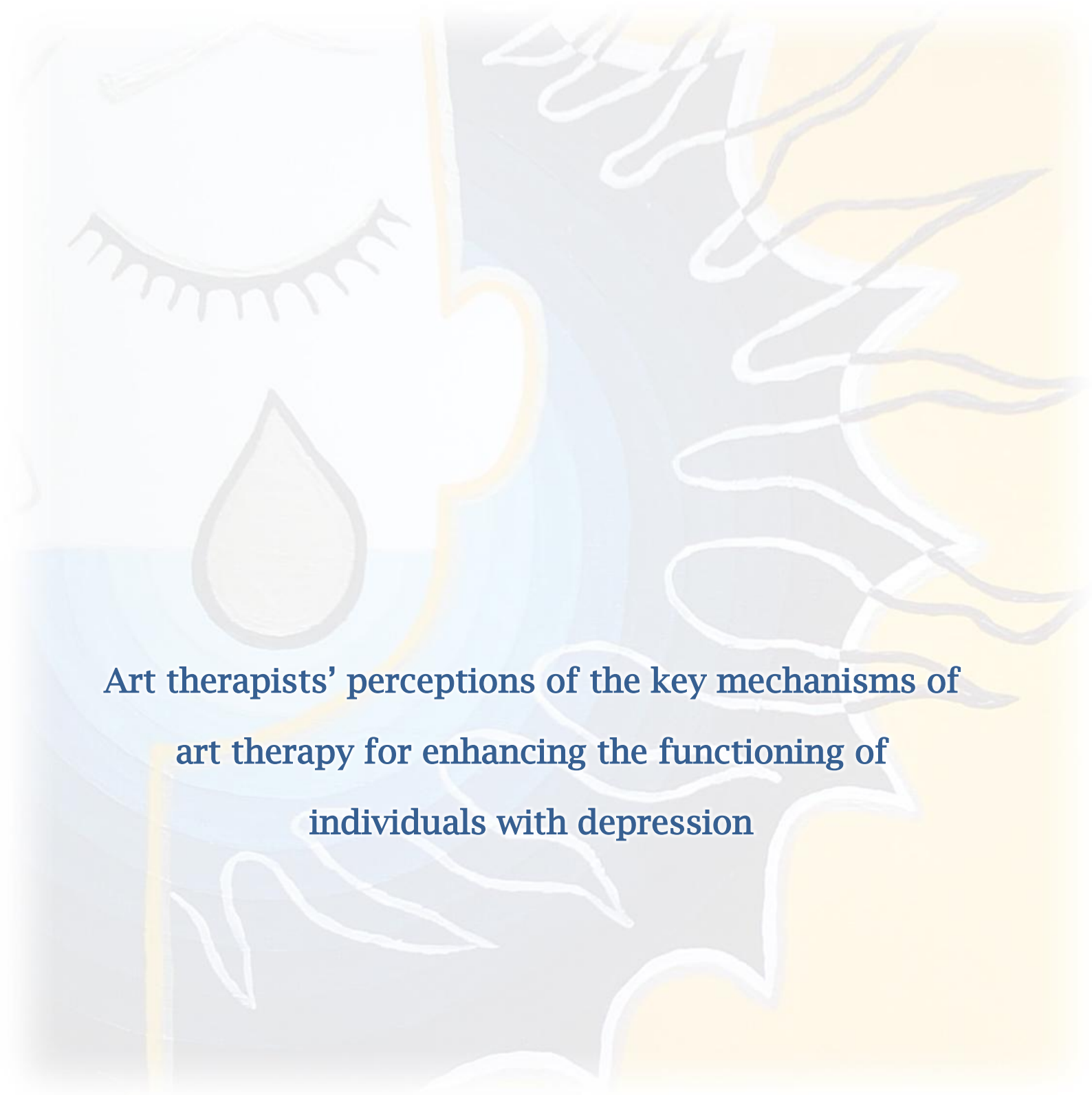

Art therapists' perceptions of the key mechanisms of art therapy for enhancing the functioning of individuals with depression

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Abstract

Inadequacies of conventional treatments for depression draw attention to the opportunities of alternative healing practices, including art therapy. Whereas there is evidence that art therapy reduces symptoms of depression, few studies have investigated the mechanisms involved. This thesis aims to explore art therapists' perceptions of the mechanisms through which art therapy may enhance the functioning of individuals suffering from depression. A qualitative study in the form of semi-structured open interviews with certified Dutch art therapists was conducted. The results indicate that art therapists identify three key mechanisms of art therapy for enhancing the functioning of individuals with depressive disorder: (1) gaining insight into the underlying causes of the depression; (2) rediscovering and strengthening people's identity; and (3) physically activating people. Especially life activities and social activity seem to increase as a result from art therapy. The data suggest that a multidisciplinary approach to depression, in which art therapists and practitioners of mainstream medicine operate as a team, may result in more efficient and cost-effective care for people with depression.

Keywords

Art therapy, depressive disorder, functioning, healing mechanisms, The Netherlands

Preface

From an early age I found joy in all kinds of creative activities ranging from making bracelets and sand figures to writing, photography, drawing and painting. Throughout the years, I developed an interest in art, and painting became a real passion of mine. I use art to display fragments of the world around me, to share my talent, to release stress, and to express my emotions. Thus, when I encountered the term *art therapy*, it immediately caught my attention. As an amateur artist and a future health scientist, I was fascinated by this concept which proposes art as a health promotion tool.

We live in an era in which more and more people are labelled as 'depressed' which is not very surprising in a world which imposes increasingly higher demands on people. Art therapy, however, might bring peace, happiness, success and, more importantly, satisfaction to the hectic life of the modern human being. Personally, I experience the benefits of artistic imagery on a regular basis. A couple of years ago, I made the painting on the front page in order to heal a broken heart. As soon as I finished the art work titled 'Drowning in sorrow' I felt very liberated and lively. Although this was not an actual art therapy experience, it clearly conveyed the powerful influence of art to me. The following quotations of famous artists speak to the healing power of art and served as an inspiration when writing this thesis.

The work distracts me more than anything else and if I could focus on it with all my energy it would probably be the best remedy. ~ Vincent van Gogh

The experience of the moment is what's important, and somehow the image, the 'thing' is left over. ~ Karel Appel

Art washes from the soul the dust of everyday life. ~ Pablo Picasso

Painting has to get back to its original goal, examining the inner lives of human beings. ~ Pierre Bonnard

This thesis is written in the context of my graduation for the Master Management, Economics, and Consumer Studies (MME) with a specialisation in Public Health and Society at Wageningen University. It is intended for art therapists, students, and everyone who has an interest in art therapy and/or depression. As an outsider I hope to offer objective and refreshing perspectives on the working mechanisms of art therapy when applied to depression.

Before you start reading the document, however, I would like to highlight a textual issue. Within a (bio)medical context I will use the term *patient* whereas I will use the term *client* within the art therapy setting. In this thesis, the difference between a patient and a client is that the latter is highly involved in treatment decisions, while the former is not or rarely. In other words, the choices of patients are limited as compared to clients. Art therapy participants are considered clients since they do not necessarily need to be diagnosed with a medical condition.

I hope you enjoy reading this thesis as much as I enjoyed writing it.

Marion Spijkerman

Acknowledgements

The creation of this thesis would not have been possible without the help of a number of people. I would like to thank everyone who inspired, motivated, and supported me during this process. I am especially grateful to Dr. Jennifer Barrett (Research Methodology Group) and Dr. Kirsten Verkooijen (Health and Society Group). Along the way, they generously provided me with advice, suggestions and constructive criticism. In addition, I would like to thank Dr. Hilde Tobi for carefully reading this thesis.

Moreover, I would like to thank my respondents for sharing their interesting stories. Their contributions were crucial for my research. Unfortunately, I cannot thank them by name because of their privacy. Finally, I would like to thank my family and friends for their interest, distraction, and suggestions when writing this thesis. In particular, I would like to thank my boyfriend Luuk for his involvement and encouragements during the past six months. Our long discussions kept me creative, inspired, and critical all along.

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1. Introduction

Depressive disorder, affecting about 121 million people worldwide (World Health Organization [WHO] 2011), is on its way to becoming 'public health enemy number one'. It is the leading cause of disability throughout the world, accounting for 9.1 and 11.8 percent of all healthy life years lost from disease in less-developed and more developed countries, respectively (Lopez et al. 2006). In 2007, the overall burden of depression in the Netherlands was 168,600 disability-adjusted life years (DALY's)[1] of which 58,900 are for males and 109,700 are for females (Schoemaker et al. 2010[a]).

People with depression may struggle with keeping their jobs, caring for their families, and continuing daily activities. As shown by Buist-Bouwman et al. (2006), individuals with depressive disorder experience significant limitations in their functioning that equal or exceed those of patients with major chronic physical illnesses such as arthritis and heart disease. Furthermore, research has demonstrated that there is a bidirectional association between depression and somatic diseases such as cardiovascular disease, diabetes, cancer, and chronic pain (Carney & Freedland 2003; Penninx et al. 1998; Spiegel & Giese-Davis 2003; Stuckey & Nobel 2009). According to the WHO (2011) each year about 850,000 deaths can be attributed to depression.

Morbidity and premature mortality associated with depressive disorder have major implications not only on the individual level, but also for society as a whole due to an increasing pressure on healthcare services, economic losses, and social costs (Paykel et al. 2005). In 2005, the costs of care for people with depressive disorder were 773 million euro (Poos et al. 2008). Respectively, 58, 15, 11, and 9 percent was used for mental healthcare, medication and resources, hospital care, and primary care. About 67.4 percent (521 million euro) of the total costs for depression could be attributed to women versus 32.6 percent (252 million euro) to men (Poos et al. 2008). Given the high prevalence of depression and the substantial costs related to this mental illness and its comorbidities, the prevention and treatment of depression should be considered a public health priority (Smit et al. 2006).

During the past decades, the number of people that receives treatment for depression has greatly increased. Between 1994 and 2007, the number of general practitioner (GP) records of depression has more than doubled (Schoemaker et al. 2010[b]). This may be due to better and earlier diagnoses of depression and an increasing number of people that seek care for depression. According to Van Wieren et al. (2010) the taboo on depression is slowly decreasing hence increasing people's tendency to seek care. Yet, about one third of individuals suffering from depression are not receiving any treatment as evidenced by national health surveys from Australia, the United Kingdom., the United States, and the Netherlands (Prins et al. 2009).

Among those being treated, even fewer are likely to receive satisfactory care. For instance, while Australian and Dutch patients diagnosed with depressive disorder mostly feel a need for non-medical treatments such as information and counselling, medication is still the most popular type of intervention (Prins et al. 2009). The number of antidepressant prescriptions in the Netherlands increased from 2.9 million in 1997 to 6.8 million in 2008 (Van Wieren et al. 2010). In the second half of 2008, 880,000 people in the Netherlands received antidepressants at their pharmacy. Antidepressants are not only prescribed to people with a depressive disorder but also to people with minor symptoms of depression, anxiety, behavioural problems, or pain (Van Wieren et al. 2010).

[1] DALY = measure of overall disease burden expressed as the number of years lost due to ill health, disability, or premature

Also, from a medical perspective, antidepressant treatment is far from ideal. Even under the optimum conditions of a clinical trial, newer antidepressants do not alleviate symptoms in 40 percent of the included (primary care) patients (Williams et al. 2000). Moreover, antidepressants may have life-endangering side-effects. Licht et al. (2010) demonstrated that, in the long term, anti-depressant medications pose an increased risk of cardiovascular diseases through causing a decrease in heart rate variability. Within this context, Ministries of Health should recognize the need to temper the widespread intake of antidepressants and prioritize the development of non-pharmacological and patient-centred approaches to reducing the burden of depression.

A realm of alternative or complementary medicine that may serve as an adjunct to conventional treatments for depressive disorder is art therapy. In brief, art therapy is a form of expressive therapy that uses art making as a modality to healing, wellness, and social transformation (Goodill 2010; Malchiodi 2007; Odell-Miller et al. 2006; Rubin 2010). Though it is still fraught with controversy, art therapy is increasingly approached as a cure for people with mental health needs (Staricoff 2004).

While the use of art in the clinical setting is an emerging area for research and practice (Greenwood et al. 2007; Rubin 2010; Staricoff & Loppert 2003), the majority of arguments for art therapy's effectiveness are based on qualitative case studies (Saunders & Saunders 2000). Only in recent years, a number of randomized controlled trials have examined the therapeutic effects of art therapy (Greenwood et al. 2007). Although these studies indicate that creating something tangible, such as a painting, reduces symptoms of depression (e.g. Bar-Sela et al. 2007; Gussak 2007; Hamre et al. 2006; Hughes 2010; Thyme et al. 2007), the mechanisms involved are as yet uncertain.

Better insight into such mechanisms may contribute toward a more comprehensive notion of 'art therapy', and thereby reinforce the development of evidence-based art therapy and maximize its clinical benefits for people with (symptoms of) depression. In addition, it may provide insight into the unique value of art therapy as compared to other therapies. This could reveal how art therapy and conventional therapies can complement one another in the treatment of depression.

An understanding of the healing mechanisms of art therapy requires insight into both the patient perspective and the therapist perspective (Smeijsters 2010). This thesis focuses on the latter since art therapists' perceptions are underexposed in the current body of literature. Art therapists' perceptions of the mechanisms through which art therapy enhances the functioning of people with depressive disorder were investigated by means of semi-structured interviews. The question being addressed is: *What are art therapists' perceptions of the key mechanisms of art therapy for enhancing the functioning of people with depressive disorder?*

Study objectives

The following set of study objectives was generated: (1) to explore how art therapy is practiced in the Netherlands; (2) to determine what changes art therapists observe in the functioning of depressed clients; (3) to explore what art therapists identify as successful mechanisms of art therapy for enhancing the functioning of individuals with depressive disorder; (4) to uncover art therapists' perceptions of the barriers of art therapy for enhancing the functioning of people with depressive disorder; and (5) to explore art therapists' attitudes toward conventional treatments (i.e. antidepressant- and verbal therapies) for depression.

Outline

Key concepts inherent in the research question are clarified in the next chapter. In chapter 3, the main theoretical underpinnings are outlined. Subsequently, the research methodology is described and motivated in chapter 4, followed by the results in chapter 5. Chapter 6 discusses the key findings of this study as well as its methodological strengths and limitations. Furthermore, some recommendations are formulated for complementary research in this area. Finally, conclusions are drawn.

2. Clarifications of key concepts

The research question contains four key concepts: (1) depressive disorder; (2) (human) functioning; (3) art therapy; and (4) mechanisms. To further clarify the research question and avoid confusion each concept is defined below.

Depressive disorder

Depression is a common mood disorder. According to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR), symptoms of depression include: (1) depressed mood or loss of interest or pleasure in nearly all activities; (2) weight gain or loss, sleeping problems, and changes in psychomotor activity; (3) decreased energy; (4) feelings of worthlessness or guilt; (5) difficulties with thinking, concentrating or making decisions; and (6) recurrent suicidal thoughts (American Psychiatric Association [APA] 2000, p. 349).

In this thesis the term depression involves both minor and major depression. The DSM-IV-TR criteria for a diagnosis of major depression specify that at least five out of six symptoms must be present for most of the day nearly every day over a period of two weeks or more. Symptoms must include either depressed mood or loss of interest in activities. A diagnosis of minor depression requires two to four symptoms. Individuals who display a depressed mood for at least two years suffer from dysthymic disorder, a milder form of chronic depression (APA 2000). The course and duration of depression varies. Although both major and minor depression are accompanied by clinically significant distress or impairment in important domains of functioning (e.g. occupation), impairment is less severe for minor depression (APA 2000).

Human functioning

As symptoms become more chronic or recurrent, sufferers of depression are likely to experience serious impairments in their everyday functioning, leading to a diminished quality of life (Kruijshaar et al. 2003; Paykel et al. 2005; WHO 2011). This thesis draws upon a study of Buist-Bouwman et al. (2006) which demonstrated that depression interrupts people's functioning within multiple domains, including: (1) life activities; (2) understanding and communication; (3) mobility; (4) self-care; (5) social activity; and (6) participation in society. These domains of functioning seem highly interconnected. From the results of Buist-Bouwman et al. (2006), it can be concluded that depression is especially disabling within the first and last domain.

As shown in Table 2.1 (page 12), each domain involves a set of socially defined roles or tasks expected within one's social-cultural and physical environment (Wiersma 1996). The quality of an individual's functioning largely depends on the extent to which he or she is able to succeed in fulfilling these roles. The description of expected behaviours may, obviously, differ across communities or cultures (Wiersma 1996).

Table 2.1 Roles and tasks within the six domains of functioning

Domain of functioning	Roles and tasks
Life activities	Work; education; household; regular activities
Understanding and communication	Concentrating on something; understanding; remembering; learning new tasks
Mobility	Getting out of the house; exercising
Self-care	Washing; feeding; getting dressed
Social activity	Relationship with family and kin; starting and maintaining friendships
Participation in society	Engagement in community activities; association memberships; voluntary work

Source: Buist-Bouwman et al. (2006, p. 494-495)

Art therapy

The term art therapy encompasses two elements: art, and therapy. Whereas art can be defined as 'a means to discover both the self and the world and to establish a relation between the two', therapy refers to 'procedures designed to assist favourable changes in personality or in living that will outlast the session itself' (Rubin 2010, p. 25). Expressive or art therapy[2] is an umbrella term for multiple creative modalities including music, dance, drama, and visual arts (Goodill 2010; Rubin, 2010; Smeijsters 2008). For the purpose of this thesis, the word art solely involves forms of visual expression such as drawing, painting, and clay modelling. Art therapy is constructed as a psychotherapeutic intervention, offered by a certified art therapist, having the potential to improve the functioning of people with a mental illness, in this case depressive disorder. Section 3.1 describes the concept of art therapy in more depth.

Mechanisms

In this thesis, the term healing mechanisms refers to affective, cognitive, and empowering responses induced by art therapy which bring about improvements in the functioning of people with depression. There are indications that such responses may be evoked via both psychological and physiological pathways (Lane 2005; Staricoff 2004). In section 3.3, potential healing mechanisms are discussed in further detail.

