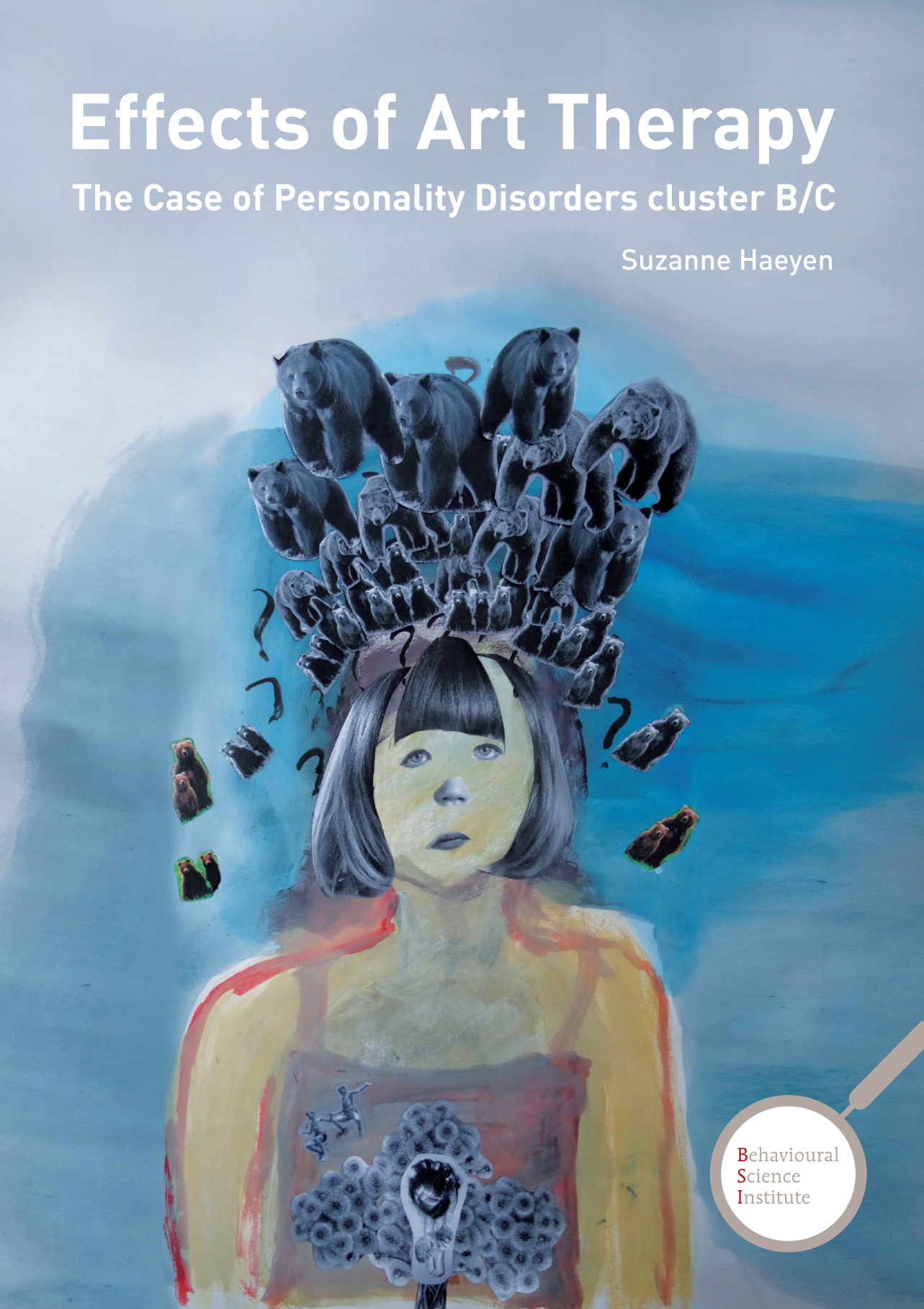
Effects of Art Therapy

The Case of Personality Disorders cluster B/C

Suzanne Haeyen



Behavioural
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EFFECTS OF ART THERAPY

THE CASE OF PERSONALITY DISORDERS CLUSTER B/C

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CHAPTER 1.

