

THESIS

DIFFUSING ART THERAPY USING THE INNOVATION OF SOCIAL MEDIA:
EXPERIENCES OF FOUR RURAL ART THERAPISTS

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ABSTRACT

DIFFUSING ART THERAPY USING THE INNOVATION OF SOCIAL MEDIA: EXPERIENCES OF FOUR RURAL ART THERAPISTS

As the practice of art therapy grows and evolves, the way in which healthcare providers disseminate information and connect with patients changes, especially through networks such as social media sites. Physicians and therapists must navigate how to represent their personal and professional lives in an evolving digital landscape. As digital technologies continue to expand, how might the innovation of social media be used by mental health providers, such as art therapists, to better reach rural populations? This qualitative study utilizes research within telemedicine, social media as a professional tool, and the diffusion of innovation theory as a basis to explore how art therapists leverage the use of social media to reach rural communities.

This study argues that individual intricacies may influence a therapist's motivation to adopt social media. Even therapists who do not participate professionally in social media understand the benefits of having a presence on those platforms. However, there remains a complex combination of risks, as perceived by the individual therapist, that prohibit the adoption process set forth by Rogers' diffusion of innovation theory. This indicates that Rogers' theory may not be the best fit for healthcare situations such as art therapy that include high risks or a high number of complex contributing factors.

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CHAPTER 1 – INTRODUCTION

Art therapy in the United States has developed over the past 60 years with the implementation of training standards and rigorous research (American Art Therapy Association, 2015). While the introduction of adult coloring books may encourage relaxation and self-care, the practice of art therapy should not be mistaken as passing fad or an illegitimate form of therapy. Popular coloring books, while an important component of health and wellness (AATA, 2015), allow for passive participation and does not encompass the full practice of art therapy. With the guidance of an art therapist, clients may realize that specific images have the power to penetrate internal experiences in ways that promote a greater understanding of emotions, which are then interpreted by an art therapist as part of their therapeutic intervention (AATA, 2015). Malchiodi (2011) states that art therapy is less about the final product that is produced and more about the therapeutic process that occurs while making that product as each individual strives to express themselves in a creative manner. Kaplan (2017) refers to art therapy as a way for people to share conscious or unconscious feelings through imagery. Art therapy can be used to address a wide variety of patient needs (Betts, 2013) and is suitable for patients of any age as it promotes patients to use more than verbal expression to engage the mind and body (AATA, 2017). Yet there are factors such as geographical obstacles, generational characteristics and technological obstacles that may prevent art therapy from reaching populations outside of urban hubs.

The U.S. Census Bureau (2010) defines 60 percent of the total counties in the United States as belonging to a completely rural or mostly rural classification. Western states such as Montana and Idaho are 50% to 100% rural (U.S. Census Bureau, 2010), which impacts rural development programs for healthcare, housing, and utility management (Rural Institute, 2015).

Certain obstacles also arise when attempting to reach rural populations, including poor internet literacy, lack of internet access (Zhang, Yu, Yan, & Spil, 2015), and political or economic differences (Ishfaq & Raja, 2015). Research has shown that health risk factors for rural populations differ from those of their urban counterparts. The Rural Health Information Hub (2017) states that additional health disparities that impact rural locations include geographic isolation, limited employment resources, and lower socio-economic status. New tools have been developed to minimize these risks and obstacles, which includes advancements in telemedicine and the use of social media as a professional tool for healthcare providers. However, Watt (2016) suggests that healthcare providers such as art therapists may find it difficult to adapt their services in areas of deprivation to create an environment that properly addresses the issues that these individuals experience surrounding rural access or poverty.

There are approximately 3.2 million people living across Wyoming, Idaho, and Montana (U.S. Census Bureau, 2016), all of which are considered to be rural western states by the Economic Research Service (2017). Across those three rural states, there are currently two art therapists registered with the American Art Therapy Association (AATA, 2018), which has prompted them to be featured on the “Art Therapist Locator” list (AATA, 2018). Even though an art therapist does not need to be registered with AATA in order to practice art therapy, AATA is a powerful resource for patients to easily locate a therapist in the surrounding area.

According to AATA, art therapy is regulated with a professional art therapy license in seven states. There are another five states where art therapy is licensed under a related license, and three additional states that recognize art therapists for hiring and/or title protection (AATA, 2017). There are 37 states that do not have a therapy classification according to AATA (2017).

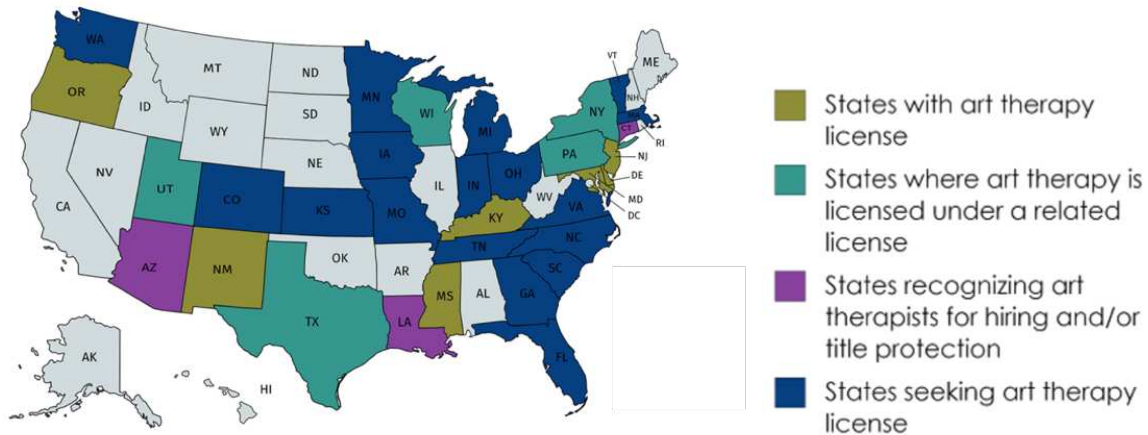


Figure 1. American Art Therapy Association (2017). Retrieved from www.arttherapy.org

A basic online search found that there are more than two art therapists in states like Montana, Wyoming and Idaho, especially in more densely populated cities, even though they may not be listed on the AATA “Art Therapist Locator.” Even so, that brings the total number closer to five or six rather than just two. Beyond the scope of what it would mean for a few art therapists to physically serve over three million people, there are also geographical implications for reaching rural populations that are hundreds and thousands of miles apart. Ishfaq & Raja state that “rural patients have greater transportation difficulties in reaching medical specialists in major cities, often at significant travel distances” (2015, p. 756).

Archibald and Clark (2014), examine how Twitter is being used by nurses in today’s healthcare society. “Twitter can allow nurse researchers to connect directly, rapidly and cheaply with communities, disseminate information, and promote translation of research into practice and policy” (Archibald & Clark, 2014, p. 3). Mental health providers who may be physically far from an individual are now able to digitally close the proximity gap via social media. Concepts such as community and relationship building, that have previously been rooted in a physical world, have now been dismantled and rebuilt to fit a digital society. Therefore, might it be possible for a

handful of art therapists in rural western states to close the proximity gap and better reach rural populations using social media as a professional tool?

This study seeks to understand how art therapists might use social media as a form of telemedicine to extend their reach in rural locations. The theoretical framework will include studies that explore the adoption of technology among healthcare providers, the strengths and weaknesses of telemedicine, social media as a tool for healthcare, and the characteristics of adoption brought forth through the diffusion of innovation theory.

CHAPTER 2 – LITERATURE REVIEW

This chapter reviews current research in issues impacting rural communities, telemedicine among rural populations, and ways in which social media platforms might be used as a professional tool to reach isolated populations. It will also be important to understand the diffusion of innovation theory, which will provide the theoretical linkage for this qualitative study. According to Rogers (1962/2003), by examining how, why, and at what rate technology, such as those used for healthcare purposes, spreads through a given society, there will be a baseline of understanding for how art therapists and their patients might adopt social media as a means for communication, relationship building, and a unique form of telehealth.

Art Therapy

In the early 1940s, Adrian Hill and Edward Adamson helped propel the practice of art therapy forward in the United Kingdom (BAAT, 2018). Art therapy was pioneered in the United States by four universally recognized writers between 1940-1970, which included Margaret Naumburg, Edith Kramer, Hanna Kwiatkowska and Elinor Ulman (Malchiodi, 2011). Since 2009, the British Association of Art Therapy has placed an emphasis on promoting art therapy throughout the country through the creation of research libraries and training programs (BAAT, 2018). The American Art Therapy Association (AATA) is the corresponding association for the United States. Art therapy, as broadly defined by AATA, is “used to improve cognitive and sensory-motor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change” (AATA, 2017, p.1).

Researchers have explored the impact of art therapy for patients who have been diagnosed with anorexia (Acharya, 1995), epilepsy (Anschel, Schwartzman, Fisher, 2005), autism spectrum disorders (Betts, Harmer, Schmulevich, 2014), and Alzheimer's (Massimi, Berry, Browne, Smyth, Watson, & Baecker, 2008), among many diagnoses. Art therapy is often highlighted for the level of success achieved with patients who have been diagnosed with conditions such as Alzheimer's and dementia or veterans with Post-Traumatic Stress Disorder (PTSD). "People with Alzheimer's have a preserved capability to paint, and that painting can be used as 'an appreciated and beneficial activity' for people with Alzheimer's" (Sharp, 2017). Sharp also states that, "that recreation including art therapy can potentially 'improve cognitive function, ability of daily living and behavioral and psychological symptoms of elders with dementia'" (Sharp, 2017).

Veteran communities have seen a high level of success with art therapy because of the veteran's ability to express the trauma of war visually as opposed to verbally (Alexander, 2017). Alexander (2017) highlights the experiences of veterans as they work with an art therapist to express their internal trauma through mask making.

"I thought this was a joke" recalled Staff Sgt. Perry Hopman, who served as a flight medic in Iraq. "I wanted no part of it because, number one, I'm a man, and I don't like holding a dainty little paintbrush. Number two, I'm not an artist. And number three, I'm not in kindergarten. Well, I was ignorant, and I was wrong, because it's great. I think this is what started me kind of opening up and talking about stuff and actually trying to get better." Hopman is one of many service members guided by art therapist Melissa Walker at the National Intrepid Center of Excellence (NICoE), which is part of Walter Reed National Military Medical Center, in Bethesda, Maryland. Images painted on their masks symbolize themes such as death, physical pain, and patriotism." (Alexander, 2017)

Other groups have been created to connect veterans with art therapy including the American Healing Arts Foundation, Operation We Are Here, Armed Services Arts Partnership, Art for Veterans, and many more. As an update to the article from Alexander on March 28, 2017,

the National Endowment for the Arts added four clinical sites (for a total of 11 sites) to increase therapy services for veterans and their families (Alexander, 2017).

While these groups may receive heightened attention in the media regarding the benefits of art therapy, there is a comprehensive bibliography provided by AATA that has compiled research articles for the effectiveness of art therapy for other communities. The range of sample studies listed on the website includes research on individuals who are intellectually disabled, have suffered abuse, who have issues in school, who have been diagnosed with a traumatic brain injury, or who may be dealing with grief (AATA, 2015). Across all these diverse groups, art is still a constant of the human experience. In a qualitative case study that examined four long-term care facility patients who had been diagnosed with dementia, it was determined that art therapy interventions enriched their quality of life. It allowed the patients to learn new skills, combat depressing thoughts and behaviors, provide an activity for them to look forward to and enhanced relationships with the staff and volunteers at the facility (King-Tucker, Knupp, Edwards, & Walters, 2014).

While the practice may be popular for these diverse groups of patients, accessing these types of mental health services can be complicated by geographical obstacles experienced among rural populations. Art therapy also requires the same detailed evaluation as other medical treatments to provide qualitative and quantitative results that indicate a rationale for use (Mirabella, 2015).