[2] The Dutch term for art therapy is 'creatieve therapie'.

3. Theoretical framework

Art therapy is a potential alternative treatment for depressed individuals who do not respond to standard treatment procedures including medication and (verbal) psychotherapy, experience intolerable side effects, or seek additional treatments to help moderate their symptoms. Section 3.1 elaborates on this treatment technique. Subsequently, section 3.2 aims to examine the scientific evidence for the efficacy of art therapy in improving the functioning of people suffering from depression. Finally, section 3.3 provides insight into the healing mechanisms of art therapy.

3.1 When art meets therapy

This section covers a brief history of the practice of art therapy, introduces two major schools of thought in this field, and illustrates the art therapy process. Insight into the philosophy and basic principles of art therapy will lead to a more comprehensive understanding of this rather new treatment option.

The emergence of art therapy in the twentieth century

Whereas the field of art therapy is relatively new, incorporating art in healing practices is not innovative. The belief that art making is related to health has been embraced across many different cultures (Malchiodi 2007; Stuckey & Nobel 2009). Since ancient times, visual expression has played an important role in healing rituals (Malchiodi 2007; Stuckey & Nobel 2009). The Navajo, for example, use a combination of song, dance, and sand painting to cure illness while using specific patterns for specific conditions (Malchiodi 2007). Also in Tibetan medicine, sand painting is used in order to provide relief from physical and psychological suffering (Malchiodi 2007). Malchiodi (2007) argues that shamans can be viewed as the ancient forerunners of art therapists. Shamans are traditional healers who utilize images and rituals to eliminate harmful and unhealthy elements from people's bodies with the intention to heal mind, body, and spirit (Malchiodi 2007). The work of the shaman can be strongly connected to the field of art therapy, which uses image making as a pathway to health and recovery.

Although the emergence of art therapy in contemporary societies was the result of many unique events (Malchiodi 2007), Margaret Naumburg and Edith Kramer (United States) are considered pioneers of the art therapy movement (Ballou 1995; Rubin 2010). They used different definitions for art (Rubin 2010). Naumburg believed that art comes from the subconscious and must be understood through free association, always respecting a person's own interpretations (Ballou 1995; Rubin 2010). Kramer, on the other hand, viewed art as a means to integrate conflicting feelings into the ego (Ballou 1995; Rubin 2010). Though they both greatly contributed to the literature and theory regarding art therapy, Naumburg seems the most influential in clinical practice (Rubin, 2010). The notions of art therapists 'avant la lettre' such as Edith Kramer and Margaret Naumburg also had a major influence on the development of art therapy in the Netherlands (Schweizer et al. 2009).

The awareness that art may be used as a tool in healing practices developed gradually, and by the early 1940s art therapy was born in Europe and North America (Rubin 2010). Since the 1950s, there was a growing interest in art therapy, and in the 1970s art therapy started to expand, becoming an acknowledged form of treatment in the health care sector (Malchiodi 2007).

The development of art therapy in the Netherlands

Schweizer et al. (2009) comprehensively describe how a couple of developments between World War I and World War II gave rise to the development of art therapy as a specific treatment procedure in the Netherlands: (1) new perceptions towards creativity; and (2) new insights regarding care and nursing in the field of psychiatry. In the first decades of the twentieth century, perceptions of free expression and traditional arts as a meaningful activity resulted in the introduction of activating therapy as an alternative treatment for chronic patients in psychiatric hospitals. This activating therapy was primarily aimed at recreational purposes and often provided by nurses. The patients' living environment improved significantly. Due to the activities in gardens, kitchens and workplaces, psychiatric institutions became largely self-supporting (Schweizer et al. 2009).

With the advent of antipsychotics and antidepressants after World War II, self-care became more and more important. There was an increasing demand for educated social workers, psychologists, activating therapists and eventually art therapists. Within the field of activating therapy, some therapists developed their own system (Schweizer et al. 2009). They discovered how various interventions could have different therapeutic effects. This gave rise to the development of the occupational-, movement- and art therapy (in Dutch: *arbeids-, bewegings-, en creatieve therapie*), often named ABC-therapy. In 1950, the ABC-therapy was formally introduced (Schweizer et al. 2009).

Art therapy rapidly evolved as a form of treatment in psychiatric and mental institutions. Initially, the development of this new profession was encouraged by psychiatrists and psychologists who believed that it offered a means of expression to those patients who had difficulties with verbal expression (Schweizer et al. 2009). In 1962, the Dutch Association of Art Therapy (*Nederlandse Vereniging voor Expressieve en Creatieve Therapie* [NVECT]) was founded. Through time, the association's name was changed a couple of times. The initial board of psychiatrists and psychologists was in 1967 replaced by art therapists from practice. These practitioners of art therapy were often artists who worked closely together with psychiatrists and psychologists (Schweizer et al. 2009). Since 1965, individuals could be trained as professional art therapists over a 4-year period. The number of training institutes expanded and formal training of art therapists was acknowledged by law in the 1980s. After the Dutch Association of Art Therapy had been merged with the associations for music and drama therapy in the 1970s, the term 'art therapy' (*creatieve therapie*) was used as an umbrella term for multiple creative modalities including music, drama, and visual arts (Schweizer et al. 2009). In 1990, the number of modalities was extended with dance and gardening (Schweizer et al. 2009). Recently, the Dutch Association of Art Therapy merged with the Dutch Association of Psychomotor Therapy (*Nederlandse Vereniging voor Psychomotorische Therapie* [NVPMT]) (Smeijsters 2008).

Presently, art therapy is a well-established field with training and research institutes, individual practitioners, institutional connections, and professional associations (Smeijsters 2008). They operate with codes of ethical conduct, standards of practice, and procedures ensuring that they comply with them (Smeijsters 2008). Yet, the title of art therapist is not legally protected, meaning that also people without an education in art therapy can use this title (Smeijsters 2008). Registration at the Dutch Association of Art Therapy, however, requires an undergraduate degree in art therapy (Smeijsters 2008). As mentioned in chapter 2, this thesis focuses on certified art therapists.

Two schools of thought

The literature is replete with definitions of art therapy which can be divided into two major schools of thought. These schools of thought are labelled 'art as therapy' and 'art psychotherapy'. Art as therapy (Kramer) involves the belief that the process of creating art is intrinsically healing. Art making is viewed as an imaginative, authentic, and spontaneous process which leads to emotional reparation, self-insight, personal fulfilment, an increased sense of wellbeing, or personal change (Malchiodi 2007). Art psychotherapy (Naumburg) on the other hand, sometimes referred to as 'art in therapy', is grounded on the notion that art is a means of symbolic communication. This approach stresses that artworks such as drawings and paintings are helpful in communicating the inner experience (Malchiodi 2007; Smeijsters 2008).

While art as therapy perceives the specific act of creation as the cause of change, art psychotherapy perceives the (verbal) communication which results from the creative act as the cause of change (Smeijsters 2008). Thus, whereas the former approach views art as a primary healing tool which directly affects people's health and wellbeing, the latter views art as a secondary healing tool with indirect beneficial effects. According to Malchiodi (2007), art therapists use art making both as a healing process and as an aid for diagnosis.

Central features of art therapy

Below, five major features of art therapy are discussed. These show how art therapy is distinct from other therapies.

Multidisciplinary

Art therapy brings multiple disciplines together, including art, psychology, and education (Malchiodi 2007; Rubin 2010). Due to their academic background in both psychology and art, art therapists are prepared to address those psychological issues that interfere with people's normal functioning (Goodill 2010; Rubin 2010). An element of education is naturally involved since the creative process is guided by the therapist (Rubin 2010).

Therapeutic

The primary goal of the art activity is therapeutic rather than educational or recreational (Goodill 2010; Rubin 2010). According to the Dutch Association of Art Therapy (in Schweizer et al. 2009), treatment goals are set within the following areas: (1) emotional problems; (2) behavioural problems; (3) conflict management; (4) ego-strengthening; and (5) social functioning. These goals are outlined in Table 3.1 on page 16.

Table 3.1 Treatment goals of art therapy

Area	Learning goals
Emotional problems	Processing traumatic experiences; expressing emotions
Behavioural problems	Structuring; avoiding chaotic behaviour; diminishing problem behaviour; managing frustrations; decreasing levels of control, increasing concentration levels; enhancing perseverance
Conflict management	Coping with differences; processing conflicts
Ego-strengthening	Uncovering possibilities and impossibilities; increasing self-esteem; accepting boundaries and limitations; developing individuality and identity
Social functioning	Collaborating with others; watching and listening to others; promoting assertiveness; setting boundaries

Source: Schweizer et al. (2009, p. 157)

Nonverbal

Whereas general psychological practice offers treatment through a verbal discourse of persuading, coaching, encouraging and moderating (Wiener 1999), art therapy relies on primarily nonverbal means (Ballou 1995; Goodill 2010; Odell-Miller et al. 2006). Therefore, art therapy is frequently labelled as a nonverbal therapy (Malchiodi 2007). Berman (2005, in Smeijsters 2008) objects to this classification by claiming that there is also a substantial part of verbal exchange during art therapy, and that nonverbal communication does also play an important role in other therapies.

Experiential

Art therapy is an experiential and dynamic treatment process as it requires the client to actively participate in his or her own treatment (Malchiodi 2007; Smeijsters 2008). The art therapist encourages participants to create images related to an event or feeling (Ballou 1995; Rubin 2010). In the creation of an image, the client is free to use various materials and techniques including drawing, painting, sculpture, and claying (Ballou 1995; Nederlandse Vereniging voor Beeldende Therapie [NVBT] 2009). Also wood, fabrics, stone, metal, gypsum, collage material and digital media can be used (NVBT 2009). From the assumption that different materials can evoke different feelings, each art material requires a unique approach in order to attain the desired psychological process (NVBT 2009). According to Smeijsters (2008) the use of art as a central component of therapy distinguishes art therapy from other experiential or nonverbal forms of therapy.

Process-oriented

Although a piece of art such as a drawing may result from the activity, the process of making art is emphasized over the product. This means that the primary goal of the art activity is not the artwork itself but the therapeutic change that occurs while creating or exploring it (Goodill 2010). In other words, the quality of the product as such is not so much important as the meaning that the client attributes to it (Smeijsters 2008).

Serving different populations in different settings

In recent years, the field of art therapy has expanded beyond its original role in the clinical setting (Rubin 2010). The use of art therapy has been documented across a variety of settings, including hospitals, nursing homes, mental health institutions, schools, and prisons or correctional institutions (Camic 2008; Malchiodi 2007; Rubin 2010; Schweizer et al. 2009). In addition, several art therapists work in private practices (Schweizer et al. 2009).

Due to the simplicity of the process people of all age categories can participate in art therapy, regardless of skill or intellectual abilities (Camic 2008; Lane 2005; Rubin 2010). Art is an avenue towards healing that is easy to engage in. Everyone has experienced the enjoyment of creating something while making drawings, collages, or sand castles as a child. As an adult, one may paint or take photographs as a hobby and visit museums and galleries (Lane 2005; Malchiodi 2007).

Art therapists work with individuals, groups, and care systems such as parent-child, family, or couple (Schweizer et al. 2009; Rubin 2010). Examples of medical, personal, and social crises that can be mastered through art therapy include trauma, grief and loss, depression, burn-out, chronic illness, and substance abuse (Goodill 2010; Malchiodi 2007; Rubin 2010; Schweizer et al. 2009). Given its strong reliance on nonverbal modalities, art therapy is particularly useful when individuals experience difficulties with verbally expressing themselves due to communication disorders, cognitive disability, low language proficiency, cultural differences, and so on (Ballou 1995; Goodill 2010; Gussak 2007; Odell-Miller et al. 2006). Also for people who are dealing with experiences or feelings that are taboo or so intense that words fail to describe them, art therapy may provide an opportunity to communicate difficult issues in a manner that is psychologically safe (Goodill 2010). Additionally, art therapy may also be indicated when people are verbally very strong and use their language as a defence mechanism (NVBT 2009). In general, art therapy may be very beneficial for those people who learn from experiencing and doing rather than from talking about their problems (NVBT 2009).

According to Schweizer et al. (2009) there can be contra-indications for certain clients or in certain treatment phases. Clients with schizophrenia or another form of psychosis, for example, are very sensitive to stimuli and might therefore be overwhelmed by visual, tactile or sensory experiences (Schweizer et al. 2009). A second contra-indication may be a lack of affinity with art (Schweizer et al. 2009). Although it is claimed that the client does not require any artistic talent to participate in art therapy, it is questionable whether art therapy is effective when a person does not have any affinity with art. While an ‘artist’ may be too result-oriented, a lack of affinity with art may withhold a person from openly expressing and experiencing him- or herself. Also physical disabilities may impede the artistic expression (Schweizer et al. 2009).

General working method

Art therapy is a systematic form of treatment for people with psychosocial problems and/or psychiatric disorders that may support, guide, and activate them or provide a meaningful activity (Schweizer et al. 2009). At baseline, the art therapist observes the client when creating a piece of art to gain insight into the nature and origin of the problem (NVBT 2009). Based on these observations, the therapist determines the inner conflicts that are causing symptoms (NVBT 2009). In consultation with the client, the therapist draws up a personal treatment plan, tailored to the client’s specific needs and life phase (NVBT 2009). This will help him or her overcome the harmful and maladaptive habits and behaviours underlying and sustaining these inner conflicts (Ballou 1995; Goodill 2010; Rubin 2010). During or after the art activity the client reflects on the created image, the used materials as well as the

experience during discussions with the therapist or, in case of group therapy, the group (Ballou 1995; Goodill 2010; NVBT 2009; Rubin 2010). Based on these evaluations the initial goals can be adjusted if necessary. Moreover, the evaluations indicate when the treatment goals are achieved and the therapy can be ended (NVBT 2009).

In summary, art therapy is an experiential form of treatment used to treat a broad spectrum of mental disorders in both clinical and non-clinical settings. This form of therapy is characterized by a dynamic, nonverbal, expressive, and process-oriented approach. The next section reveals to what extent this treatment approach is effective in reducing levels of depression.

3.2 Art therapy: Evidence and practice in mental health care

Now that the concept of art therapy has been clarified, this section determines what is already known about the beneficial effects of art therapy on people exhibiting symptoms of depression. These advantages are verified by recent research findings in the field of art therapy, covering the period between 1980 and the present. Table 3.2 (page 19) provides an overview of the effect studies included.

Although few effect studies in the field of art therapy are specifically targeted at people with depressive disorder, a large fraction reveals information on the effectiveness of art therapy in reducing symptoms of depression. Studies from various countries (United States, Israel, Germany, Canada, United Kingdom, and Sweden) suggest that art therapy can be used to address common symptoms of depression.

Thyme et al. (2007) compared the outcomes of (brief) verbal- and art psychotherapy in a randomized controlled clinical trial. Thirty-nine women with depression, of which 21 received verbal psychotherapy and 18 received art psychotherapy, participated in the study. The findings showed similar results for both art- and verbal psychotherapy. Both groups reported fewer symptoms of depression after the psychotherapy, and even fewer symptoms after a three-month follow-up. These findings demonstrate that even brief psychodynamic art therapy may have positive long-term effects on women suffering from depression.

In line with the findings from Thyme et al. (2007), a prospective cohort study of Hamre et al. (2006) suggested that nonverbal and artistic therapies can be beneficial for depressed individuals motivated for such therapies. Ninety-seven depressed outpatients from 42 medical practices in Germany were included in the study. Data collected between July 1998 and March 2005 indicated long-term clinical improvement in chronic depressed outpatients receiving art therapy.

Furthermore, Bar-Sela et al. (2007) investigated whether participation in art therapy leads to improvements in levels of depression, anxiety or fatigue in cancer patients receiving chemotherapy treatment. In a non-randomized clinical trial, sixty adult cancer patients participated in weekly art therapy sessions. Nineteen patients participated in 54 sessions, and 41 patients participated in 42 sessions. The results indicated that art therapy could improve depression and fatigue scores in cancer patients undergoing chemotherapy.

Table 3.2 Overview of the art therapy effectiveness studies reviewed

Author(s)	Year	Study design	Number of participants	Study population	Major findings
Bar-Sela et al.	2007	Non-randomized clinical trial	60	Adult cancer patients receiving chemotherapy	Improvements in depression and fatigue levels
Bell & Robbins	2007	Randomized controlled trial	50	Adults	Significant reductions in negative mood
Green et al.	1987	Randomized controlled trial	28	Chronic psychiatric outpatients	Improvements in self-concept and social skills
Grodner et al.	1982	Controlled trial	45	Psychiatric patients and staff	Improvements in mood and social interaction
Gussak	2007	Quasi-experimental pretest-posttest design	48	Male prisoners	Decreases in symptoms of depression; improvements in mood and socialization skills
Gussak	2009	Pretest-posttest control group design	247	Male and female prisoners	Improvements in depression and locus of control
Hamre et al.	2006	Prospective cohort study with a pretest-posttest design	97	Depressed outpatients	Long-term clinical improvements in patients with chronic depression
Hughes	2010	Research-based art therapy programme	21	Sub-fertile women	Improvements in self-awareness, self-esteem, problem solving, and decision making; significant reductions in hopelessness and depression
McCaffrey	2007	Randomized intervention study	60	Elderly	Reduced depression; improvements in mood and overall attitude concerning life
Monti et al.	2006	Randomized controlled trial	111	Female cancer patients	Significant decreases in emotional and physical symptoms of distress; improvements in health-related quality of life
Nainis et al.	2006	Pretest-posttest design	50	Cancer patients	Reductions in distress and negative emotions
Puig et al.	2006	Randomized controlled trial	39	Females with breast cancer	Improved psychological wellbeing by reduction of negative emotions and increase of positive ones
Thyme et al.	2007	Randomized controlled clinical trial	39	Females with depression	Fewer symptoms of depression
Thyme et al.	2009	Randomized controlled clinical trial	41	Females with breast cancer	Significantly lower levels of depression, anxiety, and somatic symptoms

This finding is supported by a recent study of Thyme et al. (2009). In a randomized controlled clinical trial, Thyme et al. (2009) examined the effects of individual art therapy sessions on adult women with breast cancer. Of a total of 41 participants, 20 participated in five art therapy sessions delivered during a five-week period of postoperative radiotherapy. The additional 21 participants were assigned to a control group. At a four month-follow-up, the art therapy group reported significantly lower levels of depression, anxiety, and somatic symptoms than the control group. These results support the notion that art therapy has a long-term effect on patients' perceived depression levels.

