Arts and vulnerable people:
examining the evidence base

Haran Sivapalan

www.lemosandcrane.co.uk

Arts and vulnerable people: examining the evidence base

By Haran Sivapalan

Introduction

The concept of art carrying psychological and social benefits is intuitively appealing. A prolific study within a hospital environment revealed that patients who had views of trees recovered more quickly than those with a view of a brick wall (Hamilton *et al* 2003). The expanding use of arts to achieve positive outcomes in health and social care, however, must be accompanied by a sound evidence base. This not only requires the execution of research projects within relevant sectors, but the subsequent critical appraisal of the results generated by such research. This review paper touches upon the types of research undertaken within arts therapy and other arts initiatives and discusses the relative merits of these studies.

"The task of art today is to bring chaos into order"

- *Theodor Adorno*

Background

There has been a strong tradition in China, Japan and other areas in the Far East of using the medium of art to promote well-being in those with poor mental and physical health. It is thought that this practice gradually infiltrated into Western culture at the beginning of the 20th Century as artists began working in asylums (Crawford, Patterson 2007). The developing scientific credence of psychotherapy led to clinical collaborations with such artists in the 1940s and the birth of formalised *arts therapy*. Creative arts have also been used to achieve other social goals outside of mental health care: a movement alluded to as '*art plus social concern*' (Brinson 1992). Since the late 1960s, artists have been involved with vulnerable people under the banner of '*community arts*' in schools, hospitals, prisons and supported housing schemes (Hamilton *et al* 2003).

What is arts therapy?

Arts therapy is a form of professionally mandated psychotherapy that utilises the creative arts to help those with psychological problems. Therapists are required to obtain a primary arts degree followed by post-graduate course in a particular form of arts therapy (British Association of Art Therapists 2000). Therapy sessions are available in both the public and private sectors. Outside of professionally regulated arts therapy, there are several other arts initiatives which also target vulnerable clients.

Types of arts therapy and other initiatives

In the UK, there are four principal forms of formal arts therapy: art therapy, music therapy, drama therapy and dance movement therapy (Crawford, Patterson 2007).

Art therapy

Art therapy refers to the use of painting, drawing and other visual media to achieve healing within the context of a tripartite relationship between the client, the therapist and the artwork (British Association of Art Therapists 2010). The formation of this relationship may be conceived to take place in 5 stages (Learmonth, Huckvale 2008):

- *Identification:* the unconscious process of being absorbed with creating a piece of art while the therapist observes as a witness
- *Familiarisation:* the client becomes a conscious spectator of their artwork
- *Acknowledgement:* the client develops and vocalises attitudes to their artwork with input from the therapist
- *Assimilation:* the client re-examines the piece of art with new understandings following interaction with the therapist
- *Disposal:* attaching significance to the artwork by exhibiting, destroying or leaving it with the therapist.

Music therapy

Music therapy endeavours to use systematic musical experiences to help clients develop relationships and address issues they may find difficult to do by using words alone (Gold *et al* 2005).

It is possible to dissect music therapy into different approach styles. The *active* approach entails the production of music such as free improvisation or recitals. Conversely, *passive* or *receptive* music therapy involves listening to music, such as that from a recording or that personally played by the therapist. Most music therapy adopts a combination of both approaches (*ibid* 2005). Therapists may also vary the *level of structuring* in music therapy to focus on either deep or superficial aspects of music. In a similar vein, therapy sessions may place emphasis particularly on the music or, alternatively, on the client's issues and needs that are highlighted by the music.

Drama therapy

Drama therapy has its provenance in the 'remedial drama' activities that emerged in the 1940s and 1950s. One predisposition of drama therapy is to serve as a 'container' for the disordered and chaotic thoughts of clients that may pose problems in traditional psychotherapy (Ruddy, Dent-Brown 2008). Another psychological mechanism employed by drama therapy is that of *aesthetic distancing* (Jones 1993). This alludes to the relative ease of expressing sensitive or embarrassing thoughts and desires (e.g. fantasies of harming someone) in the safety of the pretend world.

The content of drama therapy sessions is subject to great variability. Simple sessions may operate using a *creative-expressive mode*, whereby the emphasis is on improvisation and free creativity without interpretation of the subsequent performance (Ruddy, Dent-Brown 2008). More complex

therapy involves analysis of the client's own characteristics and how these may be portrayed in drama. Popular myths and tales from the folklore of various world cultures are also utilised to mirror the lives of clients, helping maintain feelings of normality (Schmid *et al* 2002).

Dance movement therapy

Dance movement therapy (DMT) involves using body movements and improvised dance to enact one's thoughts and feelings. It is thus particularly useful in clients who find verbal expression difficult or otherwise daunting. In addition to psychological benefits such as improved perceptions of one's own body, DMT also aims to engender physical outcomes such as improved co-ordination. In this vein, it is also used in patients recovering from brain injury and in those with other neurological impairments (Jeong *et al* 2004). There is growing research aiming to elucidate the neurobiological correlates of dance movement therapy (*ibid* 2004).

Other arts initiatives

Arts projects not within the formal framework of arts therapy tend to have a less defined emphasis on therapeutic relationships. The NHS Health Development Agency produced an *Arts for Health* report in 2000 that analysed the practice of 90 arts projects across the UK and recommended that the '*quality of artwork should be the primary focus.*' Arts-related education also forms a basis for such projects, with the intention of teaching and developing specific artistic skills (*Arts for Health* 2000).