General Introduction

INTRODUCTION AND AIM OF THE PRESENT DISSERTATION

Art therapy, a treatment based on the experience and the use of art media, is used quite frequently in mental healthcare (ZiN, 2015). Patients as well as professionals consider it important and meaningful (e.g. Haeyen, 2011a; Karterud & Pedersen, 2004). Although these clinical experiences suggest art therapy is an effective intervention, a sound scientific base for this intervention is needed. Art therapy is poorly researched and lacks solid evidence for effectivity (Reynolds, Nabors, & Quinlan, 2000).

The central objective of this thesis is to examine the effects of art therapy in patients diagnosed with personality disorders. The main research question will be: is art therapy effective? And if so, how large are the effects of art therapy, and what can be said about the nature of these effects?

In this introduction, art therapy is defined, the context in which art therapy takes place is described and the target group of this thesis is defined, i.e. patients with personality disorders. Next, an overview of current literature is presented on what we know about the effects of art therapy and about its underlying processes. Finally, the structure of this thesis is outlined.

ART THERAPY – DEFINITION AND PRACTICAL CONTEXT

Art therapy is an experiential form of treatment that makes use of art materials, creative processes and the resulting artwork to explore feelings, reconcile emotional conflicts, foster self-awareness, manage behaviour and addictions, develop social skills, improve reality orientation, reduce anxiety and increase self-esteem (AATA, 2017). Art therapy makes explicit use of the here and now and focusses on the art work as an extra pillar in the therapeutic interaction (Schweizer et al., 2009). The main goal in art therapy is to restore a patient's functioning as well as to enhance their physical, mental and emotional well-being (BAAT, 2017).

Art therapy makes use of concrete treatment objectives and is often offered along with other therapies as part of a care programme. Art therapists have been inspired by many therapeutic perspectives, such as psychoanalysis, attachment-based psychotherapy, compassion-focussed therapy, cognitive analytic therapies and client-centred approaches including psycho-educational, mindfulness and mentalization-based treatments (BAAT, 2017; Gussak & Rosal, 2016), but also by third-generation cognitive behavioural therapies such as Dialectical Behavioural Therapy (DBT), Schema Focussed Therapy (SFT) and Acceptance and Commitment Therapy (ACT) (Malchiodi, 2012; Schweizer et al., 2009).

For whom art therapy is most indicated is often related to the less verbal level of therapeutic entrance that is applied in art therapy. Art therapy stresses the 'non-verbal' and appeals on a level that is sometimes referred to as 'before, besides and beyond' words (LOO VTB,

2016; Van der Kolk, 2015). Words might not be the best or first therapeutic entry for all people. A common-sense idea is that the experiential orientation of art therapy makes it a suitable intervention for people for whom the ratio is not the desirable or possible entry, which may be true for people who are set as one-sided cognitive and have difficulties in expressing and/or recognizing their feelings and/or who are overwhelmed by their feelings. However, this can also apply to people whose verbal abilities are less strongly developed or limited (Bernstein, Arntz, & Vos, 2007; Neijmeijer, Moerdijk, Veneberg, & Muusse, 2010; Bernstein, Arntz, & De Vos, 2007).

Art therapy is offered to various groups of patients. It is practised in mental healthcare, medical, educational, forensic, private practice and community settings with diverse patient populations in individual, couples, family and group therapy formats. Art therapists work with children, young people, adults and the elderly. Patients may have a wide range of problems, disabilities or diagnoses. This includes emotional, behavioural or mental health problems, learning or physical disabilities, life-limiting conditions, neurological conditions and physical illnesses (AATA, 2017; Aerts, Busschbach, & Wiersma, 2011; BAAT, 2017) and diagnoses such as post-traumatic stress disorder, autism, dementia, depression and other disorders. Art therapy is also used to achieve personal growth (AATA, 2017). Based on the description of all the target groups, art therapy seems to fit a lot of target groups and serve a large number of goals. That provides us with a very diverse but also quite a diffuse image of art therapy. However, when focusing on mental healthcare, the image is more specific.

Elements of art therapy

We distinguish the following specific elements in art therapy: (1) the therapeutic context; (2) the art process, the active working phase in which there is something made; (3) the art product, occurring as a concrete result of the art process; and (4) the interaction, concerning all direct and indirect interventions and communication about the way one relates to the art process and the art product in contact with each other. The possible effects of art therapy are realized by specific and non-specific factors (Lambert, 1986). The main non-specific factor is the therapeutic relationship in which understanding, attention, respect and hope for change are offered. The specific factors of art therapy are related mainly to the process of art-making, the art product as well the interaction about the art product(ion).