Monti et al. (2006) studied whether mindfulness-based art therapy (MBAT)[3] can help cancer patients decrease symptoms of distress and improve quality of life. One hundred and eleven women diagnosed with cancer participated in the study. They were matched by age and randomly assigned to either an eight-week MBAT intervention or a waitlist control group. The intervention group performed drawing exercises in combination with yoga and meditation. Monti et al. (2006) found that artistic expression opened pathways to emotional healing through relaxation and symptom reduction. As compared to the control group, the women who participated in the art therapy perceived significant declines in emotional and physical symptoms of distress. Also their health-related quality of life was improved.

Similar conclusions were drawn by Nainis et al. (2006) who studied the efficacy of art therapy in reducing pain and other symptoms (e.g. depression) prevalent in adult cancer inpatients. A quasi-experimental design was implemented for this study. Fifty participants were recruited from the inpatient oncology units at a large academic medical centre. Their symptoms were assessed prior to and after participation in a one-hour art therapy session. There were statistically significant decreases in symptoms, including depression and global distress, and participants expressed the desire to continue with the art therapy.

Whereas the current research base in the field of art therapy suggests that art therapy is effective in reducing levels of depression, it is not always clear which specific symptoms of depression are improved. Most notably, art therapy has proven its ability to enhance a depressed mood. Bell and Robbins (2007) measured to what extent art making reduces stress and negative mood. Fifty adults were enrolled in this study. They were randomly assigned to either create a work of art or to view and sort art prints. The results indicated that art making leads to significant reductions in negative mood, and that these reductions can be attributed to the creation process rather than to viewing artworks.

Staricoff and Loppert (2003), however, argue that being exposed to art already has a positive impact on psychological parameters. Between 1999 and 2002 they implemented an art intervention in different units of the Chelsea and Westminster Hospital in the United Kingdom. The responses of patients to the presence (study group) or absence (control group) of visual arts indicated that exposure to visual arts is effective in decreasing levels of depression in patients at the medical day unit and the day surgery unit (Staricoff et al. 2001).

In a randomized controlled trial, Puig et al. (2006) explored the effectiveness of an art therapy intervention for enhancing emotional expression, spirituality, and psychological well-being among breast cancer patients. Participants were 39 women with stage I or stage II breast cancer. They were randomly assigned to an experimental group or to a delayed treatment control group. Over a four-week period the women in the experimental group participated in 4 individual one-hour therapy sessions involving guided drawing exercises. The findings indicated that the art therapy intervention improved the participants' psychological wellbeing by reducing negative emotional states and enhancing positive ones.

In addition, McCaffrey (2007) revealed that participation in an art therapy programme reduces depression levels in older adults with mild to moderate depression. The goal of this study was to evaluate the effectiveness of two types of garden walks in comparison with art therapy. Sixty older adults with depression, either self-diagnosed (69 percent) or diagnosed by a physician (31 percent), participated in a six-week intervention. They were randomly assigned to one of the three intervention

[3] MBAT is a combination of mindfulness meditation exercises and art therapy.

groups. The first group walked alone in a garden setting, the second group walked collectively through the garden with a guided imagery leader, and the third group joined group art therapy sessions. This latter group served as a control group. Focus group interviews at the end of the intervention indicated that all three groups were helpful in relieving depression and improving the participants' mood and overall attitude concerning life.

In a study with a pretest-posttest control group design, Gussak (2009) studied whether art therapy is effective in enhancing mood, socialization, problem solving abilities, and locus of control[4] among adult male and female prisoners. This study was implemented in both a male and a female correctional facility. Participants were randomly assigned to either a control group or an experimental group. The experimental groups for males and females consisted of 98 and 75 participants, respectively. The control groups for males and females consisted of 29 and 45 participants, respectively. As opposed to the experimental groups, the control groups continued their normal daily activities without art therapy treatment. The research was divided into two periods. In each 15-week research period the prisoners participated in 15 group art therapy sessions. Initially the sessions were primarily focused on the individual, but towards the end the sessions became increasingly group-oriented in order to facilitate problem solving and socialization skills. From the overall results, it was concluded that art therapy is effective in reducing depression and improving locus of control in adult male and female prisoners. An improvement in mood was also observed.

In a prior study, Gussak (2007) measured the effectiveness of art therapy in decreasing depressive symptoms among prisoners. The research location was a medium to maximum security, male adult prison in Florida. Over a four-week period, 48 male prisoners aged between 21 and 63 years joined two group art therapy sessions per week. The findings of this study reflected a significant decrease in symptoms of depression in those prisoners engaged in the art therapy programme. Furthermore, this study demonstrated a marked improvement in mood, problem solving, and socialization skills. These findings suggest that art therapy may assist in improving two domains of people's functioning: understanding and communication, and social activity.

Consistent with the findings of Gussak (2007), Green et al. (1987) demonstrated that art therapy could be used to improve the self-concept and social skills of chronic psychiatric outpatients. Twenty-eight patients were recruited. Over a ten-week period, half of the patients received art therapy as an adjunct to regular treatment. The other patients served as a control group. Those participants who engaged in the art therapy reported significant improvements in their attitudes toward themselves, while their therapists perceived that they were better able to get along with others, as compared to the control group. It was concluded that supportive art therapy has the potential to improve the functioning of chronic psychiatric patients in the short run.

In a previous study, Grodner et al. (1982) reported positive outcomes from a combined art/movement therapy programme with psychiatric patients and staff. Forty-five subjects, including depressive, schizophrenic, and psychotic patients as well as staff members, were assigned to one out of three treatment groups. Each group consisted of 15 participants. The first group participated in directed art/movement therapy, the second group participated in non-directed art therapy, and the third group did not participate in art or movement therapy. Both directed and non-directed activities,

[4] Locus of control refers to the degree to which individuals believe that they have control over their personal life. Individuals possessing an internal locus of control believe that life events are determined by their own actions, whereas individuals displaying an external locus of control believe that life events can be attributed to powerful others, fate or chance (Cockerham & Ritchey 1997).

lasting two hours, were facilitated each weekday over alternating three week time blocks until each treatment group obtained a total of fifteen cases. In the directed art/movement therapy group, the investigator, trained in both art and dance therapy, facilitated the use of art and dance as a means to communicate. In the non-directed activity group, participants got the opportunity to freely experiment with various art materials after an art therapist had demonstrated how the materials could be used. The findings suggested that a combination of short-term art and movement therapy at least temporarily improves mood and social interactions. However, since only art therapy was used in the non-directed activity group, it could not be concluded whether these changes were rather a result of art therapy, movement therapy, or both. It is possible that improvements in mood and social interaction in the directed activity group were solely the result of movement therapy.

Furthermore, there are indications that art therapy can be used to address feelings of worthlessness or guilt, as well as difficulties with thinking, concentrating or making decisions. Hughes (2010) designed a research-based art therapy programme to determine the effects of visual expression on the quality of life of sub-fertile women. This ongoing project involves eight two-hour group sessions guided by an accredited art therapist. So far 21 women have participated in the project. The participating women perceive many benefits, including stress reduction, and improvements in self-awareness, self-esteem, problem solving, and decision making. The art therapy provides a 'safe place' to express negative emotions such as anger and guilt. Psychological testing demonstrates clinically and statistically significant reductions in hopelessness and depression.

The above discussed effect studies are promising. They suggest that art therapy can assist in the recovery process of people with depression through improving mood, self-esteem, and social skills, and to a lesser extent problem solving skills and decision making. The findings indicate that art therapy may enhance people's understanding and communication as well as their social activity. Improvements in these domains of functioning could be viewed as precursors to improvements in life activities, mobility, and participation in society. Moreover, self-care might be improved as people gain a sense of personal worth.

Although the various effect studies report several possible healing mechanisms of art therapy, few studies have been designed to address the routes via which art therapy enhances the functioning of people with depression. The next section goes further into the healing mechanisms of art therapy which are of particular interest for this study.

3.3 Healing mechanisms of art therapy

Multiple theories support the significance of art in human development and help form a foundation to understand the healing avenues of art therapy. By drawing upon this theoretical foundation, sections 3.3.1 to 3.3.3 delineate eight potential mechanisms through which art therapy may enhance the functioning of people with depression. The mechanisms involved in the art therapy process are clustered around notions of *affect*, *cognition*, and *empowerment*.[5] These three poles are tightly intertwined and interlinked.

[5] The categorization of mechanisms into affect, cognition, and empowerment is inspired by the principle of thinking-feeling-acting as described in Schweizer et al. (2009).

3.3.1 Affect

During art therapy people are invited to create a tangible product which reflects experiences, thoughts, and feelings (Malchiodi 2007). The materials or movements may trigger several affective responses. This may involve bodily experiences such as strength or fatigue, but also emotions like pain or joy (Schweizer et al. 2009).

Mood

Smeijsters (2010) states that art can both evoke and transform emotions, meaning that art can be used to transform emotions into a desirable direction. This is affirmed by Puig et al. (2006) who demonstrated that art therapy can transform negative emotional states into positive ones. Art therapy may also foster positive feelings such as pride, hope and optimism through facilitating the recall of positive memories such as past experiences of drawing or painting as a child (Camic 2008; Lane 2005; Spandler et al. 2007). Hence, art therapy may be used to evoke positive emotions and stimulate a positive mood. This is in line with the art as therapy approach which stresses that the spontaneous process of art making can be used as a tool for emotional reparation.

People evaluate things more positively when in a good rather than bad mood. In turn, positive thinking about one's past, present and future promotes the recovery from a mental illness such as depression (Walburg 2008). According to Lyubomirsky and colleagues (in Smeijsters 2010, p. 110) positive emotions (e.g. happiness) can be associated with less fear, less aggression, creativity, interest in activities, and social behaviour. Moreover, Smeijsters (2010) suggests that a person's stress levels decrease as the number of positive emotions increase. A positive mood can also be related to self-care since a lack of (proper) self-care might be viewed as a sign of emotional imbalance. Taking care of oneself may give a boost to an individual's mood state. Feeling good about oneself may, subsequently, encourage people to restore and maintain relationships with partner, children, kin, and friends.

Expression

From the premise that it is beneficial for one's health to express rather than supress painful feelings, art therapists help people to communicate their, often unconscious, feelings of distress through artistic imagery (Goodill 2010; Malchiodi 2007; Rubin 2010; Smeijsters 2008). This can be explained from a psychoanalytical point of view (art psychotherapy). Psychoanalytical approaches such as Freudian Psychoanalysis and Jungian Analytical Psychology are the oldest and most discussed approaches to art therapy (Rubin 2010). They are based on an understanding of the dynamics of an individual's inner world, assuming that 'unresolved issues cause unconscious conflict, exerting tremendous power and resulting in painful symptoms' (Rubin 2010, p. 96).

Art therapy offers individuals the opportunity to express themselves in a non-traditional manner (Ballou 1995). Because art is symbolic and essentially value free, it is a relatively easy modality through which people can begin to express negative feelings that they have been rejecting throughout their lives (Rubin 2010). The limitation of verbal language is nicely put by Smeijsters (2010, p. 30, my translation) in the following words: 'people speak the same words, but these are only identical labels for different experiences'. Through creating art, people are indirectly able to express stressful emotions (e.g. anxiety, sadness), forbidden thoughts and feelings (e.g. related to the stigma of mental disorders), or experiences that are too hard to put into words (Gussak 2007; Rubin 2010; Smeijsters 2008; Stuckey & Nobel 2009).

As art therapy gives people the opportunity to make difficulties visible (to oneself and to others), it may also facilitate the (ability of) verbal expression (Ballou 1995; Spandler et al. 2007). In other words, the image may foster social activity. When people become more communicative about their problems they may not only seek emotional support from their art therapist, but also from their social environment (e.g. family and friends). Gussak (2007), though, stressed that creating art promotes the disclosure of feelings, even when the 'artist' does not discuss the meanings and ideas behind the artwork. This implies that artistic expression may reduce symptoms of depression without verbal exchange.

Saunders and Saunders (2000, p. 105) suggested that if people actively express their negative thoughts and feelings, either verbal or non-verbal, they are less likely to 'either internalize them in unhealthy ways or to act them out in destructive ways'. In contrast, some psychiatrists, like Aaron Beck, note that traumatic experiences are strengthened when they are being expressed which ultimately aggravates one's suffering (Smeijsters 2010). For instance, expressing anger towards the past may lead to the development of heart diseases (Smeijsters 2010). This implies that expressing positive emotions might be beneficial for one's health, whereas expressing negative emotions is not favourable.

In addition, recent findings of Flyn et al. (2010) indicate that there is only a link between suppression of emotions and depression in men and not in women. Whereas men suppress emotions more than women, women tend to experience greater levels of depression (Flyn et al. 2010). The findings of Flyn et al. (2010) indicate that accepting and suppressing emotions leads to less depression in women, while accepting and not suppressing emotions reduces depression in men. Hence, emotional expression might be especially useful for reducing symptoms of depression in men. However, due to cultural norms of masculinity men might experience a high threshold for participating in expressive therapies such as art therapy.

Distraction

While art can serve to evoke positive emotions, it may also be used to diminish negative feelings such as shame and helplessness (Smeijsters 2010; Spandler 2007). Individuals may learn to use art as an outlet for the emotional tensions or struggles associated with their depression (Collie et al. 2006; Rubin 2010; Stickley et al. 2007). Concentrating on the process of creating art may help them to focus away from difficult thoughts, feelings, and memories for a moment, bringing them into a state of relaxation (Malchiodi 2007; Spandler 2007). Moreover, positive feelings induced by the creative activity may enable an individual to paint, draw, or sculpture for hours (Smeijsters 2010). As art therapy may enable people to concentrate on something else than their mental condition, in this case the artwork, the art therapy in itself may be perceived as a form of self-care.

The relaxing effect of art therapy can also be partly attributed to physiological changes in the human body induced by the artistic endeavour. When creating art, the human brain triggers the parasympathetic nervous system (Lane 2005). This part of the autonomic nervous system causes the body to slow heartbeat, decrease blood pressure, slow breathing, pump blood into the intestines, and shift into a state of deep relaxation (Lane 2005). Furthermore, the process of creating a piece of art may cause the brain to release endorphins and other neurotransmitters affecting the brain cells and the cells of the immune system. This may result in pain relief, and stimulate the immune system to function more efficiently (Benson 1975, in Lane 2005). As Lane (2005, p. 122) states, 'endorphins are like opiates, creating an experience of expansion, connection, and relaxation'. In addition, the Chelsea

and Westminster study indicated that observing visual arts was also effective in normalizing heart rate and blood pressure and diminishing the level of the hormone cortisol which is related to the level of stress (Staricoff et al. 2001).

Where expressing and experiencing (un)conscious thoughts and feelings is an important part of art therapy, it is also necessary to give meaning to the experiences in relation to the problem or disorder (NVBT 2009). The art therapist addresses affective responses so that they lead to insight, problem solving, and eventually behaviour change (Goodill, 2010). Section 3.3.2 explains the cognitive aspect of art therapy.

3.3.2 Cognition

Cognitive approaches to art therapy propose that habitual distorted thought processes underlie maladaptive feelings and behaviours which, in turn, may cause symptoms of depression (Rubin 2010). As a consequence, identifying problematic attitudes and behaviour patterns is considered a central task in art therapy (Rubin 2010; Smeijsters 2010).

Insight

As the created art work uncovers unconscious feelings or conflicts, art therapy can be considered a learning experience (Rubin 2010). In other words, (symbolic) expression may lead to impression (Smeijsters 2008). Where the artistic experience (process) enables the client to express and release painful feelings in a safe manner (see section 3.3.1), the result (product) may help them to distance from and relate to these feelings in new and different ways (Smeijsters 2008). Through visualizing thoughts, feelings, and aspirations, art therapy may help individuals to gain a deeper self-understanding (Ballou 1995; Malchiodi 2007; Rubin 2010). Self-consciousness, in turn, inspires healing, social and emotional growth, and learning (Ballou 1995; Rubin 2010). Moreover, as understanding others begins with understanding oneself, self-insight may facilitate people's understanding and communication skills.

Identity

Art therapy may contribute to the development and maintenance of a positive identity that is not primarily defined by one's mental condition, an important element of the recovery process of depressed individuals (Spandler et al. 2007; Stuckey & Nobel 2009). Case studies show that producing a work of art gives people a sense of pride and achievement (Malchiodi 2007; Spandler et al. 2007). Participants may even begin to view themselves as an 'artist' (Stickley et al. 2007). As implied earlier, a positive identity enables people to restore relationships with significant others. Furthermore, a positive identity may reinforce people to apply for a job, participate in an education programme, or become engaged in community activities.

The cognitive processes discussed above are the basis for breaking negative, rigid or chaotic thought patterns of people suffering from depression. The following section describes via which mechanisms art therapy may enhance individuals' capacity to cope with problems, also termed 'empowerment'.

3.3.3 Empowerment

Art therapy is indirectly empowering, meaning that it stimulates people to take control over their lives and become self-reliant (Smeijsters 2008). This reflects a salutogenic orientation (Smeijsters 2008). A salutogenic approach focuses on factors that support human health and wellbeing rather than on factors that cause disease. The empowering effects of art therapy can be explained by reference to the self-determination theory (SDT), developed by Deci and Ryan in 2000. This theory presumes that art therapy can evoke sustainable behavioural changes conducive to the functioning of depressed individuals, through enhancing levels of autonomy, competence, and relatedness (Ryan et al. 2008).