There are several other projects that may fall under the remit of arts initiatives, although this is contingent upon one's definition of art. Poetry, reading (bibliotherapy), creative writing and martial arts have all been targeted at vulnerable people and incorporated into therapy.

WHAT IS THE RATIONALE BEHIND ARTS THERAPY AND OTHER ARTS INITIATIVES?

With regards to art therapy in particular, the British Association of Art Therapists state that the overarching aim of their practitioners is not to conduct *aesthetic or diagnostic assessment of the client's image,*' but rather '*to enable a client to effect change and growth on a personal level through the use of art materials in a safe and facilitating environment.*' A similar sentiment permeates other arts initiatives, which focus on widening access to the arts, group participation and social inclusion (Hamilton *et al* 2003).

Several schools of thought surrounding arts therapy exist, each with different psychological and philosophical underpinnings. Some adopt a Freudian view of arts therapy, suggesting that artistic expression, much like a dream, forms a portal into the unconscious (Ruddy, Milnes 2005). Other schools are grounded in Jungian theory and suggest that creative arts interact with our *archetypes* – innate psychological tendencies which shape subsequent behaviour (Collie *et al* 2006). Winnicott's notion of art as a *transitional object* also forms part of the psychoanalytical basis of arts therapy. In this conception, a piece of art becomes an object allowing the transition from concrete to abstract representations of the external world (Ardila 2006).

Creative arts media are posited to be particularly useful as they provide a non-verbal means of communication that facilitates self-expression in clients. This aspect is particularly salient for clients who face impairments in vocalising their thoughts and feelings. A related rationale of arts therapy is that of *affective processing* – the notion that, through creating art, a client is able to make sense of and manage their emotions (Learmoth, Huckvale 2008). Similarly, Holmes (1993) suggests that art allows us rationalise our lives so far and understand how we have come to our present situation. He coined the term *autobiographical competence* to convey this aim of arts therapy.

The symbolic meaning of art is particularly salient within a therapeutic context. The finished piece of artwork is proposed to provide insight into the artist's 'psychic content' (Smeijsters, Cleven 2006). Other arts therapists suggest that more can be inferred from the creative process of art, rather than the finished article per se. In this respect, reflections of a client's inner thoughts and emotions are found in analysing how a client paints, performs music or acts (*ibid* 2006).

There are also conspicuous non-specific reasons for why arts therapies and projects may be effective. Group activities provide opportunity for social interaction and forming new relationships. This may be described using the term *bonding social capital* – forming relationships within the same social/client group (Putnam 2000). As several narrative accounts attest, novel activities, both artistic and non-artistic, engender a sense of purpose in life (Murray, Crummett 2010). The creation of artwork also imbues a sense of achievement and self-esteem; qualities which are frequently reported to be lacking in vulnerable people.

WHICH VULNERABLE PEOPLE MAY BENEFIT FROM ARTS THERAPIES?

Arts therapies and other arts projects have been successfully implemented with a variety of vulnerable people and across a wide range of inpatient, community and educational settings. Different client groups have unique issues which may be helped with access to art. It is important to note, however, that the distinction between these separate client groups is largely arbitrary and groups may suffer from similar issues to one another. Furthermore, while some arts initiatives may be tailored to specific clients in specialised settings, others cater for a broad range of people.

Individuals with mental illness

The term 'mental illness' embodies myriad disorders, with each one exhibiting variable symptoms and severity. Art therapy evolved within inpatient psychiatric care units and has thus been trialled in individuals with what may be considered 'severe mental illnesses' such as schizophrenia. A possible psychological manifestation of schizophrenia is the *loss of ego boundaries* - the impaired ability to discern between self and non-self. Arts therapies aim to reconcile this dissonance by promoting self-expression, thereby increasing self-awareness and insight (Crawford, Patterson 2007). Another feature of schizophrenia is the relative inability to perceive symbolic or abstract meaning as demonstrated by 'literalness of expression and understanding' (Ruddy, Milnes 2005). This is known as *concrete thinking* and it is hypothesised to respond favourably to the creative and metaphorical nature of the arts.

Depression, ranked as the 4th leading cause of disease burden (Moussavi *et al* 2007), is a far more prevalent disorder than schizophrenia. The condition is typified by symptoms such as low mood,

disturbances with sleep and changes in appetite. Additionally, clients with depression exhibit *negatively biased cognitive schemas* or *dysfunctional attitudes* leading to negative evaluation of the self, the world and the future (Beck 2008). Consequently, feelings of worthlessness and hopelessness are common in depression and it these feelings that arts initiatives seek to remedy. In this respect, Franklin (1992) states that art "*validates and empowers the uniqueness of a person; making an object out of an idea puts a powerful tool in the hands of a person who feels fragile and unworthy.*"

Anxiety disorders are often co-morbid with depression (Hirschfeld 2001) and are also considered to be amenable to arts therapy and other initiatives. Notably, arts therapy has been used in the treatment of post-traumatic stress disorder (PTSD): a form of anxiety disorder characterised by *intrusive re-experiencing* of a traumatic event, *avoidance* of cues associated with that event and signs of *hyperarousal* (Collie *et al* 2006). Artistic expression is proposed to facilitate recounting of the traumatic experience and reframing of related thoughts and emotions (*ibid* 2006).