The therapeutic context

The therapeutic context includes a problem owner (the patient) and a problem solver (the therapist). The unique reason for encounter is the solving of the problem that cannot be solved by the problem owner alone and needs the special expertise of the problem solver (Frank & Frank, 1993). The therapeutic context is defined by its goal of healing. In art therapy, the therapeutic context is a non-judgemental, respectful and accepting attitude of the therapist towards the patient, the art process and the product. Often art therapy takes place in a group, but sometimes individually. Art therapists assume that, due to this context, corrective, positive

experiences are gained. In this context, the focus is on non-specific factors: the therapeutic relationship in which understanding, attention, respect and hope for change are offered.

The art process

The art process is what happens during the creation of the art work. This process is experiential, involving actions, movements and activities with the explicit use of the 'here and now'. The art process calls for creative acting in which the patient should take self-direction, has to make choices and should respond to what happens in a flexible way. In this process, the patient can experience in the here and now, through the sensory interaction with materials and colours, as well as through techniques that can trigger emotions and/or memories. Materials with different structural qualities can evoke different art-making experiences (Malchiodi, 2012; Schnetz, 2005; Virshup, Riley, & Sheperd, 1993), e.g. art materials with properties that provide high structure are easier to control, whereas those with low structure are more fluid and more difficult to control. Art materials with high structure would evoke more cognitive experiences, whereas fluid art materials would evoke more affective experiences (Hinz, 2009; Pénzes, van Hooren, Dokter, Smeijsters, & Hutschemaekers, 2015). During and after the art process, also thoughts come up. While working, the patient has a kind of self-dialogue about how to handle this process. The art process provides a play/practice field with the opportunity to experiment with new behaviour. In that field, emotions can be explored, expressed and formed that can take place in both explicit and implicit ways.

The art product

The art product is the concrete, tangible result of the art process. It shows the impact of the work process with visible traces from the individual process or from the collaboration with others. Different qualities are ascribed to this art product by art therapists, for example it would have a mirror function and it stimulates reflection.

The art product mirrors the individuality of the person by the visible personal style of shaping with characteristics in line, shape, colour and structure in the art work (e.g. Chilton, 2013; Czamanski-Cohen & Weihs, 2016; Gussak & Rosal, 2016; McNiff, 1992; Rankanen, 2016a; Shechtman & Perl-dekel, 2000; Springham, Findlay, Woods, & Harris, 2012). In this way, the art product can be linked to themes such as identity and self-image. It would also mirror feelings; emotions or inner conflicts are made visible. In the art product, conflicting or fragmented emotions can be visualized next to each other in one image and thereby showing how these emotions could be integrated. This visualization can occur at the level of the content of the image (story and meaning, symbolism) or through formal image characteristics (line, shape, colour), material handling and design aspects (abstract, figurative, composition; Hinz, 2009; Hyland Moon, 2010; Pénzes et al., 2015). Many art therapists assume that the formal image characteristics of the art product also are of diagnostic value (e.g. Betts, 2016; Cohen & Mills, 2016).

The art product also stimulates (self-)reflection by looking at representations of oneself and one's own expressed feelings in content and/or formal image characteristics. This can work in an affirmative and/or confrontational way. One can literally stand at a distance from the art product, and this calls for a fix, a position determination of the maker because it persists; what does the maker want to do with it and what meaning does it/may it have? For example, one can be proud, wanting to nurture and keep the art product or, by contrast, one can feel ashamed, wanting to hide it or even to destroy it.

Interaction

The interaction about the art work between patient and therapist concerns the art instructions or art assignments, communication during the art work and the analysis of the art work afterwards. In this interaction, the focus is on the relationship to the art process, the art product and their mutual contact. The art process and art product provide a starting point for indirect and direct communication with the therapist and others. (Self-)reflection is stimulated, especially in the interaction during the debriefing of art work. According to art therapists, reflecting on one's own and other people's art products can be aimed at improving mentalization skills (Springham et al., 2012; Verfaille, 2016). In art therapy, these mentalization skills are practised in contact with the therapist and group members, based on the art experience and the art product. The art process and art product provide a guide to practise thinking about the own inner world and that of others.