Autonomy

Art therapy offers the opportunity to practice new behaviours (e.g. improving the ability to concentrate on something) (Smeijsters 2008). It may also show people's personal strengths, and offer new ways to cope with emotional struggles (Smeijsters 2010). As such, art therapy may contribute to a sense of autonomy. Autonomy refers to the motivation to engage in a specific behaviour. A sense of autonomy may, for instance, increase an individual's capability to gain initial employment, maintain employment and obtain new employment if required. Employed adults are expected to have a higher quality of life due to the economic, social and psychological advantages associated with a job.

If successful behaviours are to be performed and maintained outside the treatment setting, however, it is important that this sense of autonomy is sustainable (Ryan et al. 2008). SDT distinguishes between intrinsic and extrinsic life goals. Intrinsic life goals are inherently satisfying goals such as personal growth, wellbeing, and relationships (Ryan et al. 2008). Extrinsic life goals, on the other hand, focus on acquiring wealth, and being famous and physically attractive (Ryan et al. 2008). Since art therapy is focused on intrinsic rather than extrinsic life goals participants are likely to maintain attitudinal and behavioural changes in their lives.

Competence

Alongside a sense of autonomy, depressed individuals must experience a sense of competence in order to break out of their socially isolated position. Positive experiences with the art materials may bring about the pleasant feeling of being successful in something. These success experiences may foster a sense of competence. Consistent with this idea, Spandler et al. (2007) indicate that art therapy may enable participants to see themselves as someone who could achieve something because creating a piece of art makes participants' achievements visible to themselves and to others.

This sense of achievement or success, fostered by the process of creating and finishing an artwork, may generate self-esteem and bring personal satisfaction to one's life, even when basic needs and safety are lacking (Malchiodi 2007; Stickley et al. 2007). Consistent with this idea, Heenan (2006) and Hacking et al. (2008) show that art therapy increases people's self-esteem and levels of empowerment. A sense of personal worth can make people feel more hopeful about life, while the energy gained from the art activity may stimulate people to break passive attitudes (Malchiodi 2007; Rubin 2010). As such, participants may be encouraged to keep active and to develop and maintain connections (e.g. exercising, social activity) (Malchiodi 2007).

Whereas the sense of competence gained through art therapy may motivate people to become employable again, the art therapy in itself may also give individuals a sense of purpose and fill occupational voids (Malchiodi 2007; Stickley et al. 2007). Having a purpose in life is recognized as one

of the driving forces for recovery from a mental illness (Spandler et al. 2007; Stuckey & Nobel 2009). It helps to give meaning to a life 'that seems filled with boredom, dysfunctional relationships, abuse, addictions, and purposelessness' (Malchiodi 2007, p. 16).

Relatedness

Art therapy also has a social element in it. The art making activities are believed to help individuals become more communicative with others (Malchiodi 2007). Group therapy in particular offers the opportunity for social contact. As individuals share their feelings and experiences with fellow-participants, they may improve their social competence (understanding and communication). The group may also feel connected and develop a sense of relatedness. This can be considered an important vehicle for social inclusion. Social inclusion, in turn, may strengthen people's control over those factors that affect their state of mental wellbeing. The development of new friendships (social activity), for example, may reinforce community participation and hence contribute to the building of social capital (Wikström 2002). As such, art therapy may contribute to the wellbeing of both the individual and the wider community.

The therapeutic relationship may also contribute to a sense of relatedness. According to Ryan et al. (2008, p. 3), 'people are more likely to adopt values and behaviours promoted by those to whom they feel connected and in whom they trust'. The art therapist's unconditional positive regard for the participant may facilitate the recovery process of depressed individuals as it strengthens people's sense of being respected, understood, and cared for (Rubin 2010). This is supported by a study of Burns and Nolen-Hoeksema (1992) who found that therapeutic empathy has a moderate to large effect on recovery from depression. The results indicated that improvements in depression scores are highly associated with the quality of the therapeutic relationship.

Based on sections 3.3.1 to 3.3.3 it is hypothesized that the key processes underlying the positive impacts of art therapy on the functioning of depressed individuals involve affect, cognition, and empowerment. Table 3.3 summarizes the eight healing mechanisms that were identified. The right column shows which domains of functioning may be affected by the three clusters. The results of the empirical study (chapter 5) reveal which of the eight proposed mechanisms are active in enhancing the functioning of people with depression in the perception of art therapists.

Table 3.3 Healing mechanisms of art therapy

Cluster	Healing mechanisms	Affected domains of functioning
Affect	1. Art therapy triggers positive emotions 2. Art therapy reinforces emotional expression 3. Art therapy provides a distraction from negative thoughts and feelings	Self-care; social activity; understanding and communication
Cognition	4. Art therapy facilitates insight 5. Art therapy helps to build and maintain a positive identity	Understanding and communication; life activities; participation in society
Empowerment	6. Art therapy supports autonomy 7. Art therapy fosters a sense of competence 8. Art therapy facilitates a sense of relatedness	Life activities; mobility; understanding and communication; social activity; participation in society

4. Methods

In order to answer the research question a qualitative study has been conducted. The research was executed during a four-month period starting mid-March 2011. Choices concerning study design, sampling strategy, data collection, and analysis procedures are made transparent and explicit below.

4.1 Study design

The purpose of this thesis was to explore what art therapists identify as the key mechanisms of art therapy for enhancing the functioning of depressed individuals. In line with the findings of Buist-Bouwman et al. (2006), the following domains of functioning were taken into consideration: (1) life activities; (2) understanding and communication; (3) mobility; (4) self-care; (5) social activity; and (6) participation in society (see also chapter 2).

Due to the limited research base on the healing mechanisms of art therapy, the nature of this research was exploratory. Dutch art therapists served as key informants. They were considered experts in their work field. Moreover, it was assumed that they are actively engaged in the recovery process of their clients. Hence, this study was built upon actual practice knowledge (Smeijsters 2008). Profound qualitative methodologies offer the opportunity to explore art therapists' knowledge and perspectives on this particular topic without neglecting unfamiliar knowledge areas or concepts. Art therapists' perceptions of the successful working mechanisms of art therapy for enhancing above mentioned domains of functioning among people with depression have been investigated through semi-structured open interviews. The interviews served to verify, and if necessary modify, the theoretical hypothesis derived from previous studies in the field of art therapy (see section 3.3). This hypothesis asserts that art therapy enables depressed individuals to improve their functioning through affect, cognition, and empowerment.

4.2 Sampling procedure

This section describes the recruitment strategy that resulted in the final study population. Subsequently, a description of the sample population is provided.

4.2.1 Recruitment of art therapists

Certified art therapists working in the Netherlands were recruited between 10 March 2011 and 17 May 2011. To take a sample of the target population, a non-random approach was used. The geographical area of subjects was limited to the following regions: Noord-Holland, Zuid-Holland, Utrecht, Noord-Brabant, Flevoland, Gelderland, Overijssel, Drenthe, and Limburg. These regions represent 82 of the 107 art therapists who are registered at the Dutch Association of Art Therapy (*Nederlandse Vereniging voor Beeldende Therapie*) or candidate for registration.[6] Contact information of therapists was acquired via the association's website. Twenty-four therapists were excluded from the research, because: the

[6] This information is dated from 5 May 2011. Note that the number of registered art therapists is subject to change.

distance was too far (11), their target group was limited to children and youth (11), they only had an Internet practice (1), or neither their e-mail nor their phone number was available (2).

In total, 49 art therapists were approached, via e-mail and/or telephone[7], to take part in the study provided that they were treating or had treated people with (symptoms of) depression. In other words, during the initial contact art therapists were screened for adequate experience with treating depression. Furthermore, they were informed about the purpose and general content of the interview, that participation is voluntary, that they will not be asked to provide personal information about clients, and that outcomes remain confidential.

Art therapists who did not respond after maximum three contact attempts were labelled as non-response. Thirty-seven out of 49 art therapists responded to the interview request. Of those who responded 28 were eligible to take part in the study. Nine respondents were excluded since they lacked experience with depression. Twelve of the 28 targets were willing to participate in the study. The additional 16 art therapists who did belong to the target group refused to take part in the study due to a lack of time (10), additional interview requests (2) or no particular reason (4). Twelve art therapists did not respond to the interview request. Figure 4.1 depicts the yield of the recruitment procedure.

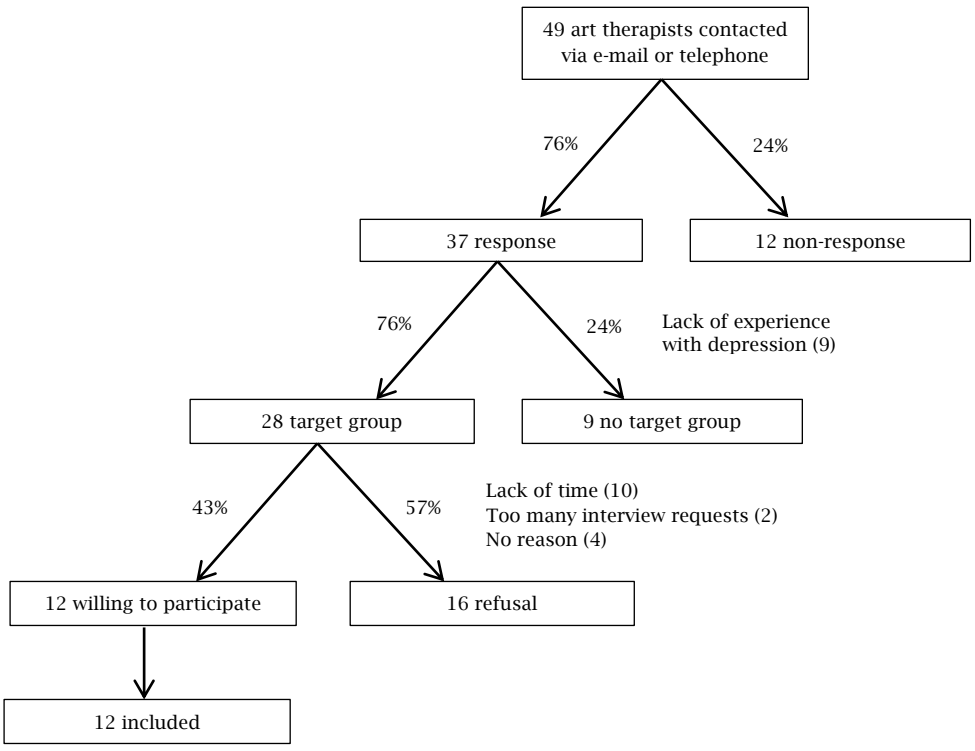

Figure 4.1 Recruitment of certified art therapists

[7] Except for one therapist, the initial contact was via e-mail. One therapist was solely approached via telephone because she explicitly mentioned on her website that she preferred to be contacted via telephone.

4.2.2 Description of the study population

The final study population consisted of 12 female art therapists. Since the vast majority of registered art therapists are constituted by females[8], this is considered a representative selection of the target population. The participants' work experience as an art therapist ranged from 6 to 45 years. The majority (11) had an educational background in art therapy (undergraduate level). Additional fields of education mainly involved the arts and/or additional therapies. The respondents worked in a private practice and/or a health care institution such as a child and adolescent psychiatry centre or a hospital. In the past, they were active in multiple occupational fields including psychiatry, mental health care, education, coaching, trauma/war, and child care. The total number of people that they were treating at the moment of the interview ranged between 3 and 40. Table 4.1 provides a detailed overview of the biographical details of the respondents.

Table 4.1 Biographical details of the respondents

R	Gender	Work experience (in years)	Educational background	Work setting	Total number of clients
1	Female	25	Architecture; art; art therapy; (currently) sandplay therapy	PP	12-16
2	Female	13	Art therapy; symbol drama; (currently) arts therapies	PP; oncology centre	15*
3	Female	20	Art therapy; psychiatric nursing; sociotherapy; art; body language	PP	35
4	Female	45	Pedagogy (not finished); industrial design; initiatory therapy; handicraft (teaching qualification for secondary school)	PP	15
5	Female	14	Art; art therapy	PP; mental health institution	40*
6	Female	29	Geography; art therapy; supervising/coaching	PP	3
7	Female	6	Art therapy	PP; child and adolescent psychiatry centre	20
8	Female	10	Art therapy	PP**; hospital (psychiatry)	20
9	Female	16	Art therapy	PP	6
10	Female	15	Art; art therapy	PP; child and adolescent psychiatry centre	22
11	Female	12	Art therapy	PP**; psychiatric clinic	17
12	Female	9	Art therapy; NLP	Child and adolescent mental health institution	16

*R = respondent PP = private practice * = number of visits per week ** = external workplace*

[8] On 19 May 2011, 94.5 and 5.5 percent of the total number of registered Dutch art therapists was constituted by females and males, respectively.

4.3 Data collection

Data were collected in the period between 18 March 2011 and 25 May 2011. In this section, the procedures of collecting data are further explained and motivated.

Semi-structured open interviews with art therapists

The art therapists have been interviewed face-to-face. The interviews took place within the respondents' home and/or work setting except for two interviews that were conducted in an external studio.[9] During the interview only the researcher and the art therapist were present. All 12 interviews were conducted in Dutch because this is the first language of both the researcher and the respondents, except for one respondent whose language of origin is German. The duration of the interviews ranged from 25 to 60 minutes; an interview lasted on average 40 minutes.

The semi-structured open interviews were performed using an interview guide consisting of a mixture of closed and open questions with a series of probes. These pre-defined questions encapsulated several preliminary topics derived from the theoretical framework. The Dutch and English versions of the entire interview guide are included in Appendix I and II, respectively. The probes or subquestions were only used if the answers to the core questions (question 1-6) did not provide the researcher with sufficient information. The carefully designed interview guide allowed respondents to develop and explain their personal perspectives and to expand on those areas which they feel are important, without being interrupted or hurried, while the researcher maintained overall control. The researcher was able to ask each respondent the same broad questions on the subject being studied without steering the conversation too much. Thus, the line of questioning was guided by the participant's responses.

The interview was divided into four stages. First, the researcher provided some information about her background and briefly explained the general purpose of the interview. The researcher emphasized the confidentiality of data, and explained how the data will be used (comments may be published but interviewees will not be identifiable). Interviews were recorded with a digital voice recorder after the verbal consent of the respondent.

In the second phase, after permission was given to tape-record the interview, some biographical details were gathered, including: gender, educational background, work setting(s), work experience, and the number of clients (with depression) that the respondent is treating at the moment of the interview and/or has treated in the past. This phase served to create a comfortable atmosphere in which mutual trust could be reached, and to create a picture of the interviewee which may be used to contextualize later responses (Bowling & Ebrahim 2008).

In the third phase, the researcher asked more open-ended questions (see Box 4.1). These were clustered around three topics or key concepts: art therapy, human functioning, and healing mechanisms. Because there is little scientific evidence for art therapy as practiced in the Netherlands, the therapists were asked to define their profession and to explain their goals (question 1). Furthermore, they were asked to describe the treatment procedure for a client with depression as well as their role in it (questions 2-3). This information could reveal to which school of thought Dutch art therapists adhere (see section 3.1), establish how art therapy is being practiced in the Netherlands, and provide insight into the specific treatment procedures for people with depression. As such, these three

[9] The majority of art therapists did practice art therapy (amongst others) within their home setting.

questions serve study objective 1. Question 4 aimed to achieve study objectives 2-3 through establishing which domains of functioning may be enhanced through art therapy, and seeking an explanation for the changes in each of these domains. Question 5 aimed to reveal which healing mechanisms art therapists consider the most important and which barriers they experience in the treatment of depression. This contributed to both study objective 3 and 4. The last question (question 6) served to explore whether or not art therapists perceive art therapy as a good adjunct to or replacement for conventional therapies for depression, thereby providing insight into the added value of art therapy (study objective 5).

Finally, at the end of the interview, respondents were given the opportunity to give additional comments and to ask questions about the research.

Box 4.1 Core questions of art therapist interviews

1. What is your definition of art therapy?
2. Can you tell me about the treatment procedure for people with depression?
3. How would you describe your role in the treatment procedure?
4. Do you observe any changes in participants' personal and/or social functioning over time?
5. What are the strengths and weaknesses of art therapy for treating people with depression?
6. How do you think art therapy fits with conventional therapies such as medication and verbal psychotherapy?

Two phases

The process of data collection took place in two phases. During each phase six interviews were conducted. In between these two phases the interview guide was evaluated and adjusted. Based on the interviews from the first phase several complementary questions were generated, some general and some more specific (i.e. What age group do you work with? What is the duration of one art therapy session? What is the size of groups? Do you collaborate with art- or psychotherapists? To what extent does the role of the art therapist differ for individual and group therapy?). These questions were added to the interview guide. Subsequently, to ensure that the data were as complete and accurate as possible, the former six respondents were requested to give some additional information via e-mail. Five of them responded to these questions.

4.4 Data analysis

During the data collection period, all 12 interviews with art therapists were tape-recorded and fully transcribed by the researcher. A negligible amount of information could not be transcribed due to sound problems (e.g. background noises). The resulting transcripts were analysed using the qualitative data analysis software program ATLAS.ti.

The analysis took place in four steps: (1) coding; (2) categorising; (3) thematising; and (4) relating (Smeijsters, 2008). The researcher made use of both a top-down approach and a bottum-up approach. First, the researcher applied a coding scheme (see Appendix III) that was designed prior to the interviews. This scheme with codes derived from the theoretical framework (see chapter 3) was used as a starting point for systematic content analysis of the qualitative narratives. The information in each transcript was organized into several abstract and overarching themes through assigning codes to small fragments (passages consisting of one or more sentences). Examples are *art therapy* and *healing mechanisms*. These codes were grouped into multiple (sub)categories in accordance with major

concepts from the theoretical framework. For instance, the code *healing mechanisms* distinguished three categories: *affect*, *cognition*, and *empowerment*. In turn, the category *affect* distinguished three subcategories: *mood*, *expression*, and *distraction*. As unfamiliar concepts emerged from the data, additional codes were developed during the analysis and added to the coding scheme (e.g. *sandplay* within the subcategory *materials* of the category *art therapy*). Finally, identified subjects were linked to one another (e.g. *group therapy* teaches participants *social skills*). Along with these linkages major concepts grew in complexity and completeness.