Art may be of assistance to individuals with several other mental health issues. It is important to acknowledge that mental health fluctuates on a spectrum from positive to negative extremes and official psychiatric diagnoses have been criticised for being somewhat artificial (Rosenberg 2006). Individuals with ephemeral or undiagnosed deteriorations in mental health may also derive benefit from arts therapy and arts initiatives.

Prisoners

According to the All-Party Parliamentary Group on Prison Health (2006), 95% of UK prisoners have at least one mental disorder and 80% have more than one. There is thus substantial overlap in needs between the incarcerated population and those with mental illness in non-prison settings. That said, the milieu of mental illness in a prison environment may differ from that in inpatient and outpatient environments, with a greater prevalence of personality disorders in the prison population (Singleton *et al* 1998). Arts therapy may form a safe outlet for feelings of anger and aggression that typify personality disorders such as *antisocial personality disorder*.

As a client group, prisoners have the added potential outcome of recidivism (or, the obverse outcome: desistance from crime) by which to evaluate the benefits of arts therapies and initiatives. Drama therapy may aim to directly target these outcomes, such as by using role plays to allow offenders to appreciate a victim perspective (Smeijsters, Cleven 2006). While recidivism may be a long-term goal, behavioural modification during prison sentences forms a short-term objective of arts therapy.

Individuals receiving palliative care

People in palliative care have complex physical and mental health needs by virtue of the terminal illness from which they are suffering. Symptoms of terminal illness including pain and weight loss coupled with side-effects of chemotherapy such as nausea and fatigue may culminate to lessen clients' quality of life (Nainis *et al* 2006). Terminal illness also has several psychological ramifications, such fears of dying and death, loss of independence, changes in relationships and anxiety over practical issues such as finance, work and housing (Barraclough 1997). Additionally, about 10-20% of

clients will suffer from anxiety or depression (*ibid* 1997). Non-drug therapies, including arts therapy, may aid psychological health by fostering a sense of control in life, providing interest and occupation when other life activities have been discontinued and providing opportunities for relationships (*ibid* 1997).

Elderly individuals

As people age, their physical, mental and social needs change. Beddington *et al* (2008) describe a natural decline in *mental capital* with age. Mental capital connotes a person's cognitive abilities, learning capabilities and resilience to stress; and the age-related decline in mental capital may be expedited by factors such as social exclusion, substance abuse and illnesses such as depression. The situation is exacerbated by the high prevalence of these factors in elderly cohorts. Loneliness, the subjective experience of social isolation, has been estimated to affect between 25 and 45% of elderly people in Western cultures (Golden *et al* 2009). Widowhood and limited social networks both contribute to loneliness, which in turn amplifies the risk of depression (*ibid* 2009). The group nature of arts activities may alleviate feelings of social isolation.

Old age also amplifies the risk of neurodegenerative disease such as dementia (Alzheimer's Society 2011). The cognitive and motor skills that are developed and exercised during artistic endeavours could theoretically play a role in preventing or mitigating the cognitive decline that typifies dementia.

Homeless individuals

The lack of secure long-term housing is associated with several chronic health problems including mental health issues. An estimated 40% of homeless people suffer from mood disorders such as depression (Schanzer *et al* 2007). The prevalence of psychotic illnesses such as schizophrenia is between 4 and 15 times higher than the general population (Crisis 2009). Substance abuse is also frequently observed in the homeless population (*ibid* 2009). Arts initiatives will thus play similar roles to that previously described for other individuals with mental illness.

Homeless people also suffer from unemployment and lack of financial security which serve to deplete self-esteem and sense of purpose in life (*ibid* 2009). In a similar fashion to elderly clients, loneliness and social isolation are major issues for the homeless and undermine resilience to the continuing stressors that characterise a homeless lifestyle. Participation in art activities may boost self-confidence and provide social resources on which to depend during difficult periods.

ARE ARTS THERAPIES AND ARTS INITIATIVES EFFECTIVE?

As vulnerable peoples' specific needs vary according to which broader client group they belong, it seems pragmatic to scrutinise the efficacy of arts therapies separately for each group. Needless to say, there is obvious heterogeneity within each client group and individual needs (and, accordingly, response to arts therapies) will differ from person to person. Augmenting this, as highlighted in the previous section, there is significant overlap between client groups – the prevalence of mental illness and substance use being high in homeless and incarcerated populations, for instance.

Individuals with mental illness

It may be argued that most academic research into the benefits of arts therapy and related initiatives has been with clients suffering from some form of mental illness. The lack of standardised research methods and outcome measures, however, mean that it is difficult to elucidate the extent to which art can positively impact mental health.

There exist several case studies which suggest that arts therapies may improve the mental health of clients with mental illness. Unfortunately, case studies are severely limited in their use for several reasons, namely; it is impossible to make accurate generalisations based on individual cases and, they are often vulnerable to reporter bias (Tellis 1997). Systematic reviews are of greater utility in determining the efficacy of arts therapies as they collate and critically appraise information from several studies within defined statistical parameters. This research approach, however, requires individual studies to quantitatively measure outcomes, using a larger study sample. Of course, the greater resources needed for this approach relative to case study/narrative methods have restricted its widespread implementation in both inpatient and outpatient environments. Nevertheless, as part of efforts to promote evidence-based healthcare, there have been some attempts at systematic reviews.