THE CASE OF PERSONALITY DISORDERS

One area where art therapy has been offered for many years is the healthcare service to people with a personality disorder.[1]

Personality disorders are enduring and inflexible patterns of cognitions, emotions, interpersonal functioning or impulse control that lead to significant distress or impairments with an impact on a broad range of personal and social situations (APA, 2013; WHO, 2015). Patients with a personality disorder have significant impairments in self (identity of self-direction) and interpersonal (empathy or intimacy) functioning, and have one or more pathological personality trait domains (e.g. negative affect, detachment, antagonism, disinhibition and psychoticism; APA, 2013). The DSM-5 lists 10 personality disorders, grouped into three clusters, i.e. cluster A (Paranoid, Schizoid and Schizotypal personality disorder), cluster B (Antisocial, Borderline, Histrionic and Narcissistic personality disorder) and cluster

1 Art therapy is an integral part of the treatment for personality disorders in many larger national healthcare institutes in the Netherlands, e.g. GGNet/Scelta, De Viersprong, Mediant, GGZ Friesland, Mondriaan, ProPersona, Synaeda, University Medical Center Groningen, GGZ Noord Holland Noord, GGZ Drenthe, GGZ Oost Brabant, Dimence and Lentis.

C (Avoidant, Dependent and Obsessive-compulsive personality disorder). Many personality disorder patients have a long history of treatment of different problems with varying degrees of success (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008). Personality disorder symptoms emerge first in late adolescence and could not be attributed to use of substances or another medical condition.

The estimated prevalence of personality disorder is 9.1% to 15% in the general population (APA, 2013). At least one personality disorder can be diagnosed in 60.4% of psychiatric patients and 56.5% of the treated addicts (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008). In the personality disorder population, cluster C disorders are the most common (44.7%), closely followed by cluster B disorders (27.3%). Cluster A disorders are clearly the least prevalent (7.7%). This does not include the patients classified with an Unspecified Personality Disorder. We focus on patients with personality disorder cluster B and/or C. This is because these personality disorder clusters are most prevalent and are often treated together in group therapy in specialized treatment in the Netherlands. Cluster A patients show eccentric, indifferent, distant or reserved behaviour, with sometimes peculiar and magical ideas. This cluster is much less present in specialized (psycho)therapy programmes because of these symptoms and the care-avoiding behaviour related to these symptoms.

Behaviour characteristics of cluster B consist of dramatic, emotional or erratic behaviour, often described as 'impulsiveness'. Usually there are impulsive and destructive behaviours in the area of emotions, identity and interpersonal relationships. Behaviour characteristics of cluster C consist of tense or anxious behaviour. The main features of patients with cluster C personality disorder are fear and vulnerability. This leads to problems in close relationships, well-being and work relations. Both cluster B and C consist of an instable and/or negative self-image and instable affects, attention-seeking behaviour and feelings of inadequacy and dependency or perfectionism. Adjustment to social environment can be a problem because the experiences and behaviours of personality disorder cluster B/C patients differ from societal norms and expectations, and interpersonal (empathy or intimacy) functioning is difficult (Eurelings-Bontekoe, Verheul, & Snellen, 2009; Ingenhoven, Van Reekum, Van Luyn, & Luyten, 2012).

Emotion-regulation problems and emotional vulnerability are central issues for personality disorders. Emotion regulation refers to the processes of how people influence experienced emotions: when we have emotions, how we experience them and how we express them (Gross, 1998). The way people express emotions plays an important role in social interactions (Gross, 2002). Emotional vulnerability is often operationalized as the sensitivity to emotional stimuli. The stronger this sensitivity, the stronger the response to emotional stimuli after emotional stimulation, and the slower the return to the emotional basic level (Linehan, 1996). These two central elements – emotion regulation problems and emotional

vulnerability – appear different for each diagnostic personality disorder group, and result in different problems in various areas of life.

Art therapy is often part of treatment programmes for personality disorders, which focus on attachment, emotion regulation, self-awareness, self-regulation, social functioning, behaviour or mentalizing skills. It is often offered in combination with DBT (Linehan, 1996), SFT (Young et al., 2003), ACT (Hayes, 2000) or Mentalization Based Treatment (Bateman & Fonagy, 2006). This frequent use of art therapy in treatment programmes for personality disorders may suggest that art therapy is grounded on a firm evidence base. In the next sections, it will be showed that this is not correct.

ART THERAPY AND PATIENTS WITH PERSONALITY DISORDERS: A NATURAL FIT?