Art Therapy and Rural Issues

Many studies indicate that residents of rural communities are more likely to be older, poorer, without healthcare coverage, and have less access to primary health care providers (Rural Health Information Hub, 2017). One element that may alleviate the therapist's ability to adapt

their services to areas of deprivation would be to offer rural communities the opportunity to access creative therapy sessions remotely. This form of telemedicine might reduce geographic or financial barriers.

A 2017 study was conducted by utilizing the Rural Veterans TeleRehabilitation Initiative (RVTRI), which was established by the Department of Veterans Affairs and allows veterans in rural areas to access video-based telerehabilitation services (Levy, Spooner, Lee, Sonke, Myers & Snow, 2017). The study refers to research from Lightstone, Bailey and Voros (2015), which concluded that remotely-delivered music therapy can be effective for patients with advanced PTSD, inter-personal activities enhanced the treatment process, geographic boundaries were not an issue with regard to issuing treatment and that it did not hinder the efficacy of the treatment.

Telemedicine in Rural Populations

The terms telehealth, telemedicine and e-health are terms used to define “the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration” (Federal Office of Rural Health Policy, 2018). Technologies used for telemedicine might include video conferencing, streaming media, or wireless communications (Federal Office of Rural Health Policy, 2018). Healthcare networks include healthcare centers that are connected to nearby hospitals through data technology and properly enabled medical equipment (Ishfaq & Raja, 2015).

Obstacles for reaching rural populations through telemedicine may include poor internet literacy, lack of internet access, or less experience with telemedicine services (Zhang, Yu, Yan, & Spil, 2015). Other obstacles may include political or economic differences, which can hinder or enhance the way in which physicians, administrators and patients communicate, plan and

execute community healthcare practices (Ishfaq & Raja, 2015). As digital technologies and the internet have continued to expand, so has the concept of a digital divide. This divide occurs between those who have or do not have access to hardware, software or the internet, but it also occurs between different genders, ethnicities and those with varying education levels and abilities (Rowell, Morrell & Alvermann, 2017, p. 158). Negative outcomes of the digital divide occur when there is a decrease in usage capability and a decrease in achievement outcomes (Wei, Teo, Chan & Tan, 2011). This may impact an individual's level of self-efficacy or judgement regarding an individual's use of technology (Wei, Teo, Chan & Tan, 2011). When put in the context of a rural community, a larger portion of the population has the potential to fall into this divide as opposed to other larger urban areas. Health scientists who have taken a deeper look at the digital divide have found a "double divide" (Chou, et al., 2009). This provides additional obstacles for those who already lack access to the internet, but who are also lacking access to health care or the ability to find health information online (Chou, et al., 2009).

With the exception of the study provided by Lightstone, Bailey and Voros (2015), there are few examples for how art therapists might bridge this divide and use telehealth as a professional tool. However, "healthcare IT has proven to be useful in helping design patient-specific care plans, enhance communication, strengthen the patient-provider relationship, decrease costs, and provide access to evidence-based guidelines of care" (Siddiqui, 2013, p. 2).

The practice of remote healthcare allows organizations and physicians to provide care in a more economical way (Zanaboni & Wootton, 2012). "Many factors are associated with successful telemedicine applications, including demonstrable savings, adequate financing, acceptance by clinicians, improved access to healthcare and avoidance of travel for patients in rural and remote areas" (Zanaboni and Wootton, 2012, p. 2). With the concept of telemedicine in

mind, would it be possible to use more accessible digital platforms, such as social media, as a form of telehealth? This would provide art therapists with easy to access platforms and the ability to connect with patients on platforms that they might be familiar with or have access to. Malchiodi (2009) states that art therapists have already taken advantage of the visual nature of the digital age. Malchiodi (2009) indicates that some therapists already receive artwork from clients using video chat programs, and rural residents utilize digital art making software to promote creative exploration and expression. Social media platforms have attracted millions of users since their introduction (Boyd & Ellison, 2007), but being able to transform these platforms from basic communication platforms into a professional tool involves awareness of the platform (Archibald & Clark, 2014), acceptance of the technology (Doyle, Garrett, & Currie, 2014), and patient acceptance (Zhang, Yu, Yan, & Spil, 2015), which will be explored in the following sections.

Social Media Use Among Physicians and Therapists

Twitter has given medical professionals, such as nurses, the ability to connect with communities, distribute information, and turn research into practice (Archibald & Clark, 2014). Healthcare providers have also begun to use social media for recruitment, to access scholarly information, or build online classrooms (Milton, 2014). McGowan, Wasko, Vartabedian, Miller, Freiherr, and Abdolrasulnia (2012), explore responses from physicians who expressed that their use of social media helped them provide more effective care (58%) and improved the quality of their care (60%) as illustrated in *Figure 2*. However, the motivations of physicians using social networking sites can often be lost in translation. Archibald and Clark (2014) note that Twitter can be used for more relaxed forms of communication, perhaps with popular public figures or

friends. “This versatility of Twitter actually reduces its perceived relative advantage because it is unclear what Twitter can and should be compared to” (Archibald & Clark, 2014, p. 3).

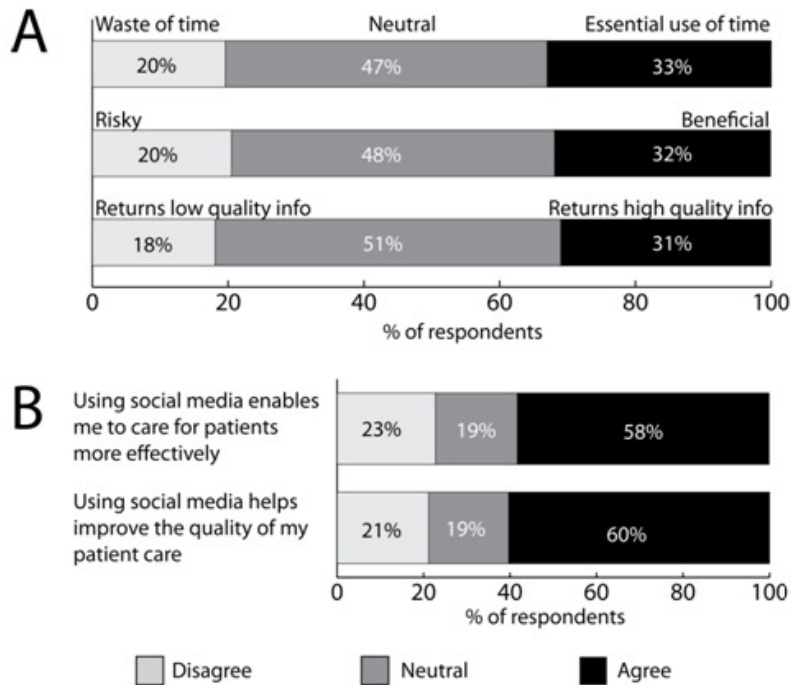


Figure 2. McGowan, et al. (2012) Figure 4: Respondents expressed how they felt about the use of social media along 3 dimensions. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/Pmc3510763/>

Social networking sites such as Myspace and Facebook have attracted millions of users over the past decade, most of whom have integrated these platforms into their daily routine (Boyd & Ellison, 2007). Given the diffusion of these SNSs, citizens in technologically advanced communities are now experiencing a blurring between their online and offline lives. New medical professionals and residents may not fully understand how their social media profiles can be a direct reflection of their level of professionalism (Thompson, Dawson, Ferdig, Black, Boyer, Coutts and Black, 2008). A physician who does not utilize social media properly may be regarded as unprofessional or incompetent (Thompson, et al., 2008). In contrast, a counseling professional who elects to adopt social media may blur the line of a formal client relationship if they are not cognizant of the things they post online.

Current research explores how social media is utilized by medical professionals that will provide a framework for how proper media practices may manifest in the realm of art therapy. One factor that previously differentiated physicians from art therapists is the Accreditation Council for Graduate Medical Education (ACGME). This council determines if a medical student moves onward into a residency program and their adoption of social media is one factor, among many, that may influence the council's decision (Physician Charter, 2002). Even so, medical professionals are continuously forced to confront changing technology and market forces (Physician Charter, 2002). Greysen, Kind, and Chretien discuss how the impact of online actions may be greater than those in person. They state that online indiscretions may be more serious than those made in person because of the potential reach that social media provides (Greysen, et al., 2010).

Not all physician activity in online environments are negative. Greysen, et al., (2010) highlight how narratives from medical students may lead to a greater understanding and appreciation of a doctor/patient relationship.

Just as we must look beyond harm reduction towards health promotion in clinical practice, we must go farther than curtailing unprofessional behavior online and embrace the positive potential for social media: physicians and healthcare organizations can and should utilize the power of social media to facilitate interactions with patients and the public that increase their confidence in the medical profession. (Greysen, et al., 2010, p. 1229)

Such a standard like the ACGME wasn't applicable to counselors and therapists until October 2016, when social media was implemented into the code of ethics for the National Board for Certified Counselors (NBCC). Social media and the proper use of such channels in an ethical context is referenced five times in the revised code of ethics from the NBCC. Some of these references included recognizing the potential harm caused by using social media with clients, confidentiality concerns, obtaining proper client consent, only using social platforms in a

professional context, and using proper electronic communication security practices (NBCC, 2016). Proper use guidelines are offered by the NBCC (2016) to include differentiating personal from professional accounts, creating professional procedures that address accepting friend request or responding to messages, and advising clients about the risks of sending messages using online media platforms.

Unlike the pressure of meeting ACGME requirements, art therapists are exploring a different use of social media involvement than a traditional physician. Miller highlights the use of social media platforms such as LinkedIn and Facebook to enhance communication among other therapists, foster creativity, and build connections (Miller, 2014). However, art therapists encounter a similar predicament as physicians do regarding how they should handle client relationships online or even more specifically on social media.

It may be awkward for your client to suddenly see your picture listed under “people you may know” on Facebook. A client who sends a “friend” request may feel rejected by a refusal, or worse, no response. A client who follows your Twitter feed may not have considered the potential impact to his own privacy. (Lansrud-Lopez, 2016)

Lansrud-Lopez also indicates that even those who use social media on a frequent basis may not be able to predict the impact that advancements in technology and social platforms have on the client-therapist relationship (Lansrud-Lopez, 2016).

Generational implications for social media. There are generational implications on both sides of the social media use spectrum: those who are using social media to reach specific populations and those who are being reached. From the consumer perspective, each new social media platform has a distinct learning curve once it’s released that includes not only the technology itself, but the terminology that comes with it (Archibald & Clark, 2014). This learning curve may be complex for those generations that are less familiar with technology, which continues to skew the perception of use and complexity for that social platform (Archibald

& Clark, 2014). However, for someone on the forefront of adoption who is trying to reach and connect with audiences on social media, the ability to harness endless amounts of analytics and data is one element of complexity they may encounter. A business page on Twitter provides the account owner with access to their audience's age, sex, interests, income, and level of engagement surrounding specific topics. Beyond demographics such as age, sex, and location, there are deeper analytics that involve sentiment analysis, trend analysis, social network analysis and visual analytics (Fan & Gordon, 2014). With access to such powerful information, the user now has an increased knowledgebase for how they might reach specific audiences online. This may require an understanding of marketing that a healthcare professional may not understand or may not be interested in, such as multi-generational marketing practices. Multi-generational marketing is the practice of crafting specific messages for specific groups of individuals with unique needs (Williams, et al., 2010). This form of marketing requires that the life stages of a product advance over time and that the messages for those products are tied to specific generational values of different age groups (Williams, et al., 2010).