Gold *et al* (2005) conducted a review of the efficacy of standard care augmented with music therapy compared to standard care alone in the rehabilitation of clients with schizophrenia and schizophrenia-like illnesses. Music therapy that spanned 20 sessions or more (dubbed *'high-dose'* therapy by the authors) was found to have a significantly positive effect on mental health. Specifically, high dose music therapy was reported to ameliorate the negative symptoms of schizophrenia, including: social withdrawal, affective flattening (a lack of emotion), anhedonia (loss of interest and pleasure), alogia (poverty of speech) and avolition (poverty of movement). Other utilised indexes further demonstrated a significant improvement in social functioning (Gold *et al* 2005).

It is important to note that these positive repercussions of music therapy are contingent upon a minimum level of sessions: 20 or so as suggested by this study. Additionally, therapeutic benefit required *active* approaches (as opposed to passive, listening approaches) in the therapy. Although the results are promising, the long-term psychological benefits of music therapy were not investigated in this study, something which is particularly salient in light of the chronic nature of schizophrenia.

Maratos *et al* (2009) also published a systematic review about music therapy, but in the context of depression. Four out of five studies examined showed significant decrements in the symptoms of depression as evaluated using established tools including the Hamilton Rating Scale, Beck Depression Inventory and the Geriatric Depression Scale. Most of these studies adopted a 'prescribed' approach, using music to induce specific moods.

A similar systematic review was conducted by Ruddy and Kent-Brown (2008) with respect to the treatment of schizophrenia using drama therapy. Due to the highly variable nature of the individual studies included, it was difficult to make any concrete and generalised conclusions about the benefits of drama therapy. Despite this, there was some evidence for increased self-esteem and

decrements in feelings of inferiority after a Chinese sample of clients received four weeks of psychodrama sessions (Zhou, Wang 2002).

Thorough systematic reviews of art therapy have also been difficult to execute. Ruddy and Milne (2005) were only able to find two studies that met their inclusion criteria for analysing the effect of art therapy on schizophrenia. Of these, Richardson (2002) reported no significant improvement in social functioning or quality of life following 12 weekly sessions of art therapy. The need for further research in this area spurred the development of the MATISSE study (Multi-centre study of Art Therapy in Schizophrenia) using clients from four centres across England and Northern Ireland (Crawford *et al* 2010). This study compared the effects of a year course of art therapy against a year of generic group activities (e.g. watching DVDs, group discussions, board games). Using validated assessment tools, the authors measured changes in well-being, social function, health-related quality of life and positive/negative symptoms of schizophrenia (*ibid* 2010). The study concluded that although group art therapy may benefit a few highly motivated people, evidence of improved patient outcomes for most people with schizophrenia was lacking (BMJ 2012).

There has also been an impetus to accumulate an evidence base for projects outside of the formalised arts therapy framework. This may be due partly to the increasing use of arts projects in conjunction with primary care, a practice referred to as *social prescribing* (Bungay, Clift 2010). Examples of such social prescribing projects include the Arts on Prescription (AoP) programme which offers community activities with artists and musicians (not trained as arts therapists) across the UK. There is qualitative evidence from AoP Stockport to suggest that social prescribing of arts initiatives engenders improvements in self-esteem, sense of purpose in life, social capital and community integration (*ibid* 2010). Although the usual caveats about the validity of this qualitative data apply, there have been attempts by AoP to use quantitative tools such as the HADS (Hospital Anxiety and Depression Scale) and Warwick-Edinburgh Mental Well-Being Scale.

Along with traditional inpatient units, forensic psychiatric institutes have also implemented arts therapy. Smeijsters and Cleven (2006), in conjunction with arts therapists from 12 centres across the Netherlands and Germany, constructed a consensus-base on the use of arts therapies in regulating aggression. The researchers, although only drawing upon qualitative data, agreed that arts therapies led clients to experience less intense subjective feelings of anger and express anger in less destructive ways (*ibid* 2006).

Elderly persons

Arts initiatives for elderly persons may differ from those implemented in mentally ill cohorts in that there are less rigidly defined therapeutic aims. For instance, arts therapies for clients with schizophrenia may be designed specifically to improve negative symptoms of the disorder, before assessing these outcomes using established measures e.g. the SANS (Scale for Assessment of Negative Symptoms) tool. On the contrary, establishing desired outcomes and measuring them in elderly people is less clear-cut. Perhaps as a consequence of this, there is a paucity of systematic review data with regards to arts and the elderly. Nevertheless, other approaches in psychology and social sciences have yielded seemingly positive results.

Murray and Crummett (2010) scrutinised the effects of community arts on older people in Manchester as part of the CALL-ME project, itself a component of the larger UK New Dynamics of Ageing Research Programme. Adopting a narrative interview approach, the authors reported the desire for social interaction and a lack of other existing activities as common reasons for elderly participation in the arts project. Given these needs for social interaction, it is unsurprising that the opportunity to meet other people, form new friendships and forge a sense of belonging were the most significant perceived benefits of this arts initiative.

Case studies of African-American women participating in the Program of All-Inclusive Care for the Elderly (PACE) have suggested that art therapy is particularly useful as a means of reviewing and attributing meaning to one's life so far (Johnson, Sullivan-Marx 2006). The same study extolled the benefits of art as a medium for emotional expression by older clients.