4.5 Ethics

Since this study encompassed a human participant approach, some ethical issues were raised. To ensure that the interviews were carried out in an ethical manner the researcher complied with the following basic ethical principles: (1) autonomy; (2) beneficence; and (3) justice (Bowling & Ebrahim 2008). The application of these three concepts is explained below.

Autonomy

All participants were treated as autonomous individuals, respecting their decisions. The researcher made sure that the art therapists entered into the research with voluntary and informed consent. Adequate information was provided during the initial contact, including: the researcher's background, how contact information was acquired, inclusion criteria (i.e. experience with treating depression), the overall research aim, the general content of the interviews (in a manner that it would not affect the outcomes), and the interview procedure (e.g. setting, duration). The voluntary nature of participation was emphasized, and art therapists were offered the opportunity to ask questions about the research via either e-mail or telephone. This allowed the subjects to freely decide whether or not to participate in the research**.** Besides, they were able to withdraw from the study at any point in time. Desires towards the interview setting were taken into consideration. During the interview itself the respondents were able to withhold information when they felt reasons to do so. They decided which information they wanted to share with the researcher.

Beneficence

Although this study can be classified as posing minimal risk of harm, the risk of potential harms resulting from study participation has been considered against the potential for benefit to subjects and society as a whole. In order to protect the participating art therapists (and their clients) against any social, emotional, or psychological harm, verbal consent was obtained prior to each interview, and it was assured that neither art therapists nor clients would be identifiable in any publication. To secure the respondents' privacy the collected data were treated confidentially, meaning that only the researcher had access to the data. The only burden imposed on the art therapists was that it required a time investment of maximum one hour. In the long term, a possible publication of the research may be beneficial for both individual participants and society at large as this may lead to an increase in knowledge of art therapy, and hence to improvements in art therapists' social position and improvements in the treatment of depression. Moreover, participation could contribute to self-reflection.

Justice

The reasons for selecting subjects were relevant to the problem being studied. For instance, art therapists were only included if they had experience with treating symptoms of depression. Each art therapist that was willing to participate was treated justly and equally, regardless of education, work experience etcetera. They were provided with similar information, and the interview procedure was equal for each respondent. Overall, burdens (i.e. time investment) and benefits (e.g. opportunity for self-reflection) were fairly distributed among the participants.

5. Results

This chapter reports on the various attitudes and perspectives held by Dutch art therapists with respect to the treatment of depression. The results are structured around the earlier presented study objectives (see chapter 1).

5.1 Art therapy in the Netherlands

The interviews provided information on major characteristics of art therapy as practiced in the Netherlands (study objective 1). Sections 5.1.1 to 5.1.5 elaborate on these Dutch practices. Treatment details are summarized in Table 5.1 (page 36).

5.1.1 Approach to art therapy

About three-quarters of the respondents viewed art as a means to gain access to and communicate emotions, thoughts or experiences that are (unconsciously) causing symptoms of depression. This suggests that art therapists' perspectives are mostly in line with an art psychotherapy approach (see also section 3.1).

> *There are many secrets and those secrets are often the cause of depression and anxiety. Through artistic imagery, dimensions and sizes and coherence, they [clients] become aware that this is only in their mind.* ~ R3[10]

> *In art therapy, you can nonverbally express your deepest thoughts. I believe that art therapy has a very different perspective than psychology or other verbal therapies, because it operates on a different level of consciousness. The unconscious becomes more apparent via drawings or the nonverbal.* ~ R6

> *That anger, that fear, and that loneliness are captured in an image.* ~ R9

> *In art therapy, someone expresses what is inside and hidden from the outside by creating an image.* ~ R11

[10] Each quotation is translated by the researcher from Dutch to English. Appendix IV provides a chronological overview of the original quotations. Filler words and irrelevant parts were removed from art therapists' statements without affecting the contents.

Table 5.1 Treatment details

R	Target group	Individuals, duos, or groups	Materials	Duration of a session	Frequency of sessions	Duration of treatment
1	Children; adults (4-65 years)	Individuals; groups (8-12 participants)	Clay; wood; paint; drawing materials; sandplay; figures	Children: 50-60 minutes Adults: 90 minutes	1-, 2- or 4-weekly	1-2 years
2	Adults (20-70 years)	Individuals; groups (6-8 participants)	Paint; clay; chalk; graphite; wood; fabrics; beads	60-90 minutes	1-, 2- or 4-weekly	10-50 sessions
3	Children; adults	Individuals; duos (i.e. siblings; parent-child)	Paint; chalk; clay; drawing materials; paper; eraser; pictures/cards; collage material	Unknown	1- or 2-weekly	Minimum 6 sessions; up to 2-3 years
4	Adults	Individuals; groups (7-8 participants)	Paint; pencils; chalk; pastel; charcoal; ink; clay; shells; collage material; fabrics	70 minutes	Groups: 2-weekly Individuals: 3-weekly	2-4 years
5	Adults (20-60 years)	Individuals; duos (i.e. couple); groups (8 participants)	Drawing materials; paint; chalk; clay; collage material	Individuals: 60 minutes Groups: 90-105 minutes	1- or 2-weekly	Groups: 10-20 weeks Individuals: up to 4 years
6	Adults (20-50 years)	Individuals	Clay; chalk; markers; pencils; paint; paper; collage material	60 minutes	2-weekly	Minimum 10 sessions
7	Children; young adults (6-21 years)	Individuals	Clay; pastel; paint; collage material; drawing materials; ink; graffiti	45 minutes	1-weekly	10 sessions; up to 9-12 months
8	Adults (18-65 years)	Individuals; duos (i.e. couple); groups (8 participants)	Paper; chalk; paint; ink; pastel; clay; boxes; film material; styrofoam; rubbish	Individuals: 60 minutes Groups: 75-90 minutes	1-weekly	Groups: 6 months Individuals: up to 1 year
9	Children; adults	Individuals; duos (i.e. siblings; parent-child)	Paint; drawing materials; clay; sandplay; figures; stone; wood	90 minutes	1-weekly	6-12 months
10	Children; adults (6-65 years)	Individuals; groups (4-6 participants)	Drawing materials; clay; stone; sculpture; collage material	Children: 45-60 minutes Adults: 75 minutes	1- or 4-weekly	10 sessions up to six years
11	Adults (19 years and older)	Individuals	Photos; clay; paint	45-60 minutes	1- or 2-weekly	Up to 50 sessions
12	Children; young adults (6-32 years)	Individuals; duos (i.e. couple; parent-child); groups	Pen; paper; pictures; graffiti; figures; fabrics; clay; rubbish	60 minutes	1-, 2- or 3-weekly	Maximum 1 year

5.1.2 Treatment settings and target groups

As mentioned in chapter 4, the respondents worked in a private practice and/or a health care institution when the interviews were carried out. They provided treatment to multiple age groups. Six art therapists worked with both children and (young) adults, whereas the additional six respondents solely worked with adults. All respondents provided individual therapy. In addition, seven respondents worked with groups, and five therapists worked with duos (i.e. parent-child, siblings, couple) though rarely. When it involves a child, the entire 'care system' including family and/or school may be (actively) involved in the treatment. The parents are often involved in an early stage.

> *I have also discussions with the parents. They [parents and child] come together. I believe that is part of the therapy. These are also therapeutic conversations. Sometimes I also do art therapy with the parents.* ~ R9

> *Personally, I often work together with family counsellors. There is usually a family counsellor in the family system. The child is in therapy with me and the family counsellor works with the parents. As a result, there is a lot of exchange.* ~ R12

The majority had experience with a broad variety of psychological and psychiatric disorders. Their experience with treating depression differed. Whereas two art therapists stated that they rarely treat individuals with depression, others estimated that at least half of their clients suffer from depressive symptoms. In general, the respondents experienced difficulties with providing an accurate number of clients diagnosed with depression. This can be partly due to the fact that a GP or psychiatrist referral is not necessarily required. As a result, a medical diagnosis is not always available. Moreover, depression is often a co-morbidity that may be overlooked. Nevertheless, most of the interviews indicate that symptoms of depression are highly prevalent in the art therapy setting.

> *I think that two-thirds of my clients have depression or depressive symptoms.* ~ R3

> *I would say that 60 to 70 percent of the people that I treat have depressive symptoms. Perhaps not major depression, but depressive symptoms.* ~ R8

> *Depressive symptoms are quite common. Out of sixteen clients, certainly half have depressive symptoms. In 2 out of 16 cases my alarm bells start ringing and I become very alert.* ~ R12

Contra-indications

The respondents mentioned a couple of contra-indications for art therapy. These can be associated with the client's personal characteristics and medical history. Psychosis was the most frequently reported (seven times). Although the art therapists did not rule out that people with psychotic characteristics can benefit from art therapy, most of them did not like to work with psychotic people. One art therapist suggested that drama therapy might be more suitable for people with psychoses. Furthermore, two respondents indicated that they do not work with suicidal people. Two respondents stressed that art therapy may not be suitable for people with major depression. Where a couple of respondents stressed that the use of antidepressants could be a requisite for effective treatment, two respondents noted that medication use may also be a contra-indication.

If medication is very repressive it is hard to gain access to emotions and bodily sensations. ~ R6

If a youngster does not use any medication it can be a contra-indication. You cannot be supportive anymore. You only receive very sad and depressed art works. As long as it [the art work] provides insight it is also constructive, but if it only becomes more and more negative it is not safe anymore to express emotions. That is too confrontational. If your art work only reflects your sadness this sadness only increases and becomes even more prominent. With a real depression I would certainly not choose that. ~ R7

According to five art therapists, a lack of affinity with art or resistance to art therapy can be an obstacle to commitment of the client. People might be anxious or feel incompetent to express their feelings through art. Initial success experiences may reduce the client's anxiety to fail, but in the case of serious resistance against art therapy it is better to seek an alternative treatment which suits the client's qualities or affinities.

If someone does not have any affinity with art whatsoever I would not use it to activate him or her. That would only increase the threshold to do something. That person might be musical instead. Then I would rather use music therapy. ~ R7

If you have an aversion to art materials I would not recommend it [art therapy]. We [art therapist and colleagues] often call it 'crafts therapy'. If you do not like crafting, making things, giving expression to something, you should not be here. ~ R12

5.1.3 Working methods

General treatment aims of art therapy appear to involve support, treatment, and revalidation. One therapist stressed that the aims of art therapy are similar to those of any other therapy.

Each therapy, that is not specific for art therapy, aims to make a person more resilient and better able to cope with emotions, so that he becomes more balanced. ~ R2

Examples of depression-specific aims that were reported by the art therapists include: (1) coping with emotions or situations; (2) self-awareness; (3) learning to set boundaries; (4) personal development; (5) acceptance of reality; and (6) compassion with oneself or others. Those aims are highly individualized. Treatment aims also differ according to group size. It seems that in group therapy the emphasis is on outer problems such as group dynamics and social competence, whereas individual therapy more or less focuses on intrapersonal problems.

The difference is that group processes mainly focus on human interaction and communication problems. In individual counselling the emphasis is on the inner problems, the inner communication. The individual approach focuses on 'Who am I and how do I communicate with my inner self?'. ~ R4

If you work individually you have very personal goals. In that case, I work with goals that are very hard to share with others. ~ R10

All therapists used a broad variety of materials in the treatment of depression. Painting and drawing techniques, clay, and collage materials were mentioned most often. Five respondents emphasized that they operate rather process-oriented and not so much product-oriented.

> *It [art therapy] is a means to an end, not meant to hang on the wall. It is part of a process.* ~ R1

> *The act of the art work is very important, more than the result. Artistic imagery is analogous to someone's system. Therefore, I observe how someone deals with assignments, how someone approaches assignments, or how someone is insecure.* ~ R3

> *It [art therapy] suits a lot of people, because it is not performance-oriented. In art therapy it is allowed to make ugly things. However, you must give yourself permission to do that.* ~ R10

The duration of a treatment session could be associated with target group, group size, and setting. Whereas the duration of adult sessions usually ranged between 60 and 105 minutes, sessions for children usually lasted between 45 and 60 minutes (with one exception). Group sessions tend to take longer than individual sessions. Moreover, in institutional settings the duration of sessions appeared to be shorter as compared to private settings.

On average, sessions were given once or twice weekly. The frequency of sessions appeared to decrease as the treatment progresses. According to the narratives, the total treatment duration for depression could range from six sessions to six years. This highly depends on the underlying causes of the depression (i.e. grief, trauma, cancer). Half of the respondents worked with periods of 6 to 10 sessions. After each period they evaluate the progress of the client, and decide whether or not to continue. The narratives suggested that treatment within private settings is more flexible as compared to institutional treatment, because the therapist is not restricted by fixed procedures or modules.

> *I love to work in a private practice, because I do not want to be obliged to treat depression in ten or twenty sessions.* ~ R2

Institutions, however, may benefit from multidisciplinary teams. Whereas collaboration between 'nonverbal' and 'verbal' therapies is encouraged within the health care setting, collaboration in private settings is usually limited to the exchange of cases (e.g. peer groups). Respondents working in an institutional setting were more likely to actively collaborate with the GP, psychotherapists, psychiatrists and/or other art therapists (e.g. dance therapist, drama therapist, and psychomotor therapist).

> *I have multiple colleagues in dance therapy. That is what I am most familiar with. Sometimes we also collaborate which is really fun. We have a couple of exercises which are related to one another. A familiar practice is the following. They [clients] make a sword with me [art therapist] and then use it to dance, move and fight in dance therapy, obviously without touching each other. This exercise is about conflict management, aggression.* ~ R8

Three respondents stated that they sometimes provide their clients with home assignments so that they can practice certain behaviours outside the therapy setting. Remarkably, one respondent

mentioned an economic reason for giving homework. She stated that therapy sessions sometimes take place on a less frequent base because only a small percentage of the art therapy costs are compensated. In this case, clients are given assignments to perform at home in between the different sessions.

5.1.4 Roles and responsibilities of the art therapist

The interviews indicated that the art therapist must fulfil multiple roles and responsibilities. These are discussed below.

The therapeutic relationship

The following characteristics of an effective therapeutic relationship emerged in the interviews: (1) an understanding of and respect for the client's personal needs and preferences; (2) shared decision making; (3) empathy; and (4) (mutual) trust. How these conditions are pursued by the art therapists is discussed below.

The former two characteristics imply client-centeredness. The majority of respondents implicitly or explicitly mentioned using a person-centred rather than a problem-oriented treatment approach. They recognized that depression is a very broad and abstract term for a condition with 'many different faces'. This was nicely put by one of the respondents:

> *Depression is one term, but not every experience of depression is the same. Beyond a lack of energy there are barely identical experiences.* ~ R4

The narratives indicated that treatment recommendations are customized in response to the client's beliefs and desires and the context in which he or she lives (e.g. home situation). Most respondents seemed to have adopted a shared decision making style, meaning that clients and/or their family (e.g. when treating children) are involved in treatment decisions.

> *I believe that it is very important that I do not decide what someone needs to change, but that someone decides himself what he wants to change.* ~ R8

> *For me art therapy is that you work on a client's goal. The client wants to achieve something but does not succeed on his own. Together you try to find a way to achieve this goal.* ~ R12

Through participatory decision making, the art therapist shows respect for the client's autonomy. This may contribute to clients' self-management skills. Some respondents stressed that the art therapist should avoid that clients completely rely on their recommendations, because that will impede the development of their ability to function independently in society. As one respondent stated:

> *It is always an issue to not keep someone [client] dependent to avoid that he keeps coming. As soon as they start having the feeling that they can manage it on their own, I finish the treatment.* ~ R2

The last two characteristics suggest that the art therapist should guarantee a positive and secure therapeutic relationship in which the client feels understood and is able to safely express him- or

herself. During the treatment process the art therapist needs to prove her trustworthiness and credibility. Three respondents believed that it is important to generate success experiences to motivate their clients and foster their confidence and trust.

However, not every respondent valued the influence of the art therapist to the same extent. Where some respondents claimed that the art therapist is accountable for treatment outcomes and progress, others attached great value to the clients' personal responsibility to achieve predetermined treatment aims.

> *What happens during that process, the choice of materials, providing an assignment, is highly influenced by the [art] therapist.* ~ R11

> *I believe that the client or patient is very responsible for what he wants to get out of it [the art therapy].* ~ R8

Treatment styles

With respect to the actual treatment process, four types of therapist roles emerged from the interviews: (1) directing; (2) guiding; (3) supporting; and (4) providing insight. The majority reported using a mix of two or more of aforementioned roles.

> *I am often coaching, but I can also be directive, thus confrontational, or supportive. That highly depends on both the client and the form of treatment that you choose, cognitive therapy or interpersonal therapy for example. I mix a lot. Especially in my individual therapies I adapt to the needs of the client. When I am with the client I keep all those theories and working methods in mind, but I look what is needed in that particular moment. In the modules [group therapy] I have to define my role more, because I work with a group.* ~ R5

The art therapists appear to be directive in the sense that they oversee the process and give the client instructions so that he or she is able to gain new experiences.

> *I am the professional. I am the one offering an assignment which I believe is beneficial for the client. That is my role as a professional. In my experience, that is directive.* ~ R6

> *You decide what you are going to draw, not me. I only give the assignment to draw. In that sense I am determinant.* ~ R4

As opposed to this directive treatment style, some respondents favoured a more or less guiding or coaching treatment style. However, while the client may sometimes freely decide which activities fit into his or her treatment, the art therapist remains the facilitator of the process. The art therapist offers materials, for example, and/or teaches drawing or painting techniques.

What matters is what the client wants and is capable of. My role is guiding, not directive. I am not going to tell someone what he should or should not do, neither in his life nor in therapy. I think it is important that the client explores and experiences his needs himself. I only need to assure that I feel what a person needs. (…) I am a witness, I am attending. I won't go reading or knitting, I won't do something myself. I observe and empathize. I try to empathize with the feelings of the client, and to feel my own feelings as well. That is basically it, witnessing and empathizing. ~ R9

Each art therapist can be considered supportive since each therapist is engaged in an emotional relationship with the client and encourages positive changes both inside and outside the treatment setting. Perhaps, providing emotional support may be viewed as the primary mission of the art therapist. Three respondents, however, stated that, although the art therapist should be involved, he or she must also keep sufficient distance.