Even though the idea of telemedicine or reaching specific clients online may be advantageous for some, with the concept of generational marketing in mind, would they be reaching the right population in need of their services? There are generational factors that affect how a millennial interacts with social media in comparison to a baby boomer. Krishen, Berezanb, Agarwala and Kachroo characterize baby boomers as being less comfortable with technology as opposed to millennials who are “‘digital natives’ due to their familiarity and comfort with the digital technology that has surrounded them throughout their lives” (2016, p. 5249). According to Krishen et al. (2016), by understanding the motivations behind the social media use of different generations, one is better equipped to understand how they might interact

with an individual or brand in an online environment. “Indeed, understanding the motivational needs of unique generational cohorts allows marketers to more effectively design precise adaptive strategies for their social media, which can impact engagement and thereby loyalty” (Krishen, et al., 2016, p. 5251).

Chou, Hunt Beckjord, Moser and Hesse (2009) state that the growth of social media use has not occurred evenly across different demographic groups.

Therefore, health communication programs utilizing social media must first consider the age of the targeted population to help ensure that messages reach the intended audience. While racial/ethnic and health status–related disparities exist in internet access, among those with internet access, these characteristics do not affect social media use. (Chou, et al., 2009, p. 1)

The studies are similar in the fact that they have both identified the importance of acknowledging generational differences when it comes to reaching certain populations on social media. Chou states that, “social media promises to be a way to reach the target population regardless of socioeconomic and health-related characteristics” (Chou et al., 2009, p. 8). This might be especially true for younger generations who would be considered “digital natives” (Krishen, et al., 2016).

Ethics in social media marketing. The National Board for Certified Counselors implemented guidelines for social media into their code of ethics in October of 2016 – over 10 years after the creation of social media sites. Even with the amendment to their code of ethics, networking platforms such as Facebook present a challenge for therapists who may not know how to present themselves in a professional manner as opposed to a personal one (Lansrud-Lopez, 2016).

For those who prefer rigidly defined and well-guarded personal and professional boundaries, social networking sites may be very uncomfortable. For others, this new territory for sharing meaningful content, images, and ideas with colleagues, friends, and

countless others alike may be liberating. The possibilities for creating community and developing collaborations are vast and unprecedented. (Lansrud-Lopez, 2016)
With the understanding that different demographics may require different targeted

marketing methods on social platforms, marketers have developed unique messaging strategies for different groups or demographics in social media environments. Younger audiences, often referred to as the “Facebook Generation”, prefer content that is primarily a mix of visual and audio elements, but that is also approachable (Scott, 2015). This makes ethical marketing practices, especially in terms of health communication and the messages being served to specific populations, even more important.

In a bulletin released to the World Health Organization by McNab in 2009, she states that, “much more needs to be known and shared about how best to use social media to achieve public health outcomes” (McNab, 2009, p. 566). The idea of the gatekeeper on social media is nearly eliminated as any type of individual or institution is now a potential content producer on social media. McNab acknowledges that health institutions can now bypass a traditional media filter, which means the content producer is responsible for ensuring that the content is correct and clear for their audience (McNab, 2009).

Milton (2014) explores common misconceptions of social media and how those interact with the ethics of nurses. It’s important to note that each medical community may have different professional standards for social media use. The National Council of State Boards of Nursing (NCSBN) has released white papers and brochures that discuss the proper usage of social media for nurses (Milton, 2014), while the NBCC has released their own version for counselors and therapists. Milton states that “Nurses have an ethical straight-thinking obligation to consider the opportunities-limitations for usage of social media as a member of a healthcare discipline that seeks to serve humankind in ways that honor human dignity” (Milton, 2014, p. 283). Milton

believes that there are potential illusions of personal privacy, opportunities for portraying false images or information, and that posting information about another individual is in direct violation of their dignity because they have been portrayed incorrectly on social media (Milton, 2014).

It is becoming increasingly alarming to read about and bear witness to narratives of professional nurses and student nurses chatting or using Twitter and Facebook to discuss and give information about persons they gave nursing services to in the course of their studies. Participating in actions such as these potentially violates the nurse-person, nurse-family, nurse-colleague, and nurse-community relationships. There is no privacy while posting and chatting on social media. Violating these private relationships opens doors to possible litigation as well as the possible loss of societal trust in the discipline of nursing. (Milton, 2014, p. 284)

Mckee and Milton both recognize the challenges of social media in terms of participation, non-participation, and how to deal with issues such as communitarianism (Mckee, 2013, p. 299).

Mckee is aware that, “There are also concerns that some social media sites disseminate information that lacks an evidence base or contradicts established guidelines” (Mckee, 2013, p. 298). However, one factor that Mckee mentions that McNab and Milton do not, is the idea of anonymity in online spaces. Mckee (2013) states that anonymity is a basic right of all subjects within research and that the use of material shared online as a data source only enhances the challenges for traditional offline structures. For example, a tweet is much easier to identify through a quick web search as opposed to a quotation from an interview (Mckee, 2013).

There is a fine balance between using social media professionally to build networks and to enhance access to important research and knowledge, while also not revealing personal information or violating precious client/physician relationships or privacy. Healthcare providers are responsible for the safety and privacy for those who receive their services in real-time and online spaces (Milton, 2014). This may be one reason that some healthcare providers have opted out of using social media, or only use the platform for other purposes outside of their profession.

The diffusion of innovation theory provides a greater understanding for why, how, and when certain individuals might adopt these technologies that may impact the way art therapists continue to explore social media as a professional tool.

Diffusion of Innovation

Everett Rogers is recognized as popularizing the theory of diffusion of innovation by outlining the way that individuals experience the adoption of a new idea, product, etc. According to Rogers, “Diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system” (1962/2003, p.5). Rogers (1962/2003) also identified five groups of individuals as they move through the adoption process: innovators, early adopters, early majority, late majority and laggards. Once an idea is introduced, such as the innovation of social media as a professional tool, Rogers (1962/2003) was able to predict the percentages of each group of individuals that would move through the adoption process.

At first, only a few individuals adopt the innovation in each time period (such as a year or month, for example); these are the innovators. But soon the diffusion curve begins to climb, as more and more individuals adopt each succeeding time period. Eventually, the trajectory of adoption begins to level off, as fewer and fewer individuals remain who have not yet adopted the innovation. Finally, the S-shaped curve reaches its asymptote, and the diffusion process is finished. (Rogers, 1962/2003, p. 23)

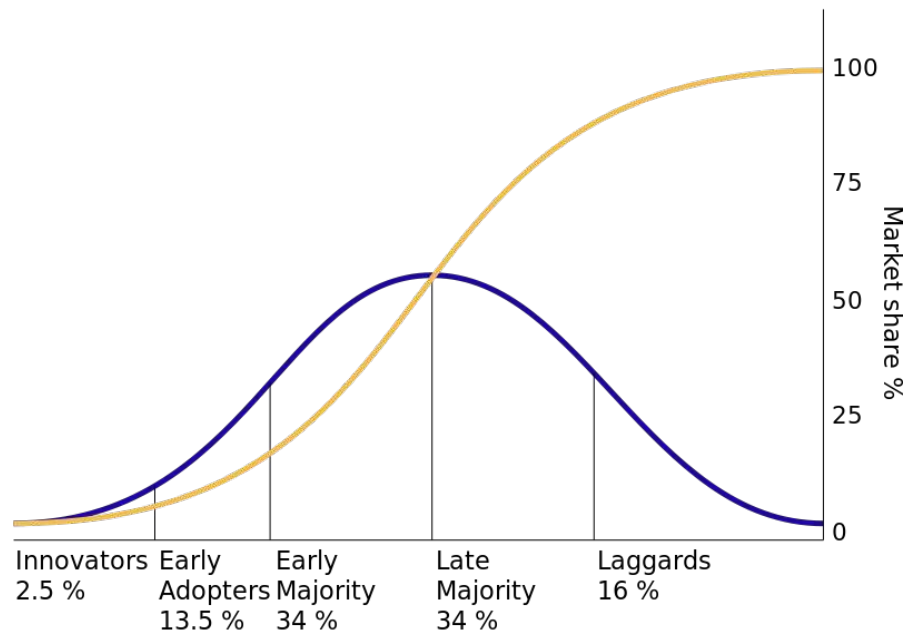


Figure 3. Rogers (2003) *Diffusion of innovations*. Retrieved from <http://bit.ly/2KcNzg8>

The first two waves of adopters, innovators and early adopters, are quick to accept technology based on its value and performance (Xu, Thong & Tam, 2017, p. 112; Moore, 1999). This is opposed to the early majority who will only adopt the technology once they understand the cost and complexity of the technology (Xu, Thong & Tam, 2017, p. 112; Moore, 1999). Rogers explains that the rate of which an innovation spreads can depend greatly on the social system involved; so much that, “the structure of a social system can facilitate or impede the diffusion of innovations” (1962/2003, p. 25).

An additional factor that may compound the process of diffusion of innovation is the concept of re-invention with regard to the technology specifically. Kaminski summarizes this concept as, “referring to the degree that an innovation is changed or modified as the adoption and implementation process is enacted” (2011). This concept is best explored through the innovation of Facebook. What began as a way for college friends to connect online has been reinvented as a marketing vehicle for businesses, among many other functions. As more people have adopted the

platform, it has changed from an accessible way to connect with an online community into a platform for seeking information, contributing to existing knowledge and selling products or services. Kaminski (2011) states that if an innovation has the potential to be reinvented then it has a greater chance of being adopted to a strong point of saturation. In the context of social media adoption in art therapy, as platforms like Twitter, Facebook and Instagram continue to be reinvented as professional tools, this may directly impact the level of adoption within the social structure of counselors and therapists that will ultimately impact the level of saturation for therapists to adopt this form of technology.

Critiques of Rogers' theory state that there has been a shift towards a more interactive form of diffusion that doesn't include a single point of adoption (Fitzgerald, Ferlie, Wood, & Hawkins, 2002). The present reassessment of Rogers includes the role of evidence and science in forming knowledge bases, the nature of adoption decisions by passive adopters, and the influence of context in a healthcare environment (Fitzgerald, et al., 2002). This argues that science-based practices such as those found in healthcare are more socially mediated and the context of knowledge paired with specific adopters are the factors that ultimately influence diffusion (Fitzgerald, et al., 2002). These contexts may include local, national, societal, institutional and political influences that reject linear models and lack sufficient research (Fitzgerald, et al., 2002).

Characteristics of adoption. The willingness to adopt a new innovation has many factors, but there are five main characteristics that influence this rate (Rogers, 1962/2003). These characteristics include: relative advantage, compatibility, complexity, trialability and observability (Rogers, 1962/2003). Relative advantage, compatibility and complexity are the first three characteristics of adoption that have a significant impact on the rate of adoption (Archibald

& Clark, 2014; Tornatzky & Klein, 1982). These characteristics have the ability to predict the adoption process of an innovation with similar levels of consistency (Archibald & Clark, 2014; Tornatzky & Klein, 1982).

Relative advantage is best described when an adopter doesn't understand that a technology has a greater advantage than the technology that supersedes it, which means there would be no motivation to explore the innovation (Rogers, 1962/2003). Also, the idea of compatibility appears early in the adoption process because if the new technology doesn't adhere to the existing values and experiences of the adopter, then the adoption process stops (Rogers, 1962/2003). This blending of existing experiences may also include social approval of peers (Tornatzky & Klein, 1982; Fliegel, Kivlin, & Sekhon, 1968). Lansrud-Lopez states social approval manifests because of the digital culture our society operates within today.

We now live in a world where instantaneous connectivity is assumed, ambient transmission of private experience is normal, an active online presence is expected, transparency is valued, and the blending of personal and professional boundaries has made distinction between the two passé. (Lansrud-Lopez, 2016)

With regard to complexity, without ease of use or the minimizing of complexity, the innovation may not be successfully adopted because it is too difficult for the user to understand (Archibald & Clark, 2014; Rogers, 1962/2003). Zanaboni & Wooten (2012) discuss the initial adoption phase that is followed by the implementation of new technology. However, "adoption decisions can be reversed during the diffusion stage, if for example an individual becomes dissatisfied with a technology, or a new or improved technology becomes available" (Zanaboni & Wootton, 2012, p. 2).