Elderly persons may often have complex health needs by virtue of their age. For example, the prevalence of dementia increases with age and approximately 64% of people living in a care home are thought to have a form of dementia (Alzheimer's Society, 2011). Accordingly, it is particularly valuable to investigate any potential benefits of art in the alleviation of age-related illness. Rusted *et al* (2006) studied 21 people with dementia who were assigned to either 40 weeks of art therapy or 40 weeks of non-art related activity groups. Comparing both groups, the researchers found significant increases in mental acuity, physical competency, calmness and sociability measured within sessions for those in the art therapy group. Despite this, no significant changes in cognition, memory or attention were reported for either group. This is not necessarily an indictment of art therapy, but perhaps more a reflection of the pathological characteristics of dementia and the limits of non-pharmacological treatment.

Prisoners

Arts programmes are hypothesised to '*respond to prisoners' basic human need for creative self-development, autonomy and expression*' (Johnson 2008). Testing such hypotheses, however, proves difficult, especially using quantitative measures. That said, such quantitative techniques have been employed when assessing more mainstream mental health characteristics of prisoners.

Gussak (2006) studied the effects of an 8-week art therapy course on a group of inmates in Florida. Before and after the course, participants were administered the Beck Depression Inventory-Short Form (BDI-II), an established diagnostic tool used to assess depressive symptomatology. Compared to a control group, inmates who received the art therapy demonstrated a significant decrease in BDI-II score (which corresponds to an elevation in mood). The results were less conclusive when using another assessment tool, FEATS (the Formal Elements Art Therapy Scale), designed to make inferences on mood from characteristics of clients' drawings. Nevertheless, improvements in depressed mood as ascertained by BDI-II were corroborated by case studies where individuals were observed to evince less depressed behaviour following art therapy (Gussak 2006).

Outside of the domain of mental illness, arts initiatives may play a role in the further rehabilitation of prisoners. A literature review conducted by Johnson (2008) describes benefits such as better adherence to education schemes and improved relationships with prison staff. The role of arts in countering recidivism is largely unexplored, although a study of 4000 Florida prisoners intimates that

art therapy as part of a larger package of prison-based community treatment is linked to decreased returns to custody within a 12-month period (Burdon *et al* 2004).

Young offenders are also potential beneficiaries of arts therapy. Interviewing 46 male juvenile offenders aged between 16 and 20 years, Persons (2009) identified the most frequently cited benefits of arts therapy sessions. All participants stated that they relished the positive recognition from peers and that the sessions helped alleviate stress, reduce boredom and increase self confidence. Additionally, 80% of participants felt that art therapy helped them forge positive relationships and prevented them from engaging in self-harm.

Homeless individuals

Arts projects designed specifically for the homeless appear to be relatively rare. Similarly, it is apparent that the framework for delivering arts therapy to the homeless is much less developed compared to arts therapy aimed at other client groups. Consequently there is paucity of research evaluating the effectiveness of art in this area.

A US study of 212 homeless youths emphasised the potential for art in promoting life achievements such as: gaining employment, returning to school, obtaining secure housing, ceasing substance use, developing pro-social behavioural skills or making concerted attempts at these aforementioned life changes (Prescott *et al* 2008). The authors revealed that the number of visits by a homeless youth to an art class over a 5 year period was positively correlated with the number of his/her life achievements (as illustrated in Figure 1). While encouraging, this relationship does not necessarily imply a causal role for art in raising the quality of life for homeless individuals.

The same study also conducted qualitative research into psychological resilience – the protective capacity to survive under stressful and adverse conditions (*ibid* 2008). The authors defined 7 components of resiliency in
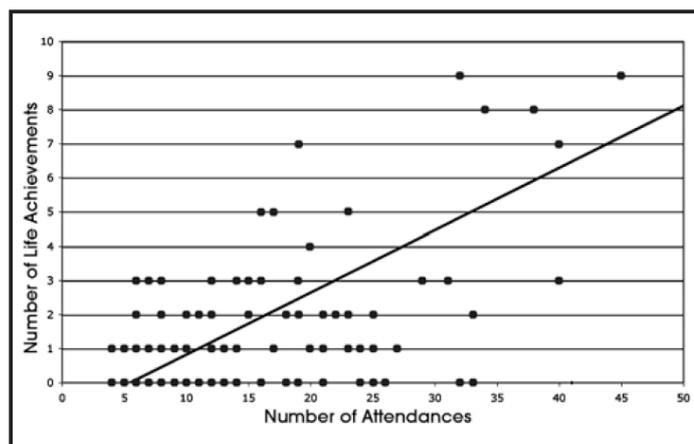
Figure 1: Positive correlation between number of life achievements and the number of attendances at an art class. (Reproduced from Prescott *et al* 2008).

line with a model posited by Wolin and Wolin (1993): insight, independence, relationships, initiative, creativity, humour and morality. Art was particularly salient in nurturing creativity and, within the context of art classes, helped develop supportive relationships.

Individuals in palliative care

There is growing use of arts initiatives in patients suffering from terminal illness and this area has subsequently attracted an increasing amount of research interest.

Geue *et al* (2010) conducted a review of 17 papers describing art-based interventions in the field of oncology. Common benefits reported by those studies using qualitative interview techniques

included the opportunity to build coping skills and feelings of enhanced personal growth. The results from quantitative studies were also promising. A significant body of studies consistently demonstrated attenuated symptoms of anxiety and depression as a result of participation in arts interventions. Associated with this, Grulke *et al* (2006) noted a decrease in participants' use of 'hopelessness' and 'fatalism' as coping styles in the face of cancer. In terms of quality of life measures, 3 studies reported increases in global scores and accentuated social functioning.