The fourth task that can be ascribed to the art therapist is providing insight. The role of providing insight seems more or less naturally fulfilled by the respondents. As the art therapists reflect on created images with their clients, they indirectly confront the latter with their underlying problems. Insight into the emotional struggles of the client is crucial to effective and sustainable treatment.

When I treated this sixteen year old girl the first phase was providing insight. I explored the underlying thought and feelings of the depression. It is very important to discover the origin of this [thought] pattern.' ~ R7

People who have been abused during the past ten years cannot be changed within ten sessions. In this case, the DDS [Diagnostic Drawing Series] might be valuable. This series shows the trauma beyond people's depression. Subsequently, I will not focus on the depression but on the underlying trauma, provided that the person can handle it. As a result, the depression may spontaneously disappear. ~ R10

The art therapists stressed that their role depends on the nature and seriousness of the problems, the treatment phase, clients' perceived needs as well as their past experiences with art materials. People who have little experience with art materials, for example, will need more guidance than people who are more experienced. Collaboration with other therapists may also affect the role of the art therapist. For instance, when an art therapist works together with a psychotherapist the verbal exchange might be minimized. Moreover, the position of the art therapist may be somewhat less prominent in group therapy than in individual therapy. In individual therapy clients solely gain insight and support via the therapeutic relationship, whereas clients in group therapy also benefit from feedback of their group members. In other words, a group therapy approach decreases emphasis on the influence of the art therapist while emphasizing the influence of social interactions between the participants.

Within a group I use the group dynamics and primarily let the group work with one another. I do not participate for example. In individual therapy I am more part of the therapy. ~ R8

Two art therapists stressed that group therapy requires the art therapist to keep more distance and establish clear boundaries, to be able to oversee and maintain control over the process.

> *I do sometimes participate in assignments. As a role model I show the opportunities. In groups, however, I distance myself more. If you get too much involved you lose sight of your group and your facilitating role.* ~ R5

5.2 Transformations in domains of functioning

The interviews suggest that art therapists mostly deal with people suffering from mild to moderate depressions.

> *Those people with depression that I have to deal with are still functioning since they are able to come and to leave.* ~ R1

Nevertheless, the respondents mentioned several changes in their clients' functioning. This section elaborates on the personal and social transformations that art therapists observe in clients suffering from depression (study objective 2).

The respondents reported changes in four domains of functioning, including: (1) life activities; (2) self-care: (3) social activity; and (4) participation in society. Adult clients often change their job status, meaning that they either reintegrate in the labour market or switch jobs. One respondent mentioned voluntary work. Children, on the other hand, may return to school. People take better care of themselves in the sense that they set boundaries, make decisions on their own, and are less likely to mutilate themselves. Less self-mutilation was mentioned by two respondents. Moreover, the interviews indicated that both children and adults engage in more social interaction. Changes may also occur in relationships with partner, children or friends. People may either gain or break friendships/relationships. Finally, the interviews indicated that clients often resume old hobbies or interests (e.g. photography, traveling), either via an association or independently, leading to more participation in society. Changes in job status, and changes in and expansion of social networks were the most frequently reported transformations in adults' functioning.

> *People in their thirties who came out of a depression change jobs. Some of them return to their old job, but most people change jobs. That is one of the most striking changes. They apply for a job and succeed. This does not apply to elderly, but they register with a hobby club or go traveling. Basically, people do other things than before. They change their social networks. Maybe the fact that they choose is the biggest difference. They choose to which groups they want to belong and these groups increase in size. The number of social contacts increases.* ~ R4

With regard to children's functioning, the respondents mainly reported improvements in social activity.

> *The child sleeps better, is happier, asks questions, and has friends.* ~ R9

She [client] shares more with others. There is more interaction with peers. She got a boyfriend, for example, which was absolutely impossible before. ~ R12

One respondent emphasized that aforementioned changes are not specific for art therapy, meaning that similar changes in people's functioning can be evoked by any other therapy as long as it is well conducted by the therapist.

In addition, the art therapists' narratives suggest that art therapy can contribute to the recovery process of people with depression through reducing multiple symptoms of depression. The art therapists mentioned that clients are happier, undertake initiatives, have more pleasure in doing things such as sports or hobbies, have more appetite, sleep better, gain more energy, can concentrate better, have better decision making and problem solving skills, and exhibit less suicidal thoughts. According to the DSM-IV-TR, this implies decreases in all symptoms of depression (see chapter 2). More self-esteem and a renewed interest in activities were the most frequently mentioned improvements in depressive symptoms.

The art therapists suggested that clients' personal and social transformations become visible both inside and outside the therapy setting. Two respondents stressed that behavioural changes within the art therapy process (e.g. using more space in an art work, more positive themes) forebode behavioural changes in the home setting or at school.

5.3 Healing mechanisms of art therapy

This section attempts to provide a comprehensive overview of the various perceptions of art therapists toward the healing mechanisms of art therapy (study objective 3). Multiple pathways to healing could be identified from the interviews. These are clustered around notions of affect, cognition, and empowerment.

5.3.1 Affect

Mood

Three respondents stressed that art therapy may encourage positive thinking through portraying positive thoughts or messages. During the process of creating, people's mood may already start to improve as they are actively focusing on this positive thought. Through time (during difficult times) the remaining end product will remind the client of this positive thought.

Creating something beautiful or positive evokes a positive feeling. This image remains in their mind. They often take it [the image] home to remind them of that positive thought. That is very supportive in the process to think more positively. ~ R5

Another strength [of art therapy] is that an image can be very helpful. For example, to portray yourself as a strong person in clay and look at it every day. ~ R10

If you make something positive or think about it, it is already partly true. There is already a change. I think that is the greatest strength. ~ R12

Expression

A couple of respondents mentioned that depressions are not so much characterized by sadness as by the absence of emotions. Six respondents embraced that depressed individuals may gain access to and express these (suppressed) emotions through the experience of creating art. In turn, experiencing and (nonverbally) expressing emotions may release stress through acceptance.

> *Art therapy is an experiential form of psychotherapy. You work in the materials, with the materials. You provide the client with experiences and let the client reflect through expressing his inner world with another language than verbal language.* ~ R5

It was argued by three art therapists that the created art work may make issues communicable, both within the treatment setting and within the client's system (e.g. family).

> *When they [clients] come home from the art therapy, they are able to show what they have done and what is causing their pain. They have a conversation object.* ~ R2

Hence, people may develop their ability to verbally express their emotions. Using verbal language instead of images is sometimes even purposely taught by the art therapist.

> *You [art therapist] also give assignments for verbal expression since we are dependent on words in our society.* ~ R6

Two respondents suggested that particularly group therapy may contribute to people's social competence because it encourages people to communicate with others.

> *In psychiatry there is little social behaviour, because they are all very self-centred. I always enjoyed letting them work together, so that they need to communicate and become involved in interactions which they normally avoid. Those artistic assignments stimulate the development of group skills and teach them not to exceed their boundaries.* ~ R2

Distraction

Two narratives implied that being in the flow of creating art may distract people from their depressing thoughts leading to physical relaxation.

> *I often treat people who are very restless. Obviously, this has to do with feeling and especially not feeling, suppressing of emotions. Through artistic imagery they are distracted and physically relaxed. They are in the flow of creating.* ~ R5

> *I believe it is a major strength (…) to be active rather than keep focusing on your negative thoughts and sadness. Thus, you are already counter-acting during the art therapy.* ~ R7

5.3.2 Cognition

Insight in thought- and behaviour patterns

Eight respondents argued that art therapy helps their clients to gain insight into the thought and behaviour patterns (e.g. lack of initiative) underlying their depression. Nine out of the twelve respondents emphasized that the created art work makes conflicts and/or desires visible or tangible. Five respondents suggested that since this product lasts through time it gives their clients the opportunity to literally distance themselves from certain problems, adjust it or put it into perspective. Half of the respondents considered this an advantage over other treatments for depression including the additional expressive therapies (e.g. dance- and music therapy).

> *Dance and music therapy are very much based on the moment, while art therapy has the advantage that you can observe it from a distance.* ~ R2

Breaking thought patterns

Two interviews suggested that clients may not only be activated on a physical level, but also on a psychological level as the exercises stimulate the human brain. These mental processes are reflected by the artistic processes.

> *It [art therapy] stimulates the creative mind. The right hemisphere is activated through the creative activity, affecting the way you think. If you think the same all the time you do not come up with new, creative ideas. Thus, it reinforces creative thinking.* ~ R5

Identity

The majority of the respondents suggested that depressed individuals are often alienated from themselves. In line with this finding, nine respondents considered rediscovering and strengthening people's identity or individuality one of the major healing mechanisms of art therapy. As a result, people may find inner peace.

> *It is about getting in touch with who you are and getting a realistic self-image, meaning that you know your abilities and your disabilities, that you do not suppress your pain, and are able to use your strength.* ~ R2

> *Those things that cannot be put into words can still be expressed via the image. As a result, someone can get in touch with oneself. If you are more in touch with yourself you are able to function better.* ~ R6

5.3.3 Empowerment

Physically activating

In nine interviews, it was indicated that one of the main strengths of art therapy is that the emphasis is on acting and experiencing. One of the respondents defined art therapy as follows:

> *Learning from your experiences, and gaining experiences in an unusual way by using your hands. Those experiences that you undergo enable you to make changes in your life.* ~ R4

The respondents stressed that people are physically activated as they must use their whole body in the process. With respect to depression, physical activity or movement was often considered the most important vehicle for healing.

> *Doing is a prerequisite. Sometimes I tell people 'We can also do the dishes'. It does not really matter what you do. If you do something your [behaviour] patterns will become visible, not only due to your experience or the other's observations of your experience, but also because you have a tangible product.* ~ R8

> *Doing, activating, is always a good cure to depression, if only you plant seeds and wait until it starts to grow, that you have hope that it may grow.* ~ R9

One art therapist emphasized that going to (art) therapy already implies a shift towards a more active attitude.

Sense of autonomy

The interviews suggested that art therapy may facilitate a sense of autonomy through practicing new behaviours and showing personal strengths. Almost half of the respondents stressed that clients are given the opportunity to practice new behaviour patterns within a secure environment (the art therapy setting). Subsequently, such behavioural changes are translated into practice, so that the client becomes self-reliant and not so much dependent on the therapist. Sometimes home assignments are used to support clients' autonomy.

> *Because the way you act in the materials is analogous to the way you act in daily life, you are able to practice and experience behaviour patterns in the materials, which may serve as an example for change. I believe that is at the core of art therapy.* ~ R8

Four art therapists mentioned that clients may discover their strengths and weaknesses, their abilities and disabilities, through art therapy. As a result, they may become better able to utilize their personal strengths.

Sense of competence

Five interviews affirmed that art therapy can reinforce a sense of competence through generating success experiences. As the art work makes achievements visible, it may facilitate hope and self-esteem.

> *The primary goal is the experience that being active is fun and that you can grow and gain success experiences.* ~ R7

> *I watch over the process to make sure that an assignment always succeeds. That is important, especially for depressed children so that they cannot become more depressed. I must ensure that they succeed in what they do and give them the feeling that they have done it themselves.* ~ R10

Sense of relatedness

Where some respondents ascribed the success of art therapy merely to the medium, others embraced the value of the therapeutic relationship. Five respondents stressed that the art therapy is also beneficial because people are being heard and understood. This may foster a sense of relatedness. Four art therapists suggested that the therapeutic relationship determines the quality of the treatment outcomes to a very large extent.

> *The [art] therapist is the most important. I believe that all those materials can only work in conjunction with the [art] therapist. Thus, you cannot cure depression through artistic interventions alone.* ~ R1

> *When no changes occur in the relationship with me [art therapist], changes will not occur outside the treatment setting. That is a measure.* ~ R4

Two art therapists emphasized that especially group therapy may reinforce a sense of relatedness through giving feedback to and motivating one another to translate insights into practice.

> *In the assignments they [group members] see very personal things from one another making them gentle and engaged. As they share their pain, they do not feel so lonely anymore.* ~ R2

5.4 Constraints in the treatment of depression

The respondents experienced multiple constraints in the performance of their profession. The barriers that the art therapists faced in the treatment of depression are discussed here (study objective 4).

In general, the therapists did not experience so many weaknesses in their profession as such. Whereas they believed that an art therapist is competent to treat a broad variety of symptoms including depression, they accused psychologists and medicine for overshadowing their field. One respondent emphasized that many people are unfamiliar with art therapy as opposed to verbal therapies which are well-known among the population. The poor reputation of art therapy could also be due to the fact that art therapy is often labelled as alternative medicine.

> *It [art therapy] is absolutely not an alternative therapy. (…) This is a therapy with solid training and registration, and educational programmes are monitored. Many other, alternative therapies are non-committal with an attitude of 'You get your degree anyway'. I do not want to be captured by this term. Unfortunately, some insurances cover art therapy among alternative therapy.* ~ R9

> *Art therapy is not included in the Act on professions in individual healthcare*[11]*. That turns us [art therapists] into a vague alternative.* ~ R11

In addition, three respondents criticized the educational institutes of art therapy for either not paying sufficient attention to verbal skills or not integrating sufficient psychological background (e.g. due to

[11] In Dutch, this law is called 'Wet op de Beroepen in de Individuele Gezondheidszorg (Wet BIG)'.

the underdevelopment of diagnostic skills during their training art therapists may not recognize depression). Two respondents stressed that there is a lack of solid effect studies in the field of art therapy. Another issue that came up is that art therapy is often not or barely compensated by insurances, particularly when delivered outside the institutional setting. As a consequence, two art therapists felt compelled to lower the frequency of sessions in order to keep it affordable for their clients.

5.5 Attitudes toward conventional treatments

This section explores art therapists' attitudes toward conventional forms of treatment for depression including antidepressant- and verbal therapies (study objective 5). As such, it also provides further insight into art therapists' perceptions of their own ability to treat depression.

The respondents unanimously believed that art therapy, verbal therapy and medication can complement and/or strengthen one another. Hence, they strongly supported multidisciplinary collaboration.

> *What they [clients] do during cognitive therapy and what they do with me during art therapy are two different sides which complement each other. They take their learning experiences from here [art therapy] to cognitive therapy, and the other way around. This interaction offers an enormous value.* ~ R5

> *I think they [art therapy and conventional treatments] go pretty well together as long as you are aware of your added value. Differences should be cherished. In my experience they may complement each other very well. Medication can even stimulate a person to take those steps [going to therapy].* ~ R8

Two therapists suggested that, although collaboration between art therapists and psychotherapists is desirable, art therapy should be recognized as an appropriate alternative and not merely as a complement.

The respondents held different perspectives toward the use of medication. Whereas some respondents argued that the use of medication might be required for the art therapy to be supportive and successful, others stressed that the use of medication might actually be a contra-indication as it limits the experience of the client. Two art therapists emphasized that medication is often overvalued.

> *The conception is more and more 'Take a pill and it goes away'. (…) I think people's tendency to not take responsibility is strengthened by medications.* ~ R1

Yet, the majority of the respondents agreed that the use of antidepressants cannot be simply excluded in the treatment of depression. They stressed that especially more severe depressions often cannot be resolved through art therapy alone.

Art therapists' attitudes toward verbal therapy were more mixed. Some respondents stressed that verbal therapy could complement art therapy, thereby diminishing the need for verbalization in art therapy. Hence, psychotherapy may strengthen the nonverbal and experiential nature of art therapy. Other respondents, however, proposed that art therapy could be an appropriate substitute for verbal

therapy, for example when people either do not have the words to express themselves or talk too well. In addition, some respondents implied that a substantial part of verbal exchange is already incorporated in art therapy, thereby making verbal therapy unnecessary.

I think it [art therapy] replaces the talking or is equivalent to talking. However, I am not able to prove it, because this has not been investigated. ~ R9

I believe that I use a combination of verbal- and art therapy myself. ~ R12

6. Discussion

This study attempted to identify art therapists' perceptions of the successful working mechanisms of art therapy for enhancing the functioning of people with depression. This section discusses some of the key findings of this study which are of interest in the debate about (alternative) treatment of depression. Subsequently, some major methodological strengths and limitations are highlighted, and recommendations are formulated for further research.

Key findings

The findings indicate that depression is one of the conditions that are commonly treated by art therapists. However, art therapy cannot be considered a universal cure for depression. Though the respondents believed that art therapists are able to make a meaningful contribution to the treatment of depression, they stressed that not every single individual may find a route to recovery through art therapy. Some affinity with art (therapy) is considered a prerequisite to effective treatment. Consistent with this idea, Rothman (2002) stresses that individuals' belief in the salutary effect of a particular form of treatment, in this case art therapy, increases the probability of treatment success. According to Rothman (2002), positive expectations are thought to have a powerful influence on the outcomes of any type of intervention. Research has shown that even if a treatment does not have any effect, offering that treatment may have a positive psychological effect (Rothman 2002).

The most frequently mentioned contra-indication for art therapy was the presence of psychotic features. The interviews indicate that artistic processes can be emotionally overwhelming for people with psychotic features, hence jeopardizing their health. Based on this finding, it seems reasonable to propose that guidance of an art therapist who is trained to recognize the potential dangers of activities and materials, thus being able to provide a secure environment, is inevitable. An artist or art teacher may overlook the dangers of artistic expression. This implies that artistic engagement in itself does not have the potential to reduce levels of depression. Everitt and Hamilton (2003) support this notion as they indicate that it is not so much the art part that assists in the healing process of individuals with ill mental health, but rather how the therapy is delivered, the environment, and the social interactions. In contrast, recent findings of Bungay and Clift (2010) indicate that there is evidence that artistic imagery, facilitated by artists rather than by trained art therapists, can improve mental health outcomes, improve community engagement, and build social capital.