Archibald and Clark use Roger's framework to examine the adoption of Twitter within the nursing community. A nurse may understand the purpose of Twitter in a professional context (relative advantage), and that the app can be integrated with other professional social platforms

such as LinkedIn (compatibility), but unless a nurse is active on Twitter, they may overlook the platform as being a source for exchanging ideas or sharing professional reports (observability) (Archibald & Clark, 2014; Doyle, et al., 2013; McGowan, et al., 2012).

Patient access and acceptance of technology. While patients may be interested in accessing health information or exchanging communication with their health provider online, there is less understanding of whether or not the services offered by those providers are desired by the patient (Wilson & Lankton, 2004). This discrepancy may hinder the patient's acceptance of that form of technology (Wilson & Lankton, 2004). Rogers' same characteristics of adoption apply to the patient in similar ways that they do to the healthcare provider (Zhang, et al., 2015). Some of these characteristics may manifest as potential obstacles for the patient, which include, "discomfort with or inability to operate technology, anticipated compliance issues, scheduling conflicts, an unwillingness to establish and work towards therapy goals and communication barriers" (Levy, et al., 2018, p. 22). Zhang, et al., (2015) examine telehealth innovations such as the introduction of an online e-appointment scheduling service as opposed to calling a physician's office to make an appointment. The results showed that known obstacles such as age, education level and occupation were also factors that may influence the patient's adoption of the new technology (Zhang, et al., 2015).

Additional motivational factors, such as those outlined in the technology acceptance model (TAM) (Wilson & Lankton, 2004), add an information technology (IT) layer of acceptance for new technology.

TAM extends the theory of reasoned action by proposing that individuals' perceptions of a technology's usefulness (PU) and ease of use (PEOU) are key contributors to behavioral intention (BI) to use the technology. The motivational model proposes that intrinsic motivation (IM) and extrinsic motivation (EM) are key in determining BI. (Wilson & Lankton, 2004, p. 242)

There are three forms of technology acceptance, as illustrated by *Figure 4*.

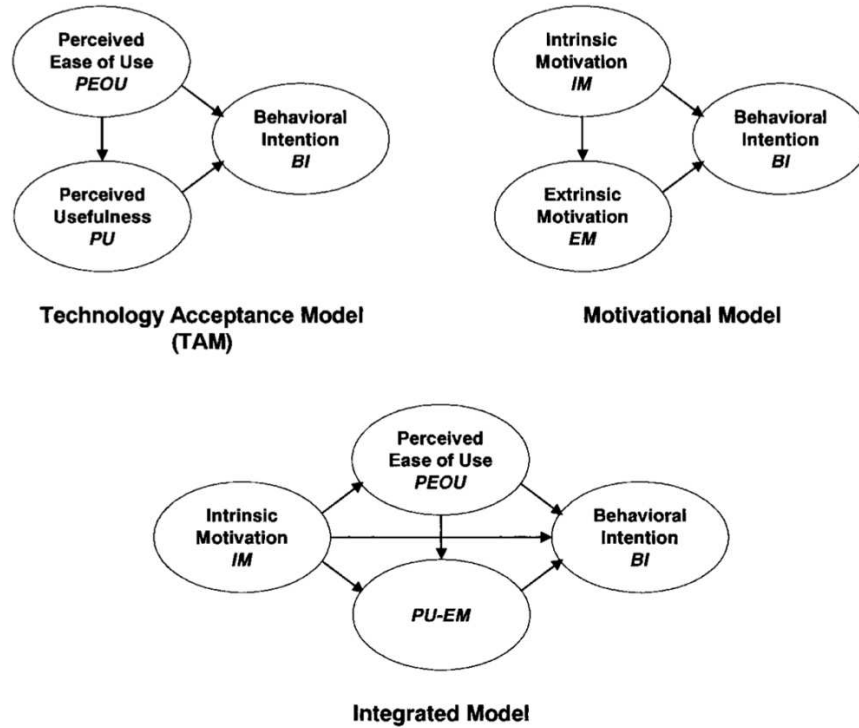


Figure 4. Wilson & Lankton (2014) *Three models of technology acceptance*. Retrieved from <http://bit.ly/2yCosC1>

In contrast to the popular characteristics of adoption, disadoption can be equally as frequent when certain expectations of technology are not met (Xu, Thong & Tam, 2017). Disadoption is often associated with the failure of a technology (Xu, Thong & Tam, 2017). This can be seen in the disadoption of early computers and the personal digital assistant (PDA) because of their poor battery life and sluggish browsing speeds (Xu, Thong & Tam, 2017).

The process of transforming a disadopter back into an adopter requires the user's evaluation of the old technology, combined with new information made available about the technology (Xu, Thong & Tam, 2017). "When a new technology generation is introduced, although its superior performance or the better value proposition may lead to positive reaction

from disadopters, their negative experience with the earlier technology generations can still hinder the readoption decision” (Xu, Thong & Tam, 2017, p. 107).

Researchers acknowledge that education level is one obstacle that may impact the adoption decision for the user, but this obstacle is only amplified when the issue of rural access is added to the patient experience. Siddiqui notes that without strategies for targeting low-income or rural areas that facilitate health literacy using mobile devices, the rapid dissemination of telemedicine and mobile health resources may become an amenity for those in more privileged/urban areas (Siddiqui, 2013).

Research Questions

This study seeks to provide insight as to how art therapists utilize social media as a professional tool to promote awareness of their practice. Communications surrounding their services as well as how they interact with clients in an online environment would provide a baseline for a potential future social media strategy in the field of art therapy. While this qualitative approach may only reach a small section of rural populations, it is a study that can be replicated or shared with other rural communities. The proposed research questions are:

- **RQ1:** How have art therapists adopted social media to inform or advertise their practice in rural locations?
- **RQ2:** How has the re-invention of social media as a professional tool impacted a therapist’s ability to communicate with patients?

CHAPTER 3 – METHODS

For this study, semi-structured in-depth interviews were conducted in-person or via phone with four art therapists from a rural western state. A semi-structured interview, as explained by Carruthers (1963), shows that in-person interviews are the best method for obtaining detailed opinions and that people tend to be more honest when providing their views in context. The interviews were approximately one hour in length and two interviews were extended to be exhaustive with responses and counter responses. In this study, being able to interact with art therapists through dialogue to better understand how they may utilize social media provided a greater understanding for how rural populations are being reached online using diffusion of innovation as a guide.

The four art therapists were selected as part of a convenience sampling method based on a list of therapists within geographic proximity to myself, the researcher. I pre-screened each of the art therapists to ensure that they were still practicing art therapy in case their online contact information was incorrect or out of date. After the selection was made, the participants were recruited through email and phone calls (Appendix A). All research, recruitment methods and consent forms followed the standards set forth by the Institutional Review Board (IRB) as required by Colorado State University (Appendix B).

One interview occurred in-person and the remaining three were conducted over the phone due to geographic distance between myself and the art therapist. I, the researcher, recorded each conversation with the permission of the participant for transcription purposes. I maintained all recordings and transcripts on a secure hard drive that is only accessible to me. Upon completion of the thesis, these recordings will be deleted.

Due to the fact that there are so few practicing art therapists in rural western states, the names and locations of the participants remain anonymous, but the size of their communities and general geographic locations have been used as descriptors during the analysis portion of this study. Participants were given the ability to decline participation in the study at any time. They also retain the right to contact me at any time via phone or email, and they also have the email contact information of my advisor, the principal investigator. Finally, participants were given the right to view any transcripts for clarity and context and they were given access to the completed study after it has been submitted to the Graduate School for publication. All of the aforementioned agreements and/or arrangements were outlined on the consent form.

Positionality

After graduating from college, I was diagnosed with an eating disorder and a mental illness that sent my nutritional balances into a tailspin and left me tormented by waves of extreme emotional highs followed by extreme lows. In a manic state, I sought any mental health facility that would be able to guide me to recovery, which is when I was first exposed to the idea of art therapy as a practice. I was paired with a therapist who was near my age at the time and who had a similar trauma profile. Being an artist in my free time, I was both intrigued and confused at how an art therapy session worked. After just a few sessions with my therapist, it was clear to me that the end-goal of art as a practice is to produce a finished product, while the end-goal of art therapy is to explore a feeling or experience without the pressure of reaching a final product. In any given session, we would talk for a few minutes about anything that I was excited about or struggling with, and then she'd ask me what creative activity I'd like to do to express those feelings. I had the option to use colored pencils, paint, clay, etc. Most of the time I would draw and we would work together to discover a logical interpretation of my drawing. My

artistic expressions were never complete and never high-quality – just doodles from the parts of my brain that I was not able to express verbally. Given that our meetings involved deep discussion, I wanted to approach this study from the same qualitative baseline.

Data Collection Procedures

The interview questions are structured in a way that I was able to sufficiently answer each of the research questions, while also exploring other topics or avenues that naturally arose during conversation. Both parties were given the option to skip a question if it seemed irrelevant or if another question that is not included on the list was more constructive to explore. This format allowed for a natural progression of topics while still providing a basic structure to the interview.

Each of the four art therapists disclosed before the interview whether or not they participated in social media. All subjects were aware of social media, even though they may not utilize the service. Depending on their participation in social media, they were provided with a specific list of interview questions labeled for participants or non-participants (Appendix D and E). I began by contacting each of the art therapists that met the necessary criteria for selection. I then followed the recruitment scripts outlined in Appendix A, which allowed me to set parameters for what the interview will include and alleviate any concerns from the participant (Jacob & Furgerson, 2012). I then emailed a copy of the consent letter to each participant (Appendix B) so we had the opportunity to review it together prior to our scheduled interview.

Once the date, time and location (if necessary) was established, I emailed each participant a confirmation message that included the list of questions (Appendix C-E) for the participant to review before our interview. In this email message, the participant was also asked to complete the list of short-answer interview questions before our meeting in an effort to streamline our

interview and be respectful of our time together. For the one interview conducted in-person, before the recording began I briefed the participant on the structure and agenda for the interview and then began my recording. For the remaining three phone interviews, I followed the same process, but utilized a secure video conference software that allowed me to extract the audio file and save the transcription of our conversation to a secure hard drive. Both the interview and audio file were deleted upon transcription of the conversation.

I shared with each participant that I reserved the right to ask additional follow up questions that may not have been listed on the questions list provided. However, I was also considerate of their time and ensured that we remained on track and that all pertinent questions were addressed. Once we completed the interview, I transcribed the audio files and sent a copy of the transcripts to each therapist for them to review. This allowed them to clarify any complex subjects or add any clarifying language to the conversation.

Analysis & Measures of Quality

An issue-focused analysis was the primary avenue for analysis, which followed the structure provided by the National Center for Postsecondary Improvement (NCPI). The NCPI (2003) defines an issue-focused analysis as being something that is understood about a specific issue based on the specific responses from the persons being interviewed. In order to achieve this form of analysis, the interview questions were structured in a way that integrates the concepts of telemedicine, art therapy promotion, generational marketing and ethics into the list of questions. Berger (2000) states that qualitative research studies require a way to make sense of the interview transcriptions by identifying patterns, themes, and categories within the transcripts, also known as coding.

By properly coding each response, I was then able to sort and integrate the responses into logical results. Berger (2000) states that there are no specific rules for coding because the material itself will dictate the patterns and codes. These codes may include perspectives of the subjects, categories of relationships or social structures, or context specific codes (Berger, 2000). This process allows links to emerge across all of the interview responses and specific concepts within the study. Each code was assigned an abbreviation by the researcher so as to easily identify the code across multiple transcripts. These are explored in detail in the following results and include: Social Media as a Tool for Relationship Building (RB), Marketing Methods for Advertisement and Growth (MAG), Utilizing Social Media to Engage Younger Demographics (EYD), and Reaching New Populations Using Social Media (RNP).