Art therapy may also have a role in assuaging the physical pain that characterises terminal illness. Using the Edmonton Symptom Assessment Scale (ESAS), Nainis *et al* (2006) assessed the physical symptoms of 50 oncology inpatients both before and aft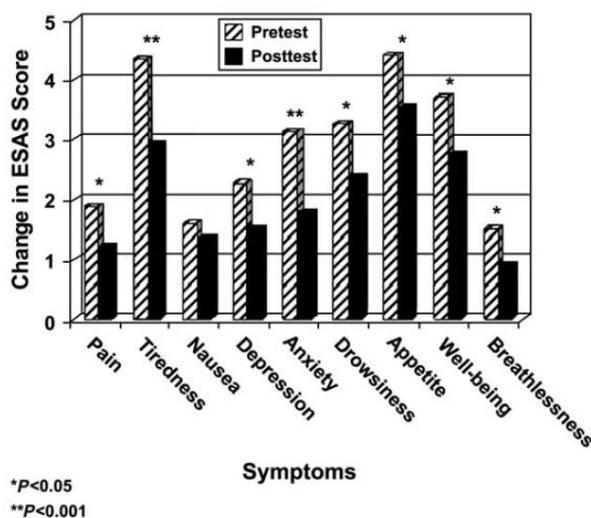er a single session of art therapy. As shown in Figure 2, patients reported significantly fewer symptoms of pain, tiredness and breathlessness. While these results are encouraging, it must be noted that no comparison or control group was used in this study design and, additionally, long-term benefits of the art therapy were not examined.

Figure 2: Reduction of symptoms after partaking in art therapy. (Reproduced from Nainis *et al* 2006).

There is also evidence to suggest that the benefits of arts therapy to palliative care patients apply across a range of age groups. Madden *et al* (2010) studied the quality of life of children receiving chemotherapy for brain tumours following a combined course of art, music and dance-movement therapy. Parents' ratings of their children's sense of pain and nausea were shown to significantly improve after the course, as did children's own ratings of how 'excited', 'happy' and 'nervous' they were.

OVERVIEW OF PERCEIVED BENEFITS

Table 1 (overleaf) provides an overview of the positive outcomes of arts projects for different client groups. Despite variation in needs and outcomes, it is possible to distil certain prevailing themes from the evidence reviewed in this paper. Much of the qualitative data and small portions of quantitative data intimate that art increases self-confidence and *self-esteem*. Self-esteem is posited to be a fundamental component of global well-being and quality of life (Diener, Diener 1995). Accordingly, it may be hypothesised that, ceteris paribus, arts have the potential to increase quality of life. Figures published in the Arts for Health report (2000) seem to corroborate this; with 82% of projects stating that participants' self-confidence increased following involvement in arts projects.

Another theme that pervades the examined data is the benefit of arts projects in building social capital. Several studies describe the formation of new relationships between clients as a positive aspect of arts initiatives. Putnam (2000) describes the phenomenon as *bonding social capital* - that which takes place between members of the same group. Again, the Arts for Health report (2000) found that 59% of projects stated that participants found new friends during their sessions.

The same report also revealed that 72% of project coordinators felt that participants developed language, creative or social skills during arts sessions (Arts for Health 2000). The intrinsic value of art education is thus an important by-product of such initiatives. Whether such education is instrumental in terms of engendering employment remains to be researched. Finally, several narrative accounts attest to clients relishing the opportunity to be creative and finding arts activities to be *enjoyable*.

Table 1: Overview of the positive outcomes of arts projects for different client groups

Specific needs/issues	Client Group	Potential benefits of arts therapy/arts initiatives
• Affective disorders • Psychotic disorders • Forensic mental illness	 Clients with Mental Illness (Van Gogh - Sorrowing Old Man (At Eternity's Gate))	• Symptomatic relief (negative symptoms in schizophrenia) • Raised self-esteem • Bonding social capital
• Physical symptoms • Anxiety • Depression	 Palliative Care (Monet – Camille Monet on Her Deathbed)	• Reduced symptoms of anxiety and depression • Better coping skills • Bonding social capital • Independence to pursue own interests
• Social isolation • Loneliness • Neurodegenerative disease • Cognitive decline	 Elderly (De Kooning – Untitled V)	• Bonding social capital • Raised self-esteem • Promotion of mental capital

• Mental illness • Poverty • Substance use • Poor social support	 Homeless (Modigliani – Beggar Woman)	• Raised self-esteem • Bonding social capital • Adherence to other health and housing services
• Mental illness • Substance use • Aggression	 Prisoners (Rembrandt – Apostle Paul in Prison)	• Raised self esteem • Reduced symptoms of depression • Reduced aggression • Better relations with prison staff

ARE SOME FORMS OF ARTS THERAPY MORE EFFECTIVE THAN OTHERS?

There is a dearth of studies directly comparing the efficacy of different types of arts therapies. The available data would intimate that, compared to other arts therapies, music therapy has a more substantial evidence base and thus arguably a greater cause for implementation in the treatment of schizophrenia. Nevertheless, it would be perilous to speculate on any differences between arts therapies without further research. A consensus study collating the thoughts of arts therapists across Germany and the Netherlands suggest that dance-movement therapy is more effective in regulating aggression compared to other arts therapies (Smeijsters, Cleven 2006). Again, this study was largely based on conjecture from arts therapists and further research is required to verify this claim.