The art therapists' narratives suggest that art therapy may evoke changes in four domains of functioning, including: life activities, self-care, social activity, and participation in society. Previous studies, though, only demonstrated improvements in understanding and communication and social activity. From the interviews, it emerged that adults mainly perceive improvements in their work career and social network, whereas children mainly perceive improvements in the number of social contacts. Especially important is the finding that art therapy may contribute to more engagement in life activities such as work, since a substantial part of the costs of depression can be attributed to economic losses for employers and society as a whole.

According to the respondents, improvements in people's functioning result from experiential learning. Although the interviews reflected all healing mechanisms that were identified in the theoretical framework, not every mechanism was equally valued. The most frequently reported vehicles for personal and social transformation include: (1) gaining insight into the underlying causes of the

depression; (2) rediscovering and strengthening people's identity; and (3) physically activating people. Where verbal therapies may also operate through providing insight and strengthening a person's identity, the third mechanism is unique and distinctive for art therapy. Most of the respondents considered the 'physical aspect' of art therapy an added value compared with conventional forms of treatment.

A major constraint to the treatment capacity of art therapists appears to be a lack of insurance coverage for art therapy which makes it a relatively expensive treatment option for many people. This provides some explanation for the fact that the social position of art therapists is still much weaker than those of verbal therapists. From above, it follows that improving the cost-effectiveness of their services is one of the main challenges for art therapists. A small minority of the art therapists already adapted their treatment methods in response to this concern by providing home assignments, thereby extending the beneficial effects of art therapy to the home setting

In the coming years, art therapists may further improve the cost-effectiveness of art therapy through expanding their services with Internet-based interventions, also termed 'e-mental health'. Although e-mental health is still in its developmental phase, the first outcomes are promising according to the Netherlands Institute of Mental Health and Addiction (Trimbos 2010). Multiple studies indicate that depression can be effectively treated with the use of online interventions (Trimbos 2010). Moreover, research toward the effectiveness of online interventions demonstrated that the treatment outcomes of evidence-based interventions are generally equal to those of face-to-face therapies (Trimbos 2010).

Especially individual treatment may be supported by e-mental health. Online interventions may reinforce autonomy. Besides, they have the potential to maximize involvement of the client's care system (e.g. family), and to provide aftercare and lower the risk of relapses. Where Internet-based treatment may be an alternative for treating mild depressions, it can serve as a supplement to the regular art therapy for more severe and complex depressions. Especially those art therapists who already make use of home assignments can easily integrate Internet-based practices into their services.

Although treatment via the Internet does not exclude therapeutic involvement, the number of face-to-face sessions per treatment could be reduced as a result of the application of online services (Trimbos 2010). This will minimize the workload of art therapists per patient, thereby enabling them to treat more people at equal cost. Thus, through making information, self-tests and treatment available via the Internet art therapists can maximize their treatment capacity and make their services better affordable for their clients. Overall, the opportunity of online care may make art therapy a treatment option for a much wider audience.

One of the most interesting findings, which is of considerable interest for further development of art therapy, was that, although some art therapists held the idea that traditional medicine undermines their position in the health care sector, they all recommended multidisciplinary collaboration. The majority of the respondents stressed that medication is a valuable complement in the treatment of more severe depression as it enables the art therapist to work in a supportive manner. Opinions toward verbal therapies were diverse. Whereas some art therapists perceived verbal therapy as a useful complement, others mentioned that this verbal aspect is already embedded in art therapy. The latter pursued a combination of medication and art therapy instead of the current combination of medication and verbal therapy. Different perspectives toward verbal therapy may be largely due to differences in working methods.

The findings suggest that mainstream medicine and art therapy should co-exist and not exclude one another. A combination of art therapy, verbal therapy and/or antidepressant therapy may provide a more efficient approach to treating depression, since each of these therapies has its own unique value. Treatment of depression involves feeling, thinking, and doing. Whereas medication may affect people's emotions or mood (affect), verbal therapy may give people insight into their thought and behaviour patterns (cognition), and art therapy may enable people to transform these negative thoughts and behaviours into positive ones (empowerment). Some art therapists already experienced the benefits of multidisciplinary collaboration (e.g. with psychologists, psychiatrists or general practitioners), especially those working in an institutional setting.

However, whereas a multidisciplinary approach to treating depression may result in more efficient and cost-effective care for people suffering from depression, the realization of more large-scale partnerships is not likely as long as the health care sector does not recognize the added value of art therapy. Therefore, strategies to improve the poor image of art therapy should be explored.

Methodological strengths and limitations

The research design that has been used is quite unique as most qualitative studies in the field of art therapy focus on patient experiences. Hence, this qualitative study may enrich the current research base. Although the data from this study greatly contributed to an understanding of the processes through which art therapy may enhance the functioning of people with depressive disorder, some weaknesses must be considered.

A first limitation is that those art therapists who participated in the study might have used the interview to create a desired impression of their profession. Obviously, the subjects had very positive attitudes toward art therapy. Therefore, they might have (unconsciously) neglected negative experiences with clients, while overemphasizing the healing mechanisms of art therapy. Besides, art therapists are not able to monitor all their clients after the treatment has ended. Positive trends might not always be sustained outside the therapy setting, meaning that physical activation and other aspects of the therapy might only provide relief within the treatment setting.

Secondly, with respect to the interview guide, it may be argued that terms such as 'functioning' are quite abstract. This was on purpose with the aim of not influencing the respondents' answers too much. However, such terms may have been differently interpreted, thereby threatening the validity of the outcomes. The interviews indicated that there was a lot of variation in the respondents' experience with depression. Different interpretations of depressive symptoms may have led to the under- or overestimation of the number of clients with depressive symptoms. In addition, different ideas about depression may result in different treatment methods and, hence, outcomes. The respondents seemed to apply slightly different methods. Unfortunately, the small sample size did not allow for comparisons between different art therapy features.

Recommendations for further research

This study shows multiple knowledge gaps, and thereby opportunities for follow-up studies to gain a more accurate and comprehensive overview of the healing mechanisms of art therapy. Further large-scale research is required with sample sizes large enough to detect statistical differences in healing mechanisms under different domains of functioning. Healing mechanisms may also differ for various therapy conditions (e.g. individual versus group therapy), target groups (e.g. males versus females, children versus adults) and treatment settings.

Since art therapy involves a person-oriented approach rather than a complaint-oriented approach, qualitative methodologies might be the most appropriate to investigate the healing mechanisms of art therapy. Nevertheless, quantitative research in this field is worth investment, because that is more likely to convince funders in the current economic and political climate to compensate the use of art therapy, not only in institutional settings but also in private practices. Moreover, Dutch research in this particular area should be reinforced because foreign studies may not always be applicable to the Dutch situation due to variations in art therapy practices. Dutch evidence may contribute to legal recognition of art therapy as a cure to depression, and hence improve the social position of art therapists in the Netherlands. With respect to the cost-effectiveness of art therapy, it is recommended to further investigate opportunities for Internet-based art therapy and establish strategies for multidisciplinary collaboration.

7. Conclusion

As no similar studies have been conducted in the Netherlands so far, this research appears to be breaking new ground. It provides the first empirical evidence of the healing mechanisms of Dutch art therapy with regard to the treatment of depressive disorder. Based on the findings of the present study, art therapy can be considered a way of reconnecting people with their identity, enhancing social networks, gaining a renewed interest in social participation, and ultimately improving people's sense of wellbeing. Dutch art therapists perceive the self-insights and physical activity induced by the artistic imagery as the key mechanisms of art therapy for enhancing the functioning of people with depressive disorder. Empowerment is often used as the key to healing from depression. From this finding, it follows that art therapy has a unique value as compared to traditional healthcare approaches to depression which seem primarily focused on affect and cognition. Hence, this study greatly contributes to the current research base on the treatment of depression.

Moreover, this paper shows practical strategies to improve care for people with depression. The most important finding in this respect is that, although this study does not provide very strong evidence in favour of multidisciplinary treatment, the data seem to indicate that partnerships between art therapists and practitioners of traditional medicine will result in more efficient and cost-effective care for people with depressive disorder. Collaboration with mainstream medicine appears largely supported by art therapists. In the light of the current burden of depression, a multidisciplinary approach to treating depression involving art therapists, psychologists and physicians is worth further investigation.

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Appendices

Appendix I: Interview topic guide (Dutch)

Datum, tijd:
Locatie, plaats:
Respondent nummer:

Introductie

Mijn naam is Marion Spijkerman en ik studeer Public Health and Society aan Wageningen Universiteit. In het kader van mijn afstudeerthesis onderzoek ik hoe beeldende therapie mensen die lijden aan depressie kan helpen om hun persoonlijke en sociale functioneren in de maatschappij te verbeteren. Daarvoor ben ik geinteresseerd in uw werkwijze, opvattingen en ervaringen. Er zijn dus geen goede of foute antwoorden, het gaat om uw mening en ervaring. Uw antwoorden worden vertrouwelijk behandeld, wat betekent dat u niet identificeerbaar zult zijn in eventuele publicaties. Het interview duurt naar schatting 45 minuten. Als iets niet duidelijk is kunt u mij gerust onderbreken. Ik zou dit gesprek graag willen opnemen, zodat ik uw antwoorden volledig kan uitwerken. Vindt u dat goed?

Biografische kenmerken

- **Geslacht: M / V**
- **Opleiding**
- **Werkomgeving**
- **Wat is uw werkervaring als beeldend therapeut?**
  - Sinds hoeveel jaar beoeftent u het beroep van beeldend therapeut?
  - Kunt u mij iets vertellen over de plekken waar u gewerkt heeft?
- **Aantal cliënten**
  - Hoeveel mensen zijn er op dit moment in totaal bij u in behandeling?
  - Hoeveel mensen met depressie zijn op dit moment bij u in behandeling?
  - Hoeveel mensen met depressie heeft u (naar schatting) behandeld in het verleden?

Beeldende therapie

1. **Hoe definieert u beeldende therapie?**
   - Wat is uw missie/visie?
   - Wat zijn de belangrijkste kenmerken van beeldende therapie?

2. **Kunt u me meer vertellen over de behandelprocedure voor mensen met depressie?**
   - Hoe gaat u stap voor stap te werk?
   - Wat voor activiteiten vinden plaats?
   - Welke materialen worden gebruikt tijdens de sessies?
   - Over wat voor thema's praat u met de cliënt?
   - Hoe vaak vinden sessies plaats?
   - Wat is het aantal sessies per cliënt?
   - Werkt u met individuen, koppels en/of groepen?

3. **Hoe zou u uw rol in het behandelproces omschrijven?**
   - Hoe zou u de relatie met de cliënt omschrijven?

Functioneren

4. **Ziet u na verloop van tijd veranderingen in het persoonlijke en/of sociale functioneren van depressieve mensen die bij u onder behandeling zijn?**
   - Vinden veranderingen plaats in: dagelijkse activiteiten (bijv. werk, opleiding of huishoudelijke taken); concentratie en communicatievaardigheden; mobiliteit; zelfzorg; sociale activiteiten en het onderhouden van relaties; maatschappelijke participatie (bijv. lid van vereniging, deelname aan buurtactiviteiten, vrijwilligerswerk)?
   - Kunt u deze veranderingen beschrijven en uitleggen hoe beeldende therapie daar aan bijdraagt?

Mechanismen

5. **Wat zijn de sterke en zwakke punten van beeldende therapie met betrekking tot de behandeling van mensen met depressie?**
   - Wat zijn de belangrijkste dingen die beeldende therapie succesvol maken in het verbeteren van het functioneren van mensen met depressie?
   - Wanneer is beeldende therapie een minder gunstige behandelmethode?

6. **Hoe denkt u dat beeldende therapie aansluit bij traditionele behandelmethoden zoals medicatie en verbale psychotherapie?**
   - Wat vindt u van beeldende therapie als supplement of substituut voor traditionele behandelmethoden voor depressie?
   - Wat is de toegevoegde waarde van beeldende therapie? Waarom?

Afsluiting

- Zijn er nog belangrijke dingen met betrekking tot beeldende therapie en depressie waar ik niet naar gevraagd heb?
- Heeft u tot dusver nog vragen met betrekking tot het onderzoek?

Appendix II: Interview topic guide (English)

Date, time:
Location, place:
Respondent number:

Introduction

My name is Marion Spijkerman and I study Public Health and Society at Wageningen University. For my Master Thesis I investigate how art therapy can help people suffering from depression improve their personal and social functioning in society. Hence, I am interested in your working methods, perceptions, and experiences. There are no good or wrong answers; it is about your opinion and experience. Your responses will be kept confidential, meaning that you will not be identifiable in any publications. The duration of the interview is estimated at 45 minutes. If something is unclear, feel free to interrupt me. I would like to tape-record this interview, so that I can fully transcribe your responses. Do you agree?

Biographical details

- **Gender: M / F**
- **Educational background**
- **Work setting(s)**
- **What is your work experience as an art therapist?**
  - For how many years have you practiced the profession of art therapist?
  - Could you tell me something about the places where you have worked?
- **Number of clients**
  - What is the total number of people that you are treating at this moment?
  - How many people with depression are you treating at this moment?
  - What is the (estimated) number of people with depression that you have treated in the past?

Art therapy

1. **What is your definition of art therapy?**
   - What is your mission/vision?
   - What are the main features of art therapy?

2. **Can you tell me about the treatment procedure for people with depression?**
   - What is your step-by-step approach?
   - What sorts of activities are being done?
   - What kind of materials do you use during the sessions?
   - What sorts of things do you talk about?
   - How often do sessions take place?
   - What is the number of sessions per client?
   - Do you work with individuals, couples and/or groups?

3. **How would you describe your role in the treatment procedure?**
   - How would you describe the therapeutic relationship?

Human functioning

4. **Do you observe any changes in participants' personal and/or social functioning over time?**
   - Do changes occur in: daily activities (i.e. work, education, household); concentration and communication skills; mobility; self-care; social activity; participation in society (i.e. association membership, participation in community activities, voluntary work)?
   - Can you describe these changes and explain how art therapy contributes to these changes?

Healing mechanisms

5. **What are the strengths and weaknesses of art therapy for treating people with depression?**
   - What are the key things that make art therapy successful in enhancing the functioning of people with depression? Why does art therapy work?
   - When is art therapy a less favourable treatment option?

6. **How do you think art therapy fits with conventional therapies such as medication and verbal psychotherapy?**
   - What do you think of art therapy as a supplement or replacement to conventional therapies for depression?
   - What is the added value of art therapy? Why?

Rounding-off

- Are there any important things regarding art therapy and depression that I have neglected to ask about?
- Do you have any questions about the research so far?

Appendix III: Coding scheme

Codes	Categories	Subcategories
Biographical details	Region	Noord-Holland
		Zuid-Holland
		Utrecht
		Noord-Brabant
		Flevoland
		Gelderland
		Overijssel
		Drenthe
		Limburg
	Gender	Male
		Female
	Education	
	Work setting	Healthcare setting
		School
		Prison
		Home setting
		Private practice
	Years of work experience	
	Number of clients	
	Prevalence of depression	
Art therapy	Features	Simplistic
		Nonverbal
		Experiential
		Process-oriented
	Materials	Drawing
		Painting
		Sculpture
		Clay
		Wood
		Fabrics
		Stone
		Metal
		Gypsum
		Collage material
		Digital media
	Frequency of sessions	
	Duration of a session	
	Treatment duration	
	Group composition	Individual
		Group
		Parent-child
		Family
		Couple
	Target groups	Children/youth
		Adults
		Elderly
	Treatment aim	Emotional functioning
		Behaviour
		Conflict management
		Ego-strengthening
		Social functioning
	Strengths	
	Weaknesses	
	Contra-indications	Psychosis
		Lack of affinity with art
		Physical disabilities
	Collaboration with other caregivers	Psychotherapists
		Psychiatrists
		General practitioners
		Art therapists
School of thought	Art as therapy	
	Art psychotherapy	

Role of the art therapist		
Changes in domains of functioning	Life activities	Work Education Household
	Understanding and communication	Concentrating Understanding Remembering Learning
	Mobility	Getting out of the house Exercising
	Self-care	Washing Feeding Getting dressed
	Social activity	Relationships Friendships
	Participation in society	Engagement in community activities Association memberships Voluntary work
Healing mechanisms	Affect	Mood Expression Distraction
	Cognition	Insight Identity
	Empowerment	Autonomy Competence Relatedness
Attitudes toward conventional treatments	Complement Alternative	

Appendix IV: Original quotations

5.1 Art therapy in the Netherlands

5.1.1 Approach to art therapy

Er zijn veel geheimen en die geheimen zijn vaak de veroorzakers van depressie en angst. Door beeldend werk, door maten en grootten en samenhang, wordt dat gewoon gezien dat dat maar in hun gedachten kan zitten. ~ R3

Beeldende therapie is voor mij een vorm waarin je non-verbaal uit kunt drukken dat wat het diepste in je leeft, dat wat je ten diepste beweegt en bezig houdt. En dat beeldende therapie daar een heel andere invalshoek heeft dan psychologen of andere verbale therapieen, omdat het op een ander bewustzijnsniveau werkt. En ook het onbewuste veel meer in tekeningen of via het non-verbale naar voren kan komen. ~ R6

Die boosheid, die angst en die eenzaamheid krijgt een beeld. ~ R9

Wat er binnenin leeft, wat er is maar wat niet in contact komt met buiten, brengt iemand in beeldende therapie naar buiten door het maken van een beeld. ~ R11

5.1.2 Treatment settings and target groups

Verder heb ik dan oudergesprekken, maar die [ouders en kind] komen wel samen. Dat vind ik wel onderdeel van de therapie. Dat zijn ook wel therapeutische gesprekken. Soms doe ik daar ook beeldend werk mee, met ouders. ~ R9

Ik werk hier zelf heel veel met gezinsbegeleiders. Er zit vaak wel een gezinsbegeleider in het gezinssysteem. Dan heb ik het kind in therapie en werkt de gezinsbegeleider met de ouders. Dan heb je daar ook heel veel uitwisseling over. ~ R12

Ik denk dat wel tweederde van mijn klanten eigenlijk richting depressie of depressieve klachten zit. ~ R3

Ik zou wel willen zeggen dat misschien wel 60 tot 70 procent van de mensen die ik zie in ieder geval wel depressieve klachten hebben gehad. Misschien niet allemaal hele diepe depressie, maar wel depressieve klachten. ~ R8