Codes within these categories can be further explicated. Relationship Building may include any activities that may or may not be personal or professional in nature. Marketing Methods for Advertisement and Growth may include messaging on social media or a professional website, or through word-of-mouth. Utilizing Social Media to Engage Younger Demographics would include clients between the ages of 5-25 who are primarily digital natives. Reaching New Populations Using Social Media would incorporate populations that may be rural, urban or indefinite.

In addition, to ensure that each participant remain anonymous, AT will represent Art Therapist, and the corresponding numbers for each were randomly assigned to assist with identification.

Examples of this coding process are illustrated as follows. Responses to questions number 4 and 6 from the interviewees who use social media (Appendix D) were coded to correlate with the concepts of relationship building or telemedicine practices. In addition,

question 7 from interviewees who have not adopted social media corresponded with the concept of adoption and personal ethics. Sorting allowed for the organization of these different excerpts from the interviews based on those concepts and sorted them into further specific categories. Specific excerpts from our interview were then outlined logically under each of those coded concepts. Finally, the process of integration created an interpretation between the main response categories (coding) and each specific answer (sorting) to better understand how each interview accumulates in the form of generalizable results and led to implications for future research (NCPI, 2003).

An additional form of analysis was provided by implementing a negative case analysis. This type of analysis uses contrasting examples from other respondents that contradicts or questions the predicted outcome (Emigh, 1997). In this instance, this type of analysis assisted with validity by including viewpoints from art therapists who have not adopted any form of social media, which was utilized to contradict explanations given by therapists who have adopted social media as a means to provide further analysis into emerging trends.

The measures of quality include credibility, duplication and member checking. Credibility was established by selecting participants who practice in rural communities, are actively involved with the community, and who have experience using social media. In addition, this type of dissemination may be duplicated within other populations attempting to disseminate their message within rural populations. For example, a similar study may be duplicated at a rural non-profit, health organization or educational center that has only recently adopted social media as a means for disseminating their message to rural populations. Finally, by selecting a smaller number of participants and using member checking tactics, a double approach to interviewing lent itself to triangulation. Carruthers explains triangulation as a way to examine the same

phenomenon from multiple perspectives (Carruthers, 1990). This was achieved by using an answer from one therapist and ask another therapist to confirm, expand, or deny their answer.

CHAPTER 4 – RESULTS

This section will explore the five different categories that were identified as a result of the interview transcript coding process. These categories include Social Media as a Tool for Relationship Building (RB), Marketing Methods for Advertisement and Growth (MAG), Utilizing Social Media to Engage Younger Demographics (EYD), Reaching New Populations Using Social Media (RNP), and Privacy and Relationships in Online Environments (PROE).

Among the four therapists that participated in this study, it was unanimous that the patient and their privacy come first, regardless if therapy interactions occur online or offline. This is quickly followed by the privacy of the therapist and their practice. Each therapist was aware of how they should behave on social media based on the NBCC Code of Ethics, however, they placed greater emphasis on face-to-face interactions over their interest in pursuing social media as a professional tool for their practice. They expressed that the personal and emotional experience for both parties that comes with art therapy allows them to glean additional information from their patients based on their facial expressions and body language. While each therapist felt confident in their understanding of social media as a professional tool, three of the four stated that they were hesitant to introduce social media into their practice because of concerns over privacy and ethics.

Social Media as a Tool for Relationship Building

Among the therapists who use social media, it was unanimous that they use social media as a tool for relationship building as opposed to specific promotional initiatives. This form of relationship building manifested in both personal and professional contexts for two art therapists. One preferred to use social media to connect with clients in a passive way outside of their

session time. This is especially helpful for clients who may be physically distanced from the therapist. The other therapist preferred to use social media to engage with other professionals in the field as well as other individuals that influence their own personal interests and ethics.

AT4 used the app Marco Polo (a video walkie talkie app) to communicate with an adolescent client outside of their regular appointments. AT4 approved this form of communication with the client's parents before engaging in communication with the client on the app. The client would send AT4 videos of themselves doing backflips on the trampoline (a goal this particular client has been working towards) and then ask AT4 in the video if they saw them complete the flip. "I was able to make a video back to her [and] you can use robot voices. It was really cool [that] we got to do that mid-week," (AT4, personal communication, April 24, 2018).

This was one example of how an art therapist utilizes a social platform for relationship building outside of scheduled appointment times. AT4 felt that this form of communication is sometimes the only way they can get their client to be vulnerable with them. According to the therapist, this is based in large part to the comfort level of the client with the app Marco Polo. This is the same app they use to communicate with their peers and its a less intimidating environment for the client to share about difficult topics (AT4, 2018). Communication outside of scheduled appointment visits was not something that was emphasized by the therapists involved in this study, however AT4 indicated that they often rely on other forms of communication such as text messaging or email to schedule, confirm or reschedule appointments.

AT1 preferred to use social media for personal purposes to connect with professionals in the field and post about certain experiences. Even though this therapist did not engage in communication with clients, they are still aware that anything they post personally may compromise their professional career if they were not conscious of the content. AT1 indicated

that everything they post on social media is through a professional lens so as not to promote any action or activity that they wouldn't want their clients to partake in, which is due more to an overabundance of caution as opposed to interest in building relationships or seeking new clients. Their concern over using social media in a professional context to enhance relationships is the client's loss of verbal and physical expression. "The kids that I see in middle [school], elementary [school], teenagers, high schoolers, have never lived a life without social media, quite literally. They don't give their brain time to disconnect from other people's experiences and emotions," (AT1, personal communication, April 20, 2018). By being inundated with information from social media, AT1 was concerned that clients ensure they take time to give their bodies and minds the break they need from technology.

[Social media provides] a false sense of connection and it keeps people in a place. I have clients that will use social media to visit suicide and self-harm platforms that promote those things as coping. It's really unsafe and really unhealthy. (AT1, personal communication, April 20, 2018)

While both AT4 and AT1 utilized social media for relationship building, their approaches differed based on the goal they were trying to achieve: creating an offline connection with a client that would allow them to be vulnerable in new ways versus connecting with professional peers in the community and developing a professional reputation. These differences are significant because it highlights the therapist's preference for using social media as a tool to interact with clients versus a tool for professional development. Even though both forms of social media use are important, the therapist's level of comfort with these platforms may influence them to adopt the use of social media in different ways.

Marketing Methods for Advertisement and Growth

While there were opportunities for therapists to utilize social media for marketing purposes, these four specific art therapists preferred to avoid this form of communication. They

each indicated that a significant portion of their clients travel upwards of 60 miles to visit their practice, which is only complicated by difficult roads or adverse weather conditions in rural locations. However, none of the therapists indicated that they were actively seeking clients or using specific marketing methods to grow their practice. Most of the therapists in this study came from varied backgrounds before beginning their practice or joining a practice. AT1 joined a practice immediately upon graduation in 2016 and is working on developing professional connections in the community. AT2 was previously involved with suicide support groups at a local hospital and with social services at a local school, which is how they made many of their networking connections that allowed them to start their own practice in 2007. AT3 has lived in their community since 1980 and was a hairstylist before returning to school to become a therapist. Those community connections allowed AT3 to begin and maintain their practice starting in 2007. AT4 moved to the city in which they now practice over 12 years ago after moving the practice from another rural western state. Each of these therapists reside in a community that varies from 34,000-74,000 residents (U.S. Census Bureau, 2016), but the majority of the therapists indicated that they have clients that travel from communities with less than 1,000 residents.

AT1 mainly relied on word-of-mouth, ads on Psychology Today, communication via their company website, and local community outreach. They stated that they achieved community outreach through responding to local inquiries from students in the area or by promoting their summer camps at events in town.

As long as I live here, I don't think I need to [do more advertising], because it's small enough here that if you're established, things happen via word-of-mouth. And being the only art therapist, I just don't think I need to. If I moved somewhere else, like to a big city, I think I would certainly use [advertising on social media]. (AT4, personal communication, April 24, 2018)

AT4 and AT1 agreed that if they started a new practice or wanted to expand their current practice, that they would be willing to explore additional marketing and promotional methods on social media. AT2 and AT3 agreed that they weren't personally comfortable using most social media platforms, or technology in general, and will most likely never use social media platforms to advertise or grow their practice. AT2 has seen the negative impact of poor advertising among art therapists who improperly define art therapy or encourage a more relaxed do-it-yourself style of art therapy that AT2 doesn't support. AT2 has had previous interactions with therapists who have websites that improperly promote the work they do.

In some way [it's] the falseness of those pretty pictures or those words of wisdom that have some hollow backing. I know some people who do that or who have websites that aren't practicing clinicians. At the end of the day this is a job and we are supposed to help people. I don't care about the [online] audience, I just want to be more of a clinician. It's dangerous to a certain degree. (AT2, personal communication, April 9, 2018)

AT2 has so many connections within the community that any attempt to make a better website or have a stronger online presence would feel inauthentic to AT2. They would prefer the real-time experience of flinging paint around the studio and allow the power of word-of-mouth to continue building their client base. Even with word-of-mouth and community connections, AT2, AT3, and AT4 agreed that their practice was too full to accept new clients, therefore making additional marketing initiatives a low priority for them.

Engaging Younger Demographics on Social Media

All of the participants indicated that they understood the importance of having an online presence in the form of a website or Google listing. AT4 observed that some clients, especially in the 9 to 16-year-old age range, preferred to communicate with them on social media platforms such as Instagram. This allowed AT4 to communicate with clients outside of a clinical setting to enhance relationship building more so than to communicate with them about a previous or

upcoming session. AT4 enjoys this form of communication with younger clients because it is a form of passive interaction, and they are careful to keep their interactions minimal (liking a post or generic comments). The therapist indicated that by using their name as their Instagram handle, instead of their practice name, when they liked a client's post it doesn't look obvious that it was liked by a therapist. In that respect, it wasn't obvious to an adolescent's peers that they were in therapy, which may lessen the concern for bullying or unwanted attention (AT4, 2018). This form of interaction was a way for AT4 to observe the progress their client is making in their personal life that may or may not relate to what they've been discussing in the client's session.

This is important to AT4 to gain more context about other activities or experiences that are happening in their client's life. "I was just online looking at several kids of mine who are involved in 4H, and they'll post that their pig has gained five pounds and that sounds so funny, but it's like, 'Yes! I can see that, which means he's gained some weight and that's great because that means you're taking good care of her'," (AT4, personal communication, April 24, 2018). Using social media as a professional tool allowed this therapist to have context to enhance interactions with her clients that are passive and approachable. Even though the studio may be miles away, the therapist is able to maintain a relationship with their client via Instagram.

AT3, who did not participate in social media professionally, was still empathetic to younger audiences and how they communicate or process certain topics. "I definitely have to communicate [in a] developmentally [appropriate way]. [If] it's grief [or] trauma related, and [I'm] talking to kids about life and death, grief, trauma, and what happens in our body [that] takes a different form than when talking [with] adults," (AT3, personal communication, April 18, 2018). AT3 is also aware of making sure to acknowledge younger clients who may try to send a friend request on Facebook.

I don't check my Facebook for months at a time. The difficult thing is I had a few requests and I don't see them. When I help them accept it's not my main way of communicating, and also share the professional piece, I think everyone I've had to tell that to takes it well. (AT3, personal communication, April 18, 2018)

By acknowledging that younger populations are present on social media, and may be digital natives, the therapist was able to understand the client's communication preferences and incorporate that into their therapy. Understanding different demographic dynamics helped the therapist approach and work through difficult or complex topics. While social media can be a helpful tool for engaging younger audiences as presented by AT4, none of the therapists in this study indicated that their sessions with clients would suffer or that they feel they would be missing crucial information if they were not able to gather supplemental information from their client's social media channels.

Reaching New Populations Using Social Media

Even though each therapist indicated that their practice is currently full, they were still cognizant of maintaining community relationships as well as a digital presence should clients want to contact them in the future. Even though AT1 and AT2 do not participate in social media professionally, they each contemplated the future of their careers and how the digital landscape might impact them moving forward.

