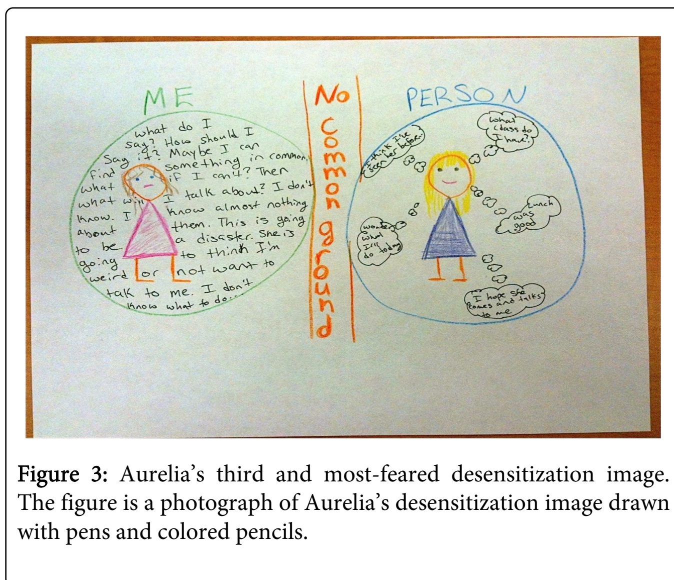

Figure 3: Aurelia's third and most-feared desensitization image. The figure is a photograph of Aurelia's desensitization image drawn with pens and colored pencils.

An increased awareness of my own feelings of vulnerability created by the "double distance" helped me view her incomplete homework as a result of her busy school life rather than resistance (C9). This was supported by the fact that Aurelia was able to describe what her mastery image about being introduced to someone new would have looked like.

In-person termination session

My final art e-therapy consideration (C10) arose before Aurelia's last session: how do I facilitate an appropriate termination? Part of me felt that terminating over the Internet would further the independence instilled by e-therapy. However, I also wanted to challenge her to leave the comfort of at-home sessions at the end of her therapy. For clients previously unable to come in-person due to severe anxiety, such as those with agoraphobia, it is necessary to hold follow-up sessions after the first in-person session to discuss the accomplishments of facing this fear. However, an in-person termination session may not be as useful for clients who are unable to come into the office due to a remote location or financial constraints. In Aurelia's case, coming in-person for her seventh session constituted more of a small stressor than a phobically avoided situation, and we could have scheduled a follow-up session if she had appeared especially anxious.

My primary reason for terminating in-person with Aurelia was to facilitate an art review of all her work over the course of the previous seven weeks (C7). I knew it would be easier for her to bring all her pieces in-person and have my help hanging them up chronologically. Simple features of our "termination gallery"—neutral wall color, diffuse lighting, and uniform wall tacks—gave Aurelia's pieces the appearance of an artist's collection. As we discussed each piece in turn, Aurelia was able to note tangible features of her progress and rate the likelihood of anxious cognitions experienced in previous weeks. Although a large-scale in-person art review at the end of art e-therapy may not always be possible for a variety of reasons—remoteness of the client, nature of the artwork, etc., the novelty of meeting face-to-face seemed appropriate in Aurelia's case to mark her artistic accomplishments and decreased anxiety over time.

Discussion

Taking these ten considerations into account, I was able to assess the costs and benefits of using art e-therapy with Aurelia as well as evaluate its potential usefulness with other severe anxiety disorders. The primary benefits of using this modality for anxiety—rather than in-person art therapy, CBT, or online CBT alone—included increased independence, convenience, and a sense of "meeting the client where she was." As previously stated, both the art and online components of Aurelia's treatment required her to be more self-directed. After learning CBT concepts with me in e-therapy sessions, she had to download her manual and homework, select her own art materials and process at times, and complete art pieces. The treatment was simultaneously more convenient. Due to traditional CBT's costly courses of in-person sessions in mostly metropolitan areas, it may be underutilized at rates as low as 10% of potential clients [8], and art therapists using CBT are even less accessible. Therefore, art e-therapy may offer accessible and varied treatment to underserved clients. E-therapy is also more affordable to clients by limiting the number of sessions. Self-help resources, such as manuals, videos, and independent art activities, can be offered through email and web portals. Increased convenience for Aurelia seemed to work hand-in-hand with "meeting her where she was." We were able to begin and build rapport in a comforting space for her and gradually move towards desensitization activities outside her home.

Despite these benefits, there is a tradeoff of disadvantages art therapists may face using e-therapy. These disadvantages include the other side of increased independence for clients, risks to confidentiality, and some decreased clarity of the art making process. Although I believed Aurelia's increased independence led to longer-lasting treatment effects, it also involved greater risk. Aurelia was responsible for protecting and storing her artwork, which resulted in a piece breaking before I saw it in-person. Although I could easily hear Aurelia's tone of voice and see her upper body during e-therapy, I could have made a more complete assessment of her affect and behavior in-person. If an emergency had arisen during an e-therapy session, I would not have been in the same room with her. Art e-therapy also implies greater risks to confidentiality. If appropriate data encryption is not used for live video meeting software or if digital client files are not password protected, this confidential information can be hacked and disseminated. The other detriment to using art e-therapy is that, no matter how high the quality of a video call or digital artwork image, some aspect of the art making process may be less clear. Although I was able to see Aurelia's artwork reasonably well in e-therapy, I could not appreciate small details and textures—especially in her paintings and some pastel drawings—until I saw them in-person.

Weighing these costs and benefits of using art e-therapy and my considerations from the reported case, this treatment modality merits further study to determine its effectiveness as an alternative to other treatment methods—such as traditional CBT—that have been underutilized [7,8]. The reported study had only one participant; therefore, art e-therapy cannot be isolated from art therapy or CBT as the cause of Aurelia's decrease in anxiety. Confounding factors such as Aurelia's partial diagnosis of ADHD may have also influenced the clinical outcome. Just as online CBT has been compared to in-person CBT, art e-therapy should be compared to in-person CBT, in-person art therapy, and online CBT in larger-sample group efficacy studies. Art may add a concrete component to the abstract tasks of CBT protocols and a tangible record of decreased anxiety [1]. Also, the

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artistic decision-making inherent in the creative process complements the independence required by an online CBT program. For clients who are unable to leave their home or control negative and anxious thinking, art e-therapy may offer a unique treatment option that is more cognitively and financially accessible.

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