Depressieve klachten, dat komt wel veel voor. Van de 16 wel zeker de helft, depressieve klachten. Dat mijn alarmbellen aan gaan en ik heel erg waakzaam ben, dat is zeg maar met 2 van de 16. ~ R12

Medicatie, als die erg onderdrukkend is kun je moeilijk bij het gevoelsleven komen, moeilijk bij de lichamelijke gewaarwordingen. ~ R6

Als een jongere helemaal niet ingesteld is op medicatie kan dat wel een contra-indicatie zijn. (…) Dan kun je helemaal niet meer steunend bezig zijn, krijg je alleen maar hele sombere en depressieve werkstukken. Zo lang dat inzichtgevend is is het ook opbouwend, maar als het alleen maar afzakt dan is het niet meer veilig om je emoties zo te uiten en dat is natuurlijk te confronterend. Dat leidt eigenlijk nergens toe als je alleen maar je somberheid in je werkstukken ziet, want dan zie je het terug en dan is het alleen nog maar groter. Het is alleen maar nog meer aanwezig. Bij een echte depressie zou ik daar zeker niet voor kiezen. ~ R7

Als die helemaal niks heeft met het beeldend werken zou ik dat ook niet als ingang kiezen om iemand te activeren, want dan heb je alleen maar een nog hogere drempel om iets te gaan doen of iets van jezelf te laten zien. Diegene is misschien muzikaal. Dan zou ik eerder muziektherapie doen. ~ R7

Als je aversie hebt tegen beeldende materialen zou ik het niet aanraden. Wij noemen het heel vaak knutselruimte of knutseltherapie. Als je niks hebt met knutselen of dingen maken, expressie geven aan iets, dan moet je niet hier zijn. ~ R12

5.1.3 Working methods

Elke therapie, daar is beeldend dan niet specifiek in, heeft tot doel dat een mens veerkrachtiger wordt en zijn emoties beter kan hanteren waardoor die in het leven meer in evenwicht komt. ~ R2

Het grote verschil is dat wanneer je met groepsprocessen werkt het vooral gaat over het tussen menselijk contact en ook de problemen die mensen hebben op het gebied van communicatie met anderen. Bij individuele begeleiding is het zwaartepunt gericht op de intrapsychische problematiek, de communicatie met zichzelf. (…) Het accent in de individuele benadering ligt op: Wie ben ik en hoe communiceer ik met mijn innerlijk? ~ R4

Als je individueel werkt heb je echt persoonlijke doelen. Dan werk ik ook aan doelen die heel moeilijk zijn om met anderen te delen. ~ R10

Het [beeldende therapie] is een middel tot doel, een bijzaak, niet om aan de muur te hangen of zo. Het is een stuk van een proces. ~ R1

Het handelen van beeldend werk is eigenlijk heel erg belangrijk, meer dan het resultaat. Beeldend werk loopt analoog aan het systeem waar iemand in zit. Ik kijk dus heel erg, niet alleen naar het beeldend werk, maar hoe iemand met de opdrachten omgaat, hoe iemand dat aanpakt of hoe iemand onzeker is. ~ R3

Het [beeldende therapie] is geschikt voor heel veel mensen, omdat het in principe niet prestatiegericht is. Dat maken mensen er soms zelf van. Beeldende therapie is soms ook gewoon scheuren of juist lelijke dingen mogen maken. Maar je moet wel een zekere toestemming geven aan jezelf om dat te durven ontdekken. ~ R10

Daarom werk ik ook graag in een eigen praktijk, omdat ik niet in modules, in tien sessies of twintig, een depressie wil moeten kunnen behandelen. ~ R2

Ik heb meerdere collega's danstherapie. Dat is waar ik het meest mee bekend ben. Ik doe ook wel eens dingen samen trouwens. Dat is heel leuk. We hebben een aantal oefeningen die we doen die we dan ook koppelen. Een bekende oefening die we doen is dan maken ze [cliënten] bij mij een zwaard en dan gaan ze daar bij dans mee dansen en bewegen en mee vechten uiteindelijk, zonder elkaar te raken natuurlijk. Dat gaat om conflicthantering, agressie. ~ R8

5.1.4 Roles and responsibilities of the art therapist

Depressie, dat is één term, maar niet elke beleving van depressie is hetzelfde. Of beter gezegd, er zijn er nauwelijks die hetzelfde zijn, alleen dat er weinig energie is. ~ R4

Dat vind ik ook een hele belangrijke, dat ik niet bepaal wat iemand moet veranderen, maar dat iemand zelf bepaalt wat ie wil veranderen. ~ R8

Beeldende therapie is voor mij dat je werkt aan een doel van een client. De client wil iets bereiken en dat lukt niet alleen. Dus je gaat samen kijken: Hoe kan je dat dan wel bereiken? ~ R12

Het is altijd een beetje zoeken dat je niet iemand [cliënt] afhankelijk houdt die dan gewoon graag blijft komen. Zo gauw ze het gevoel hebben 'Nou kan ik weer een beetje zelf" dan rond ik het af. ~ R2

Alles wat er in dat proces gebeurt, dus de keus van het materiaal, het geven van de opdracht, daar heeft de [beeldend] therapeut natuurlijk enorm veel invloed op. ~ R11

De cliënt, patiënt, vind ik heel erg verantwoordelijk voor wat die komt halen. ~ R8

Vaak ben ik coachend, maar ik kan ook wel directief zijn, dus confronterender, en soms heel steunend. Dat ligt heel erg én aan de cliënt én aan welke behandelvorm je kiest, dus of het cognitieve therapie is of interpersoonlijke therapie. Waar sluit je bij aan? Ik mix wel veel, zeker in mijn individuele therapieën sluit ik heel erg aan bij wat nodig is. Bij de cliënt heb ik al die theorieën en werkwijzes wel in mijn achterhoofd, maar kijk ik wat op dat moment nodig is of van toepassing is. In de modules [groepstherapie] moet ik daar iets meer een rol in bepalen, want dan werk je ook met een groep. ~ R5

Ik ben de professional. Ik blijf degene die een opdracht aanbiedt waarvan ik denk dat de ander daarmee gebaat is, dus dat is mijn rol als professional. Dat voel ik als sturend. ~ R6

Ik bepaal niet wat jij gaat tekenen bijvoorbeeld, jij bepaalt wat je gaat tekenen. Ik geef alleen wel aan 'Ga tekenen', dus in die zin bepaal ik wel. ~ R4

Het gaat om wat de client wil en wat die kan. Mijn rol is begeleidend, niet directief. Ik ga iemand niet vertellen wat die moet doen of laten, niet in zijn leven en ook niet in de therapie. Ik vind het belangrijk dat de client zelf ontdekt en zelf ervaart wat die nodig heeft. Het enige waar ik voor moet zorgen is dat ik dat ook aanvoel, wat iemand nodig heeft. (...) En dat ik getuige ben, ik ben er bij. Ik ga niet zitten lezen of breien, ik ga niet zelf iets doen. Ik kijk mee en ik voel mee. Ik probeer me in te voelen in hoe de client zich voelt, mijn eigen gevoelens te voelen. Dat is het eigenlijk, getuige zijn en invoelen. ~ R9

Met het depressieve meisje van 16 wat ik hier zie was de eerste fase vooral heel inzichtgevend. Toen ben ik echt ingegaan op de achterliggende gedachte en gevoelens van de depressie. Het is wel heel belangrijk om te ontdekken waar is dat [gedachte] patroon ontstaan en wat zit daar achter eigenlijk. ~ R7

Mensen die 10 jaar lang mishandeld zijn kun je niet in 10 sessies veranderen. Daarvoor is de DDS ook waardevol. Komen mensen voor depressie dan zie je in zo'n serie dat er eigenlijk een heel groot trauma achter zit. Dan ga ik niet aan de depressie werken. Omdat die trauma's zo hoog in die tekeningen naar boven komen, gaan we, in overleg hoor, als ik denk dat iemand het aan kan, met het trauma aan de gang. Dan gaat die depressie soms vanzelf over. ~ R10

Bij een groep werk ik veel meer vanuit de groepsdynamiek en laat ik de groep vooral met elkaar aan het werk. In de groep doe ik niet mee bijvoorbeeld, en in individuele therapie ben ik zelf veel meer onderdeel. ~ R8

Ik doe bij sommige opdrachten ook wel eens mee, als 'role model' laat ik dan zien hoe het kan. Maar in groepen blijf ik daar meestal wel wat buiten. Als je echt mee gaat doen dan hou je te weinig overzicht, te weinig de rol van de procesbegeleider. ~ R5

5.2 Transformations in domains of functioning

Die mensen die ik krijg met een depressief beeld functioneren eigenlijk nog een beetje, want die zijn nog in staat hier te komen en weer weg te gaan. ~ R1

Mensen van rond de 30 die uit een depressie komen veranderen van baan. Sommigen gaan weer terug in de baan die ze hadden, maar de meesten veranderen van baan. Dat is één van de opvallendste dingen. Ze gaan solliciteren en ze vinden een andere baan. De ouderen, daar kun je dat niet af meten. Die blijken zich dan bij een bepaalde hobbyclub aan te melden, of ze gaan reizen maken. Afijn, ze doen andere dingen dan ze daarvóór deden. Wat ze daarvóór deden veranderen ze, ze stappen over naar vooral misschien ook andere mensen waarmee ze om willen gaan. Misschien is dat de grootste verandering, ze kiezen. (...) Ze gaan zelf kiezen voor andere groepen waarmee ze omgaan, en de groepen worden groter. Het aantal mensen waarmee men contact heeft breidt zich uit. ~ R4

Het kind slaapt beter, is vrolijker, het stelt vragen, het heeft vriendjes. ~ R9

Ze gaat meer delen met anderen, er is meer interactie met leeftijdsgenoten. Ze kreeg bijvoorbeeld een vriendje en dat was daarvoor echt onmogelijk. ~ R12

5.3 Healing mechanisms of art therapy

5.3.1 Affect

Dat geeft op zich al een prettig gevoel, want je bent iets moois of iets leuks of iets positiefs aan het creëeren. Dat plaatje blijft in hun hoofd. Ze nemen het [plaatje] ook vaak mee naar huis, zodat het thuis ook blijft herinneren aan die positieve gedachte. In die zin is dat heel helpend en heel steunend in het proces om positief te gaan denken. ~ R5

Ook een sterk punt is dat een beeld je heel erg kan helpen. Bijvoorbeeld: Maak jezelf als een heel sterk persoon in klei en kijk er elke dag eens naar. ~ R10

Als je iets positiefs maakt of erover denkt is het al een beetje waar. Dan ontstaat er al verandering. Dat is het sterkste punt denk ik. ~ R12

Beeldende therapie is een vorm van psychotherapie waarbij je ervaringsgericht werkt. Je werkt in het materiaal, met het materiaal. Je laat de cliënt ervaringen opdoen en je laat de cliënt reflecteren door expressie te geven aan hun innerlijke wereld met een andere taal dan verbaal. ~ R5

Als ze [cliënten] van de beeldende therapie naar huis gaan kunnen ze laten zien wat ze gedaan hebben, waar hun pijn is, en hebben ze een gespreksvoorwerp. ~ R2

Je [beeldend therapeut] geeft ook oefeningen om het te verwoorden, want daar moeten we het uiteindelijk mee doen in onze samenleving. ~ R6

In de psychiatrie kunnen opdrachten heel gestructureerd aan sociaal gedrag werken, want daar is vaak weinig sociaal gedrag, omdat ze allemaal zo met zichzelf bezig zijn. Dat heb ik altijd erg plezierig gevonden, om ze daar ook eens samen te laten werken. Dat je toch een keer moet communiceren, waardoor ze toch in interacties komen die ze normaal vermijden. Dus die beeldende opdrachten die helpen best wel om groepsvaardigheden te ontwikkelen en ook om te leren dat je binnen je eigen grenzen moet blijven. ~ R2

Ik heb heel vaak mensen die heel onrustig zijn en dat heeft natuurlijk alles te maken met voelen of niet willen voelen vooral, onderdrukken van emoties. De oppervlakkige laag is dat ze door beeldend werk te maken afleiding hebben en zich fysiek ontspannen. Ze worden meegenomen in het proces van het creëeren. ~ R5

Wat ik heel sterk vind is het activeren, het bezig zijn, het stukje inzicht geven en het in het handelen zitten in plaats van in je negatieve gedachte en in je somberheid. Dus eigenlijk ben je al bezig met tegengesteld handelen tijdens het beeldend werken. ~ R7

5.3.2 Cognition

Met de dans en met de muziek, dat zijn natuurlijk ook creatieve therapieën, maar die moeten het zo hebben van het moment. Beeldend heeft het voordeel dat je er ook nog afstand van kan nemen en er naar kan kijken. ~ R2

Het [beeldende therapie] stimuleert ook het creatieve brein. De rechter hersenhelft wordt gestimuleerd door iets creatiefs te maken wat weer een effect heeft op hoe je denkt. Als jij de hele tijd hetzelfde denkt dan bedenk je niet nieuwe, creatieve dingen. Dus het helpt ook de creativiteit van het denken te stimuleren. ~ R5

Het gaat natuurlijk over dat je contact krijgt met wie je zelf bent en dat je daarin een reëel beeld krijgt, dus dat je weet wat je kan, dat je ook weet wat je niet kan, en dat je je pijn niet wegduwt, maar ook je kracht kan gebruiken. ~ R2

Dat wat niet benoemd kan worden dat kan via het beeld eruit komen. Daardoor kan iemand meer contact met zichzelf voelen, en als je meer contact met jezelf ervaart kun je ook beter functioneren. ~R6

5.3.3 Empowerment

Van je ervaringen leren, en op een ongebruikelijke manier ervaringen opdoen via je handen. Dus echt met je handen werken. Door die, niet bedachte ervaringen, maar ervaringen die je ondergaat kun je veranderingen leren aanbrengen in je leven. ~ R4

Het inzetten van het doen is een voorwaarde. Ik zeg wel eens tegen mensen: We kunnen ook gaan afwassen. Het maakt niet zoveel uit wat je doet, maar als je iets gaat doen dan komen daar je [gedrags]patronen in naar voren, die worden zichtbaar. Niet alleen door wat je beleeft tijdens het doen of wat de ander ziet dat je beleeft, maar ook doordat je een tastbaar werkstuk hebt. ~ R8

Het doen, sowieso activeren is altijd goed tegen depressie, al is het maar dat je weer plantjes zaait en wacht tot het gaat groeien, dat je die hoop hebt van er komt misschien toch iets op. ~ R9

Omdat er een analoge parallel is tussen materiaal en patronen, hoe je werkt in materialen en hoe je doet in het dagelijks leven, kun je dat ook in het materiaal oefenen, ervaren, wat voorbeeldervaring kan zijn voor verandering. Dat is heel erg wat beeldende therapie is, denk ik. ~ R8

Het eerste hoofddoel is de ervaring dat iets doen leuk is en dat je daarin kan groeien en succeservaringen op kan doen. ~ R7

Ik bewaak het wel dat een werkstuk altijd lukt. Dat is wel belangrijk, vooral voor depressieve kinderen , dat ze niet depressiever kunnen worden. Ik moet heel goed zorgen dat het lukt wat ze doen, maar hun het gevoel geven dat ze het zelf gedaan hebben. ~ R10

Het allerbelangrijkste is de therapeut. Ik denk dat al die materialen überhaupt niet werken, maar dat die alleen in de samenhang met de therapeut misschien een betekenis kunnen hebben. Je kan niet alleen je depressie genezen met beeldende interventies denk ik. ~ R1

Als de relatie met mij [beeldend therapeut] niet verandert, verandert die daarbuiten ook niet. Dat is eigenlijk een graadmeter. ~ R4

Die [groepsleden] zien heel snel in elkaars werkstukken van elkaar hele persoonlijke dingen en dat maakt milder, maakt betrokken. Het relativeert, of de gedeelde pijn maakt dat je je niet zo eenzaam meer voelt. ~ R2

5.4 Constraints in the treatment of depression

Het [beeldende therapie] is absoluut geen alternatieve therapie. (...) Dit is een therapie met een gedegen opleiding en een registratie en een controle op de opleiding en op de vakken en de werkstukken die studenten maken. Een heleboel andere, alternatieve therapieën zijn een beetje vrijblijvend van 'Je diploma krijg je toch wel'. Daar wil ik niet mee genoemd worden. Helaas vallen we bij sommige verzekeraars bij de vergoedingen wel onder de alternatieve therapie. ~ R9

Beeldende therapie is niet opgenomen in de Wet BIG. Dat maakt ons een vaag alternatief. ~ R11

5.5 Attitudes toward conventional treatments

Wat ze [cliënten] bij cognitieve therapie doen en bij mij doen in beeldende therapie, dat zijn twee verschillende kanten die elkaar heel erg aanvullen. Wat ze in de ervaring hier [bij beeldende therapie] leren over zichzelf nemen ze weer mee naar de cognitieve therapie, en andersom. Het is een wisselwerking die een enorme meerwaarde biedt. ~ R5

Ik denk dat het [beeldende therapie en traditionele behandelmethoden] heel goed aansluit, als je maar goed je toegevoegde waarde weet. De verschillen zijn juist om te koesteren. Het kan mekaar juist heel goed aanvullen. Het is mijn ervaring al dat het in principe heel goed aansluit. Medicatie, dat kan iemand juist de steun geven om die stappen te zetten [om in therapie te gaan]. ~ R8

De opvatting is steeds meer 'Een pilletje en dan moet het over zijn' en daarmee eigenlijk de oorzaak. (...) Mensen gaan uit die eigen verantwoordelijkheid en die tendentie wordt versterkt, denk ik, door medicaties. ~ R1

Ik denk dat het [beeldende therapie] inderdaad heel goed het pratende vervangt of gelijkwaardig is aan praten. Alleen kan ik het niet bewijzen, want er is geen onderzoek naar gedaan. ~ R9

Verbale therapie en beeldend, ik heb het gevoel dat ik het zelf in één combineer. ~ R12