AT2 took a sabbatical for 2018 and is not currently taking on new clients so as to reevaluate the practice and what kind of services they would like to proceed with in the future. One element of that reevaluation included the potential of using telemedicinal practices on social media to reach a larger rural population. They were interested in creating an Instagram channel that shares facts about art therapy or photos of the studio to help their practice feel more approachable. AT2 expressed that clients often long for the kind of expression that comes with

art making, but are often intimidated by the perfectionism that accompanies the art they're accustomed to seeing, and worry that their own art won't live up to the ideals they've created.

AT2 also discussed the power that art therapy possesses in reference to sparking interest from potential clients through the use of artwork and imagery shared via their website. According to AT2, by showing the grit and realness in the work through images of the studio or of released artwork, it also allows potential clients to feel comfortable and makes the practice more approachable. "There's something hokey about my website because it's so homespun and not clean or too polished. Same thing with the [studio] space, right? This building is funky. That's a big part of how I want to work," (AT2, 2018). However, AT2 was also interested in learning how to host sessions online as a form of telemedicine to reach larger populations. Even if they weren't creating art together, AT2 would like to be able to offer some form of online service for clients who live over an hour away.

When I'm feeling ready to go back to work and I'm clearer about who I want to bring that to, it'll be important for me to participate more actively [online] and try to target some audiences or speak in a way through social media, or the web in general, to tell people what's happening here. (AT2, personal communication, April 9, 2018)

This motivation comes from AT2 following certain blogs of other artists who serve as inspiration to their own creations. By not participating in these online spaces, AT2 feels as though they are missing an opportunity to be a similar source of inspiration and connection for others outside of their immediate community (AT2, 2018).

AT1 is the only therapist among the group that works as part of a practice and not as an independent practice owner. They have considered creating a business Facebook account should they ever decide to start their own practice to enhance awareness among potential clients.

If it was a new business, and it was a new business I was starting, then yes, it's that searchability factor. You just have to make sure that it's up to date and accurate and that you're promoting what you're actually doing at that time. (AT1, personal communication, April 20, 2018).

AT1 recently learned while studying for a licensure exam that if an independent therapist is not currently taking on clients, they are not able to include any promotional images online due to false promotion. While AT1 would be interested in creating a Facebook page to help reach new audiences, they were primarily concerned that an out-of-date page would be considered part of that false promotion if not managed properly. AT1 indicated that if they were to create a social channel for their practice, that they would most likely share specific information about the practice or updates from the field of art therapy, but would never consider posting client artwork. Each of these therapists had an interest in participating with social media channels at some point, but it was obvious that their current work environment or workload was preventing them from pursuing additional involvement with social media in their immediate future.

Privacy and Relationships in Online Environments

Three of the four art therapists would prefer not to engage professionally on social media because of concerns over privacy and ethics. AT3 hesitated to adopt social media professionally because of intense concerns over their personal and professional privacy. After working a brief stint as a therapist in an adult detention center, AT3 would often communicate with inmates who found enjoyment in hacking into people's bank accounts. AT3 also reflected on a breach of security that occurred with an insurance provider in which a therapist's laptop was stolen and personal information about clients and therapists were illegally released. These personal experiences have prevented AT3 from pursuing any involvement on social media professionally. AT3 mentioned the time associated with maintaining professional social media accounts, which was a concern echoed by the other three therapists.

I go to these professional meetings specific to children's health – and one [participant who is] also a therapist, said, "I stalk my clients online so I watch to see what they're doing, so if they're sad or suicidal I can interface with them." There's a level of potential danger there, not only for encouraging codependency, but perhaps causing extreme burnout. (AT3, personal communication, April 18, 2018)

AT1 was very aware of the code of ethics implemented by NBCC and indicated that they wouldn't want anything they post personally to reflect on them negatively and always post to social media with their professional identity in mind. AT1 was concerned that a client could potentially discover something they posted on social media and ask them questions about it. In this instance, they would want to ensure that any statements they make in an online environment aligned with their personal and professional ethics. They were also concerned that having a social media presence would encourage the false sense of connection that some of their clients already struggle with. By having that client express themselves in-person through their body or their art, AT1 would feel more comfortable with those relationships and interactions.

I'm very glad there [are guidelines for using social media]. That [is the] idea of posting client's work that made my skin crawl. I understand that for some clients that might be therapeutically relevant, but otherwise I feel that it's so personal and so private. If that client really wants to promote or spread the word about art therapy then I get it. It makes sense clinically that this person feels empowered to share their experience. (AT1, personal communication, April 20, 2018).

AT4 allows clients to send friend requests on Facebook, Instagram and Marco Polo, but they are always cautious of the type of content they post.

I'm very careful not to post things that are personal and/or that I wouldn't want everyone to see. It is very helpful to use Instagram with tweens and teens because they like to post art and it is a good self-esteem booster in my opinion because the feedback they get from me and others is almost always positive. (AT4, personal communication, April 24, 2018)

While AT3 doesn't accept friend requests from clients on Facebook, they are also cautious of what they post because they wouldn't want anyone who views that post to feel targeted. AT3 is aware that they are interacting with communities that are already in a vulnerable

state, and they wouldn't want anything they post online to be taken personally by the wrong audience or have the post be interpreted as being targeted at a specific individual (AT3, 2018).

People can follow guidelines just like we follow the code of ethics to the degree to which they decide. I know nobody likes their freedoms being impinged upon and I am not a fan of censorship either. However, the fact of our position is we work with projection to a certain degree. We just need to be thoughtful. (AT2, personal communication, April 9, 2018)

Even though AT2 has a personal Facebook page, they rarely post to it due to concerns over keeping the lives of their children private. AT2 is disenchanted by the idea of participating in social media because the user has the ability to filter out the parts of reality that they don't like. "You don't see the realness and vulnerability. You don't get to see and feel within the world and I don't like the edited versions," (AT2, personal communication, April 9, 2018). AT2 personally struggled with using social media because they admitted that they don't enjoy spending too much time in front of technology. However, they also stated that this is something they have to remain aware of because it is woven into the lives of their children and their clients, and they don't want to be ill prepared to talk about subjects regarding social media and technology. Even if these therapists do or do not participate in social media, they are aware that these platforms are not going away and they must recognize the significance of the use of these platforms in each of their client's lives.

In this section, five different categories that emerged from the interview transcripts were explored. These categories were Social Media as a Tool for Relationship Building, Marketing Methods for Advertisement and Growth, Utilizing Social Media to Engage Younger Demographics, and Reaching New Populations Using Social Media. All four of the therapists were familiar with social media and had varying personal and professional reasons that influenced the adoption of social media within their practice. With the NBCC Code of Ethics in

mind, each therapist was mindful of their actions in online environments and unanimously agreed that patient privacy was their primary concern. Greater emphasis was often placed on face-to-face communication because of the personal and emotional experiences of both parties during the practice of art therapy. However, due to the demographics of their client base, most of the therapists indicated that they were interested in pursuing more ways that they might adopt social media and telemedicine initiatives into their practice so they might better serve rural populations in the surrounding areas.

CHAPTER 5 – DISCUSSION

Accessibility to technology in today's digital culture has made it possible for individuals who are physically distanced from urban centers to have the potential to close the proximity gap via digital platforms such as social media. The question was posed if it might be possible for art therapists in rural western states to interact with a larger number of clients by utilizing social media as a professional tool.

The research questions for the qualitative study were as follows:

- **RQ1:** How have art therapists adopted social media to inform or advertise their practice in rural locations?
- **RQ2:** How has the re-invention of social media as a professional tool impacted a therapist's ability to communicate with patients?

This discussion argues that individual intricacies and factors outside of Rogers' diffusion of innovation theory may influence a therapist's motivation to adopt social media and explores how personal beliefs, ethics and understanding of technology may prohibit adoption.

Factors in Adoption

Rogers (1962/2003) identified five groups of individuals as they move through the adoption process: innovators, early adopters, early majority, late majority and laggards. Innovators are the least likely to encounter obstacles during the adoption process, as opposed to laggards, which are the last group of individuals to adopt an innovation due to a number of factors that influence their decisions before, during and after the adoption process. Rogers (1962/2003) also emphasizes the five characteristics of adoption, which include relative advantage, compatibility, complexity, trialability and observability. Each therapist had a unique

combination of adoption characteristics that were made evident during the interviews. Rogers (1962/2003) indicated that compatibility appears early in the adoption process because if the new technology doesn't adhere to the existing values and experiences of the adopter, then the adoption process stops. All of the therapists in this study indicated that they were not actively seeking new clients. This means that there was no relative advantage to seeking out additional marketing or promotion opportunities because it wasn't advantageous to their current practice. AT1, AT2 and AT3 discussed their personal and professional concerns surrounding their involvement with social media in a therapeutic context that relates to compatibility. In this instance, using specific social media platforms such as Instagram or Twitter was outside of the personal level of comfort or interest for some of the therapists, which is consistent with the term as previously defined in which the new technology doesn't adhere to the existing values and experiences of the adopter (Rogers, 1962/2003). AT3 expressed their compatibility issues with social media and will most likely remain a laggard because of their personal unwillingness to adopt technology due to their concerns over privacy based on an interaction with an inmate while working at an adult detention center. Milton (2014) placed a high emphasis on healthcare providers upholding the safety and privacy for those who receive their services in real-time and online spaces, which AT3 is very concerned about violating should they elect to utilize social media. AT4 had similar personal and professional concerns around their involvement with social media, yet they still adopted the platforms knowing that they had the NBCC Code of Ethics and their own communication policies to refer to for guidance on how to navigate social media in a professional context.

AT2 has a personal Facebook page and has an interest in exploring more tools for connecting with other artists online, however they have yet to act on creating professional

accounts, which might qualify them as a laggard. Due to a lack of understanding of the different social media platforms and forming comparisons of how other therapists are successfully or not successfully implementing social media into their practice that caused AT2 to hesitate. McKee (2013) recognizes that there is concern over social media sites distributing false information or information that lacks sufficient evidence. AT2 has witnessed false practice promotion from others in an effort to promote themselves as successful therapists, which has dissuaded AT2 from participating professionally with social media so as not to be associated with false claims about the practice. AT2 also understood the relative advantages of using social media to foster creativity and build relationships as mentioned by Miller (2014), but was very cognizant of how their actions might impact their adolescent children as they navigate the world and their relationship with social media.

AT1 understood the relative advantage of being present on social media channels as a way for people to find their practice information online, much like a digital phonebook, and expressed an interest in starting a Facebook page should they ever open an independent practice. They are comfortable with using Instagram and Facebook for personal purposes, but are still cautious so as not to post any content that might reflect poorly on them and their profession. It appears that AT1 struggles the most with trialability and observability. Trialability is how easily a product can be explored before the user has to commit, much like a 30-day free trial, which is not offered for social media platforms. Observability involves the adopter being able to see the benefits of using an innovation either through side-by-side comparison or testimonials. AT1 developed concerns in these areas after learning that a therapist can get in trouble if they improperly promote or advertise availability at their clinic. This might align with Thompson, Dawson, Ferdig, Black, Boyer, Coutts and Black (2008), which states that new medical

professionals may not understand how their social media profiles can be a direct reflection of their level of professionalism. The results from Thompson, et al., state that the majority of participants in the study had at least one piece of information that made them easy to identify on social media. AT1 knows that even a photo of a therapist posted on a social media site when they are not currently accepting new clients can be cause for an ethical violation according to the exams required for licensure.