With regards to the structure of arts sessions, there appears to be a tacit consensus that group settings for arts initiatives are superior to individual settings (Crawford, Patterson 2007). One would speculate that this is partly due to the role of bonding social capital. Another consideration to make is that arts initiatives seem to attract a clientele that is highly skewed toward the female sex. It is possible that there are barriers to accessing arts programmes for male clients that prevent them from reaping the full benefits of such programmes. A few narrative accounts from the CALL-ME community arts project insinuate that *'older men were more apprehensive about organised social activity'* (Murray, Crommet 2010).

CONCLUSION

Although this review alludes to some of the extrinsic and tangible benefits of arts initiatives, it may still be argued that any artistic endeavour made by any party is of inherent value. In this vein, there is concern from artists about the scientific evaluation or these initiatives, as they feel it detracts from the true values of art. The question thus arises whether such evaluation is actually required. With regard to arts therapies, one would argue that if the main predisposition is to treat mental disorders, albeit partially, then such therapies must be subject to same assessment as other treatments such as medication or cognitive and behavioural therapy. This argument is less germane to other community arts initiatives, but if these arts initiatives have social goals, then it would be pragmatic to assess how well these goals are met using quantitative tools.

On a related note, we have decried the use of purely qualitative data including narrative accounts. Some may question whether such data is actually less valuable as evidence, considering that the subjective thoughts and feelings of clients are highly significant to how successful we judge an arts project to be. This is a valid point, but for the arts movement to gain momentum and credence within the world of health and social care, then it is best to adopt this sector's rigorous assessment measures. Furthermore, a variety of research approaches will serve to elucidate the mechanisms by which arts are beneficial for vulnerable people.

As this review has shown, there is a paucity of robust evidence to make any definitive judgments on the efficacy of arts projects. Results from qualitative studies are promising and substantiate the need for further research to be undertaken.

LIMITATIONS

There are several limitations pertaining to each individual study reviewed in this paper. It is beyond the scope of this review to expatiate upon each and every study. Broadly speaking, quantitative studies seemed to lack adequate randomisation, causing valid comparisons between art groups and control groups to become more difficult. Many studies suffered from low sample populations, impairing the opportunity to perform full statistical assessment. Additionally, several of the assessment tools used in psychology have fundamental weaknesses. For instance, scales used to assess depression are by their nature subjective and vulnerable to variation in observer ratings. The multitude of weaknesses in existing studies only serves to heighten the need for further research, perhaps in the form of large scale, prospective studies.

References

All-Party Parliamentary Group on Prison Health. (2006). The mental health problem in UK HM prisons. House of Commons.

Alzheimer's Society (2011). [Online]. Available at http://alzheimers.org

Ardila, C.L (2006). Psychoanalysis, art and interpretation. *Annuary of Clinical and Health Psychology;* **2:** 57-64.

Barraclough, J. (1997). ABC of palliative care: depression, anxiety and confusion. *British Medical Journal;* **315:** 1365.

Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. *American Journal of Psychiatry;* **165:** 969-977.

Beddington, J., Cooper, C.L., Field, J., Goswami, U., Huppert, F., Jenkins, R., Jones, H.S., Kirkwood, T.B.L., Sahakian, B.J. & Thomas, S.M. (2008). The mental wealth of nations. *Nature;* **455:** 1057-1060.

Brinson, P. (1992). Arts and communities: the report of the national inquiry into arts and the community. London: Community Development Foundation.

British Association of Art Therapists. (2010). What is art therapy? [Online] Available at http://www.baat.org/

Bungay, H. & Clift, S. (2010). Arts on Prescription: a review of practice in the UK. *Perspectives in Public Health;* **130:** 277-281.

Burdon, W.M., Messina, N.P., & Prendergast, M.L. (2004). The California Treatment Expansion Initiative: aftercare participation, recidivism, and predictors of outcomes. *The Prison Journal;* **84:** 61-80.

Collie, K., Bottorff, J.L. & Long, B.C. (2006). A narrative view of art therapy and art making by women with breast cancer. *Journal of Health Psychology;* **11:** 761-775.

Crawford, M.J. & Patterson, S. (2007). Arts therapies for people with schizophrenia: an emerging evidence base. *Evidence Based Mental Health;* **10:** 69-70.

Crawford, M.J., Killaspy, H., Kalaitzaki, E., Barrett, B., Byford, S. *et al* (2010). The MATISSE study: a randomised trial of group art therapy for people with schizophrenia. *BMC Psychiatry;* **10:** 65.

Crisis (2009). About homelessness. [Online]. Available at http://www.crisis.org.uk

Diener, E. & Diener, M. (1995). Cross cultural correlates of life satisfaction and self-esteem. *Personality Processes and Individual Differences;* **68:** 653-663.

Franklin, M. (1992). Art therapy and self-esteem. *Art Therapy: Journal of the American Art Therapy Association*; **9**: 78-84.

Geue, K., Goetze, H., Buttstaedt, M., Kleinert, E., Richter, D. & Singer, S. (2010). An overview of art therapy interventions for cancer patients and the results of research. *Complementary Therapies in Medicine;* **18:** 160-170.

Gold, C., Heldal, T.O., Dahle, T. & Wigram, T. (2005). Music therapy for schizophrenia or schizophrenia-like illnesses. *The Cochrane Database of Systematic Reviews;* **2:** 1-21.