These individual intricacies that influenced each therapist's motivation to adopt social media provide greater insight into the internal dynamics that prohibit adoption. The results align with the findings from Fitzgerald, Ferlie, Wood, and Hawkins (2002), who argue that science-based practices often found in healthcare are more socially mediated and that the context of knowledge paired with a specific adopter is the primary impact for diffusion. According to Fitzgerald, et al., scientific evidence is the most powerful form of knowledge, which is commonly found and highly regarded in healthcare. Fitzgerald, et al. (2002), also indicates that the adoption of knowledge is impacted by social networks and interrelationships that are dedicated to continuing the support of a specific idea or knowledgebase across networks. These non-linear and complicated models of diffusion and factors of adoption go beyond what can be explained by Rogers (Fitzgerald, et al., 2002). Even for the therapists who do not participate professionally in social media, they still understand the benefits of being present on those platforms. Yet there remains a complex combination of risks, as perceived by each therapist, that is further influenced by their personal experiences that may prohibit the adoption process set forth by Rogers. While Rogers' theory is better suited for explaining the adoption process of larger societal groups, it is harder to define the adoption process using the same model for

individuals or groups of individuals who might be confronted with issues involving ethics and privacy that are more common among healthcare providers.

These specific groups and interrelationships can be explored on Twitter, which is often a trusted educational resource for nurses because it allows them the ability to connect with communities, distribute information, and turn research into practice (Archibald & Clark, 2014). These communities also find a use for social media when it comes to building online classrooms (Milton, 2014). All of these practices have been established in a social context on the basis that niche communities, like nurses and healthcare providers, behave certain ways on social media. This might be compared to educational contexts where niche communities have been created on social media for educators who are physically distanced from other educators or want to explore professional development opportunities. Adoption may be more likely in these communities because the opportunity for these specific social interactions may only exist online.

There are also social intricacies such as access to technology and adoption among clients that may also prohibit a therapist's rate of adoption. Rogers explains that the rate of which an innovation spreads can depend greatly on the social system involved, which can often "facilitate or impede the diffusion of innovations" (1962/2003, p. 25). Considering that many rural western states still have areas defined as frontier, there should be serious consideration put towards access and education surrounding technology and the subsequent adoption of social media. In addition, each of the therapists recognize an advantage to using social media platforms, yet they still aren't able to overcome issues with compatibility or complexity. By weighing relative advantages against these issues, they are making a personal choice to put more weight on one concept over the other, which also prohibits adoption.

Generational Implications

Archibald and Clark (2014) discussed that the learning curve for older generations who are less familiar with technology can continue to skew the perception of use and complexity of social platforms. Each therapist indicated that they had clients ranging from 5-75 years old, however it was interesting to note that the therapists who utilize social media or who were interested in adopting social media had a client base that was majority kids and teenagers to young adults (AT1 and AT4). As opposed to the therapists who had not adopted social media into their practice or who were not interested in adopting social media, which had a client base that was majority young adults to seniors (AT2 and AT3).

AT3 stated that most of their clients were 50 years old and older and that social media wasn't a good fit for them or their clients. Krishen, Berezanb, Agarwala and Kachroo (2016) characterize baby boomers as being less comfortable with technology as opposed to their millennial counterparts. By understanding their motivations behind social media use, one can understand how different generations might interact with other brands or individuals online (Krishen, et al., 2016). This is in part a compatibility issue, in that this technology doesn't adhere to the previous experiences of this generational group because they weren't exposed to technology until later in life. Similar to what Fitzgerald, et al. (2002) found, the social context of a specific group prohibits the adoption of social media rather than promoting it.

AT4 had high success interacting with younger clients online via the app Marco Polo, Instagram and through email communication. Most of these interactions were client-driven according to their comfort level of communicating with AT4 in an online environment. AT4 also had the fewest obstacles with regard to the characteristics of adoption. This therapist understood the relative advantage of connecting with younger audiences on platforms that they are

comfortable with and the therapist felt confident in their use and understanding of the platform, which allowed for compatibility. Platforms such as Marco Polo are also user-friendly with a straightforward interface that eliminates concern for complexity. AT4 was the only therapist who expressed confidence in their understanding of the platform, their client needs and the goals that they had for utilizing social media in a professional context when interacting with younger generations, which outweighed any potential risks. AT1 was early to adopt social platforms for personal purposes, but their professional use of these platforms aligns with research from Archibald & Clark (2014) in that they utilize the platform to connect other specific professionals in the therapy community rather than the patient-centric approach of AT4.

Three therapists do not engage with clients directly on social media and one therapist only engages with a younger demographic. This continues to enforce a generational gap which enhances the digital divide in this context. While the digital divide may be closing for people who actively engage with technology and social media platforms, it remains an open gap for individuals who elect to not use social media based on the demographics of their clients because of issues related to complexity. For those who do elect to use social media, it may be because their younger client base is more comfortable expressing sensitive topics and emotions through socially mediated platforms and they are more willing to blur professional boundaries with their therapist. Those therapists may also have a great understanding for the relative advantage of interacting with these clients on such platforms.

Rural Implications

As stated by Rural Health Information Hub (2017), residents of rural communities are more likely to be older, poorer, without healthcare coverage, and have less access to primary health care providers. Based on the geographic location of the art therapists who participated in

this study, this is how much of the surrounding areas would be defined. Even though each therapist in this study lives and practices within communities that are upwards of 30,000 people, there are communities just a few miles away that experience a drastic decline in population and access to the same amenities as their larger neighboring cities. AT2, AT3 and AT4 all mentioned that they had clients who traveled from over 60 miles away for their art therapy services because they were the closest provider. AT4 was able to combat some of these geographic obstacles by using social media as a way to passively interact with their clients between sessions. Even though they were not actively participating in an art therapy session together – similar to a telemedicine session – the therapist was able to check in on their day-to-day lives and have a greater understanding of how everyday events that their client shares on social media might impact their next session together. An additional relative advantage for AT4 to utilize social media is that younger clients are more comfortable sharing about difficult topics on social media and it helps them to gain greater context of things they might be talking about in session, especially if their meeting times are spread out due to geographical distance. Malchiodi (2009) discussed how therapists might receive artwork from clients using video chat programs and the ability for rural residents to utilize digital art making software. AT4 uses the example of one client that they see once per month and how they have agreed to utilize email communication between sessions because the client prefers to create very large pieces that would be difficult to transport. The client is able to email photos of the piece and send comments back and forth with AT4 between sessions.

For AT4, the use of social media among rural clientele was adopted because of a combination of personal factors from the client that includes younger early adopters of technology who have a greater understanding of relative advantage and minimal issues with

platform complexity. However, AT3 indicated that their client base is comprised of an older demographic from rural locations. Therefore, generational gaps and privacy concerns among this group of clients prohibited them from adopting social media to overcome geographical boundaries. Again, this demonstrates that there are personal intricacies at play that outweigh certain aspects within the process of adoption, which may encourage or hinder such a process.

Relationship Building

Lansrud-Lopez (2016) discussed how social networking sites may be very uncomfortable spaces for those who prefer rigid personal and professional boundaries and very exciting for others as they explore creating community, sharing ideas and forming collaborations. AT3 has a strict policy and communication plan for not accepting friend requests on their private Facebook page. “I've been able to explain to them in person that I can acknowledge their friendship request, but because we have a professional relationship I didn't accept your request and I don't want that to change,” (AT3, personal communication, April 18, 2018). Lansrud-Lopez (2016) discusses the potential rejection that a client may feel if a friend request is not handled properly by the provider, which is one reason why AT3 elects to address her personal policy of not accepting friend requests from clients so as to avoid any feelings of rejection.

As opposed to the views of AT3, AT4 has adopted social media and views it as an exciting opportunity to interact with clients and fellow professionals in new and engaging ways. “It is very helpful to use Instagram with tweens and teens because they like to post art and it is a good self-esteem booster... I [keep] posts simple, well thought out, and [I respond] to people personally through messenger or [direct messaging] rather than responding to a whole group if clients are involved in any way,” (AT4, personal communication, April 24, 2018). AT4 believes it is important to have a presence on social media not only for opportunities to passively engage

with clients, but also to seek out educational tools within the field of art therapy. AT4 uses their full name as their username on social media so that they represent themselves as a person instead of a business entity. They also closely manage their social media accounts and are mindful of the NBCC code of ethics when posting or interacting with others in online spaces. Even though it may appear to be a personal account, they still adhere to professional and ethical guidelines.

AT2 would be an example of a middle ground between AT3 and AT4. They are interested in pursuing more professional opportunities on social media such as offering sessions online or creating a blog to inspire other artists. However, AT2 believes that most of their relationship building happens in person as they observe a client's non-verbal or somatic cues. AT2 also has compatibility issues with understanding all the ways that social media can be used as a form of professional communication, which makes them feel as though they wouldn't be able to observe those same non-verbal cues in a technologically mediated environment.

Each therapist has individual reasons for adopting, or not adopting, social media as a relationship building tool. Each social media platform has a different user interface or level of complexity when it comes to the features included in each app that may make one platform feel more invasive or public than the other. For example, AT4 was more comfortable with platforms such as Marco Polo that include direct messaging features, which adds an additional layer of privacy that may not be immediately accessible on Twitter or Facebook. This decreased usage capability and achievement outcome may enhance the digital divide, specifically for AT2 and AT3, which is similar to research from Wei, et al. (2011). This is coupled with an unawareness that there might be niche communities or scholarly information available on social platforms (Archibald & Clark, 2014, Milton, 2014). Even though these social tools have been reinvented to

fit a professional context (Kaminski, 2011), there is still a low level of saturation, which is impacting the traditional rate of adoption as outlined by Rogers.

All of these individual intricacies such as rural and generational differences and personal factors that fall both inside and outside the definitions of Rogers' diffusion of innovation theory influence a therapist's motivation to adopt social media. This dichotomy of intricacies suggests it is often personal internal dynamics common among healthcare providers and therapists that would most likely prohibit adoption. Based on personal and professional boundaries, plus the strong word-of-mouth that occurs in the rural communities these therapists serve, there is no need to advertise or promote their practice based on the strong word-of-mouth that exists in their communities. This could be as much a product of the profession as the personal ethics of each therapist. Adoption of social platforms as a professional tool is also complicated by generational factors or a lack of interest in understanding the nuances of each platform. Each therapist indicated the need to retain face-to-face communication in order to properly translate non-verbal cues and there are few positive examples of other therapists using this form of communication ethically or correctly. However, some of the therapists who have yet to adopt social media are still interested in using this form of communication as a relationship building tool – either with clients directly or with other professionals in the field. This would allow them to retain face-to-face communication, supplement sessions with online interactions, and dismiss any concerns over violating their boundaries on ethics and privacy.

Each therapist in this study has an understanding or awareness of social media to some extent, however there remains a strong personal internal dynamic that prohibits them from adopting certain technologies, which may not be generalizable to other contexts, but is significant within the population of this study. Their adoption is more reliant on the context of

the content being shared and the interactions that they experience with their clients as opposed to the complexity of using social media. This may be caused by a personal preference to not share or discuss sensitive subjects in a digitally mediated environment. Therefore, Rogers' theory might not be the best vehicle to explain the adoption process for this specific group of healthcare providers handling sensitive contexts. Fitzgerald provides a more granular explanation that healthcare professionals and the leading actors within that group might rely more on socially mediated contexts and that the needs of the individual outweigh a mass adoption formula. This is because of three key factors, which include the process of establishing credibility of new knowledge, interactions between actors and innovations and the characteristics of specific communities that accounts for their interactions with those actors and a specific context (Fitzgerald, et al., 2002).

CONCLUSION

As art therapy grows, the ways in which healthcare providers disseminate information and connect with patients is changing. Therapists interested in utilizing social media as a professional tool to reach rural populations must navigate concerns over ethics, privacy, and professional boundaries. These individual intricacies are crucial factors in understanding why and how an art therapist might adopt social media platforms as a professional tool. This is an important contrast to Rogers' diffusion of innovation theory and helps illuminate how internal dynamics may prohibit adoption.

With approximately 3.2 million people living across rural western states including Wyoming, Idaho and Montana, the number of potential clients far outweighs the number of available art therapists in the region. Archibald and Clark (2014), examine how Twitter might be a professional tool that can allow healthcare researchers to easily connect with communities and transform research into practice. However, Fitzgerald, et al. (2002) states that there is insufficient research into the influence of context and professional groups involved when referencing the traditional adoption models set forth by Rogers.

The research data do not support the idea of a single adoption decision, but rather a more prolonged and negotiated process between individuals and groups. Alliances may be formed and reformed. Diffusion occurs when a coalition for change builds up which includes a sufficient range of the many stakeholders – including at least some of the most powerful ones – to generate a sufficient power base. (Fitzgerald, et al., 2002, p. 1441)

Rogers views the adoption process as a linear progression that is influenced by a series of factors along the way. Fitzgerald (2002) argues that the adoption process is far more complex and non-linear than originally outlined by Rogers. According to Fitzgerald (2002), adoption is not likely to occur because of potential trust issues between groups, in addition to many

interprofessional and interorganizational boundaries that individuals must navigate before the adoption process can take place. Any hinderances or hiccups in that process will put the adoption process at risk of reaching completion. With this foundation in mind, there remains an opportunity to explore how other art therapists are using social media in a specific healthcare context to navigate these complex networks and enhance relationship building, advertise their practice and engage with varying demographics in online environments.

Limitations

While this study was intended to only reach a small group of practicing art therapists in rural populations, it minimized the ability to gather a large aggregate of member checking responses. Data collection procedures excluded a second quantitative method such as surveys administered to clients of art therapy to better understand how the patient interacts with their therapist in online environments. While this study includes interviews from four rural art therapists, they were able to provide an in-depth understanding of the dynamics within one rural area. However, there are more art therapists that serve rural areas around the country that could provide additional insight to this study were the geographical boundaries to be expanded.

Recommendations for Future Research

Future research may include the creation of a survey that can be administered to art therapy clients to better understand how they interact with their art therapists both online and offline. There were common problems and concerns that the participants of this study shared such as issues with ethics and privacy. By increasing the number of participants, future research may explore how therapists might overcome those concerns if given the opportunity. For example, AT2 was very interested in starting a blog for other art therapists so they might share the activities happening in their studio that was helpful during therapy sessions. While this didn't

relate to specific results of this study such as relationship building among clients, it would be beneficial to explore similar themes that might emerge among a larger study population. All participants of the study indicated that their primary method of promotion within the community was achieved via word-of-mouth. It would be useful to explore if the patient were to interact with their art therapist in a social media environment, would that enhance the client's willingness to promote the practice via word of mouth? It would also be beneficial to include art therapists in this study who were looking to expand their practice as each of the four involved in this study were not actively seeking new clients. It is also recommended to conduct in-depth interviews with a larger group of art therapists from a larger geographical sample area who serve urban and rural populations in an effort to increase the number of responses for each coding category and to enhance member checking. One subject that was not explored that should be considered in future research was the concept of telemedicine and how it equates to billable hours for the art therapist. Would using social media to interact with clients be considered part of their normal session fee, an additional session fee or not billed at all?

It has been determined that individual intricacies influence a therapist's motivation to adopt social media, which falls outside of the larger societal processes set forth by Rogers. This knowledge is helpful to further explore how personal beliefs, understanding of technology and ethical concerns may be influenced or changed to encourage adoption as opposed to prohibiting it. This might prove to be beneficial to other groups that deal with sensitive contexts such as educators, social workers, and other healthcare communities and how they might navigate implementing social media as a professional tool.

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APPENDICES

APPENDIX A

THERAPIST RECRUITMENT SCRIPTS

Email Recruitment Dialogue

Dear (Name),

My name is Laura Dick, and I am a graduate student at Colorado State University, attending remotely while living in Bozeman, Montana. I am currently working on my graduate thesis and my research involves social media use by art therapists.

I am most interested in how art therapists use social media to promote awareness of their practice in rural locations. This may also include how art therapists communicate their services as well as how they communicate directly with patients. My goal is to better understand how the innovation of social media is being used by art therapists in rural locations around Montana.

I'm contacting you because after searching for art therapists in the area, your practice would be a wonderful addition to my research. I would like to conduct an in-person interview with you, which I anticipate will last about an hour to an hour and a half. To accurately document our interview, I will provide a recording device to help me accurately transcribe our conversation.

Might you be available to participate in my study on a date of your choosing in May 2018? Please feel free to contact me with any additional questions or concerns and I look forward to speaking with you soon.

Sincerely,

Laura Dick
(970) 213-7434
leesposi@colostate.edu

David Wolfgang
Assistant Professor
Department of Journalism and Media Communication
Colorado State University
Fort Collins, CO, USA 80523-1785
David.Wolfgang@colostate.edu
(970) 491-5975

Confirmation Email

Hello (Name),

Thank you so much for your interest in participating in my graduate thesis study. Before we can proceed, please review the consent letter included with this email. Upon your consent, please complete and return the attached pre-interview questions, which have also been attached. Is there a date and time that works best for your schedule to complete our in-depth interview? We can conduct this portion of the interview in person or over the phone, whichever is easiest for you. Please note that you will have the opportunity to review the transcripts at the conclusion of the interview and request a summary of the results.

Should you have any questions or concerns at any time, please feel free to contact me via phone or email. Again, thank you and I look forward to completing our interview!

Phone Recruitment Dialogue

Hi (Name). My name is Laura and I am a graduate student at Colorado State University while living full time in Bozeman, Montana. I am working on completing my thesis research, which involves exploring how art therapists use social media to reach rural populations. I searched for art therapists near Bozeman and your name came up in my search. I would like to extend the invitation to join my study, which would involve a brief pre-interview via email and an hour or so long interview in May. To ensure that I transcribe our conversation correctly, I would like to bring a recording device, with your permission. Would you be interested in being a participant my study?

If Confirmed:

Thank you! Before we can proceed, I will be happy to email you the consent letter for my study. Upon your consent, please complete and return via email the short list of pre-interview questions, which I will include along with the consent letter. Once that is complete we can move forward with our in-depth interview. Please note that you will have the opportunity to review the transcripts at the conclusion of the interview and request a summary of the results.

As I mentioned, I would like to conduct the interview in May 2018. Is there a day and time that works best for your schedule? (Agree on date and time). Do you have any additional questions or concerns for me? (Answer questions). Thank you so much for your time. That is everything that I need for now, but should you have any additional questions, you can reach me at leesposi@colostate.edu or call me at (970) 213-7434. I look forward to meeting you on (insert date).

If Denied:

Thank you so much for your time. Please tell me any colleagues that you might recommend I reach out to for this study. (Record information if any). Again, thank you for your time and have a wonderful day.

APPENDIX B

CONSENT LETTER

Dear Participant,

My name is Laura Dick and I am a researcher from Colorado State University in the Journalism & Media Communication department. I am conducting a research study to explore how art therapists use social media to promote awareness of their practice in rural locations. This will also include how art therapists use social media to communicate their services or interact with clients on social media. The title of this project is *Diffusing Art Therapy Using the Innovation of Social Media*. The Principal Investigator is David Wolfgang, Assistant Professor in the Journalism & Media Communication department and the Co-Principal Investigator is myself, Laura Dick.

We would like you to participate in a brief pre-interview (short-answer questions to be completed via email) followed by one in-depth interview in-person or over the phone. Should the interview take place in-person, the location will be of your choosing. Participation will take approximately one hour. Your participation in this research is voluntary. There are no known risks to this study. If you decide to participate in the study, you may withdraw your consent and stop participation at any time without penalty. When we write about the study to share with other researchers, we will write about the combined information we have gathered. You will not be identified in these written materials.

Any information that we collect from this research project that identifies you will be kept private. Any information about you will have a number assigned to it in place of your name. Only the researcher will know what your number is. It will not be shared with or given to anyone except the principal investigator. In addition, all interview recordings will be transcribed and stored on a secure USB storage device that will be terminated at the conclusion of the research study.

The knowledge that we get from this research will be shared with you before it is made available to the public. Each participant will have the opportunity to review their transcripts at the conclusion of the interview and request a summary of the results. While there are no direct benefits to you, we hope to gain more knowledge about the use of social media by art therapists in rural locations.

Should you have any questions or concerns, please contact Laura Dick at leesposi@colostate.edu or David Wolfgang at david.wolfgang@colostate.edu. If you have any questions about your rights as a volunteer in this research, contact the CSU IRB at: RICRO_IRB@mail.colostate.edu; 970-491-1553.

Sincerely,

David Wolfgang
Principal Investigator
David.wolfgang@colostate.edu

Laura Dick
Co-Principal Investigator
leesposi@colostate.edu

APPENDIX C

PRE-INTERVIEW QUESTIONS

Please return these pre-interview questions electronically as indication of your consent to participate in this study. These are short answer questions that can be answered via email before the in-person or phone interview is completed.

- How long have you lived in this community?
- When did you begin your art therapy practice?
- Tell me about which social media platforms you use personally.
- Tell me about which social media platforms you use professionally.
- How long have you been using those social media platforms?
- Who creates the content to publish on social media?

APPENDIX D

INTERVIEW QUESTIONS (SOCIAL MEDIA PARTICIPANTS)

Please answer as many questions as you are able to or feel comfortable with. If you feel that I have not asked a question that you would like to address, please feel free to add on any additional comments or answers. After receiving and reviewing your answers, I may follow up with you should I have any additional questions, points of clarification, etc. Please note that you will have the opportunity to review the transcripts after the conclusion of the interview and request a summary of the results.

Open-Ended Questions (Long Answer, to be completed in person or over the phone)

1. How would you describe your audience on social media?
2. What do you do to encourage people to find you on social media?
3. Tell me why you communicate your services on social media?
4. How have you adopted social media as a tool for promoting your services online?
5. What guidelines do you follow when you post to social media?
6. In what ways do you encourage different generations to interact with you on social media?
7. How do you address credibility when posting to social media?
8. How do you address anonymity of your clients when posting to social media?
9. What are some of the professional marketing challenges you face using social media?
10. What might your practice look like in an online environment in 5 years?

Thank you so much for your time! I am so thankful for your contribution to my research study. Please feel free to contact me with any additional questions or follow up items and/or thoughts. If you have requested follow up interview, copy of the transcripts, or copy of the completed thesis, I will be in touch via email to make sure you receive those items

APPENDIX E

INTERVIEW QUESTIONS (SOCIAL MEDIA NON-PARTICIPANTS)

Please answer as many questions below as you are able to or feel comfortable with. If you feel that I have not asked a question that you would like to address, please feel free to add on any additional comments or answers. After receiving and reviewing your answers, I may follow up with you should I have any additional questions, points of clarification, etc. Please note that you will have the opportunity to review the transcripts at the conclusion of the interview and request a summary of the results.

Open-Ended Questions (Long Answer, to be completed in person or over the phone)

1. Please explain the different types of demographics within your practice?
2. How might you communicate your services to rural populations differently than urban populations?
3. Tell me why you have not adopted social media for your practice?
4. In what ways might you reach new generations of patients who live in rural areas?
5. How do you market your services to your community?
6. How else are you engaged within your city/community?
7. Give an example of any concerns you might have regarding personal or professional ethics when therapists post to social media?
8. What are some of the challenges you face by not engaging with social media?

Thank you so much for your time! I am so thankful for your contribution to my research study. Please feel free to contact me with any additional questions or follow up items and/or thoughts. If you have requested follow up interview, copy of the transcripts, or copy of the completed thesis, I will be in touch via email to make sure you receive those items

APPENDIX F

INTERVIEW DATE AND DURATION

THERAPIST	DATE OF INTERVIEW	DURATION	TYPE
AT1	04/20/2018	33:46	Phone
AT2	04/09/2018	36:13	In-Person
AT3	04/18/2018	56:48	Phone
AT4	04/24/2018	43:55	Phone