Golden, J., Conroy, R.M., Bruce, I., Denihan, A., Greene, E., Kirby, M. & Lawlor, B.A. (2009). Loneliness, social support networks, mood and wellbeing in community-dwelling elderly. *International Journal of Geriatric Psychiatry;* **24:** 694-700.

Grulke, N., Bailer, H., Stähle, S. & Kächele, H. (2006) Evaluation of an art therapy offer for oncological

patients in an acute hospital: a pilot study. *Musik-, Tanz-und Kunsttherapie*; **17**:21-29.

Gussak, D. (2006). Effects of art therapy with prison inmates: a follow up study. *The Arts in Psychotherapy;* **33:** 188- 198.

Hamilton, C., Hinks, S. & Petticrew, M. (2003). Arts for health: still searching for the Holy Grail. *Journal of Epidemiology and Community Health;* **57:** 401-402.

Hirschfeld, R.M. (2001). The comorbidity of major depression and anxiety disorders: recognition and management in primary care. *Journal of Clinical Psychiatry*; **3:** 244-254.

Holmes, J. (1993). John Bowlby and attachment theory. Routledge.

Jeong, Y., Hong, S., Lee, M.S., Park, M., Kim, Y. & Suh, C. (2005). Dance movement therapy improves emotional responses and modulates neurohormones in adolescents with mild depression. *International Journal of Neuroscience;* **115:** 1711-1720.

Johnson, C.M. & Sullivan-Marx, E.M. (2006). Art therapy: using the creative process for healing and hope among African-American older adults. *Geriatric Nursing;* **27:** 309 -316.

Johnson, L.M. (2008). A place for art in prison: art as a tool for rehabilitation and management. *Southwest Journal of Criminal Justice;* **5:** 100-120.

Learmonth, M. & Huckvale, K. Art psychotherapy: the wood in between the worlds. *New Therapist;* **53:** 11-19.

Madden, J.R., Mowry, P., Gao, D., McGuire Cullen, P. & Foreman, N.K. (2010). Creative arts therapy improves quality of life for pediatric brain tumor patients receiving outpatient chemotherapy. *Journal of Pediatric Oncology Nursing;* **27:** 133-145.

Maratos, A., Gold, C., Wang, X. & Crawford, M. (2008). Music therapy for depression. *Cochrane Database of Systematic Reviews;* **1:** 1-20.

Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V. & Ustun, B. (2007). Depression, chronic diseases and decrements in health: results from the World Health Surveys. *The Lancet*; **370:** 851-858.

Murray, M. & Crummett, A. (2010). 'I don't think they knew we could do these sorts of things': social representations of community arts by older people. *Journal of Health Psychology;* **15:** 777 -785.

Nainis, N., Paice, A.J., Ratner, J., Wirth, J.H., Lai, J., Shott, S. Relieving symptoms in cancer (2006): innovative use of art therapy. *Journal of Pain and Symptom Management*; **31**:162-169.

NHS Development Agency. (2000). Art for health: a review of good practice in community-based arts projects and initiatives which impact on health and wellbeing. London: NHS Development Agency.

Persons, R. (2009). Art therapy with serious juvenile offenders: a phenomenological analysis. *International Journal of Offender Therapy and Comparative Criminology;* **53:** 433-453.

Prescott, M.V., Sekendur, B., Bailey, B. & Hoshino, J. (2008). Art making as a component and facilitator or resiliency with homeless youth. *Art Therapy: Journal of the American Art Therapy*

Association; **25:** 156-163.

Putnam, R.D. (2000). Bowling Alone. New York: Simon and Schuster.

Richardson, P. (2002). A randomised control trial of group interactive art therapy as an adjunctive treatment in severe mental illness. *National Research Register.*

Ruddy, R. & Milnes, D. (2005). Art therapy for schizophrenia or schizophrenia-like illnesses. *The Cochrane Database of Systematic Reviews;* **4:** 1-25.

Ruddy, R.A. & Dent-Brown, K. (2007). Drama therapy for schizophrenia or schizophrenia-like illnesses. *The Cochrane Database of Systematic Reviews;* **1:** 1-25.

Rusted, J., Sheppard, L. & Waller, D. (2006). A multi-centre randomized control group trial on the use of art therapy for older people with dementia. *Group Analysis;* **39:** 517-536.

Schanzer, B., Dominguez, B., Shrout, P.E. & Caton, C.L. (2007). Homelessness, health status, and health care use. *American Journal of Public Health;* **97:** 464-469.

Schmid, G.B., Eisenhut, R., Rausch, A., Ito, K., Dampfle, S. & Frei, K. (2002). Phantasy therapy in psychiatry: rediscovering reality in phantasy. *Forschende Komplamentarmedizin Und Klassiche Naturheilkunde;* **9:** 283-291.

Singleton, N., Meltzer, H. & Gatward, R. (1998) Psychiatric morbidity among prisoners in England and Wales. London: Office for National Statistics.

Smeijsters, H. & Cleven, G. (2006). The treatment of aggression using arts therapies in forensic psychiatry: results of a qualitative inquiry. *The Arts in Psychotherapy;* **33:** 37-58.

Tellis, W. (1997). Introduction to case study. *The Qualitative Report;* **3:** July.

Wolin, S. J., & Wolin, S. (1993). The resilient self: how survivors of troubled families rise above adversity. New York: Villard Books.

Zhou, Y. & Tang, W. (2002). A controlled study of psychodrama to improve self-esteem in patients with schizophrenia. *Chinese Mental Health Journal*; **16**: 669-71.