Therapists and patients believe that art therapy contributes considerably to the treatment result. In this section, a link is made between the problems of patients with a personality disorder and the previously described specific characteristics of art therapy (art process, art product and interaction).

Emotion-regulation problems

Personality disorder patients often have trouble experiencing and dealing with emotions. The **art process** offers a space for exploration and experiencing emotions and/or (inner) conflicts. Feelings or themes that are difficult to process or to handle can be explored without being directly expressed in words, as described in many handbooks on art therapy (e.g. Malchiodi, 2012; Moschini, 2005; Schweizer et al., 2009). This can help personality disorder patients to recognize these often conflicting emotions and to find a more constructive way to deal with these. Integration of conflicting emotions can be pursued through the art work (Eisdell, 2005; 2011; Simon, 2005). Experientially working with art materials often offers a trigger to activate emotions (Keulen-Vos, 2013; Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007; Pifalo, 2006; Schouten et al., 2014). This is also important in case of traumas and in particular childhood traumas, which are often seen in patients with personality disorders (Ingenhoven et al., 2012). Difficult or conflicting emotions are often avoided by personality disorder patients because these are so hard to handle. By this art process (including sensory and affective perception and reflection), patients learn to undergo, recognize, process and possibly accept difficult emotions or themes (e.g. Rankanen, 2016b; Rubin, 2001).

The **art product** is concrete and tangible and could mirror the affective experience of personality disorder patients, their emotions, inner conflicts and identity. This can have a confirming effect, but also confrontational. For example, for a personality disorder patient, this can mean that the art work reflects that their anger is stronger than acknowledged. The

art products of personality disorder patients often show the inner conflicts or fragmentation of the self. Patients with a personality disorder often merge with their emotions (fuse or coincide with emotions), and, as a result, this engulfs them. This often leads to avoidance, suppression or diversion. Taking a more distant perspective is often difficult for them when merging with emotions, and the art product can assist in this process. The art product is a visible representation of one's own emotions. Because it is showing emotions in externalized form, one can literally stand at a distance from these emotions and is 'forced' to take a position towards it; one has to relate to it. This is described in descriptive literature and in case studies (e.g. McMurray & Schwarz-Mirman, 2001; Neumann, 2001; Toles, 1998). The art product can stimulate emotional perception, 'defusing' of emotions – as opposed to merging with or fusing with emotions – (Hayes, 2000), self-insight and a more observant or sometimes also more down-to-earth perspective. The art product can offer a bridge for communication, especially when fear or resistance is high (e.g. Lefevre, 2004; Moschini, 2005).

The **interaction** component consists of stimulating (self-)reflection in discussing the art work with the therapist. Personality disorder patients often get caught up in direct interactions with others, and because the art work is used as an extra pillar in the therapeutic situation, this can make interaction less direct and therefore less threatening. Transference between therapist and patient is then diluted because transference also goes to the art media and art product (Gussak & Rosal, 2016; Malchiodi, 2012). Interaction related to the art process and art product can be direct as well as indirect. Emotions can be expressed in the art work without direct communication about these emotions with the therapist. The therapist can witness expressed emotional content without words or use indirect interventions to support expression (Daszkowski, 2004; Schweizer et al., 2009). Direct communication with the therapist and others is used to improve the patients' understanding and handling of own emotions.

Self-regulation problems

Personality disorder patients often suffer from weakened autonomy and an unstable, diffuse or negative self-image. In the **art process**, the personality disorder patient is responsible for the creation of the art product, and this asks for self-management or self-direction. Very often the art assignment of the therapist is so widely formulated that the patient himself can determine how the product will look like. During the making of the art product, the personality disorder patient has an internal dialogue and can experience autonomy. In the art process, choices and considerations are crucial. Experiencing more self-management or self-direction and awareness of own choices contributes to the strengthening or improvement of the sense of self, of individuality, self-awareness and self-image. This is supported by many studies and descriptive literature (e.g. Czamanski-Cohen & Weihs, 2016; Gatta, Gallo, & Vianello, 2014; Haeyen, 2007; 2011a/b; Malchiodi, 2012; Neumann, 2001).

The **art product** itself shows the patient who they are, both by the content of the image as by its formal image characteristics as many experts agree (e.g. Gussak & Rosal,

2016; Springham et al., 2012). 'What you make is how you are.' The content of the art product is a mirror of the patient's characteristics. Personality disorder patients often experience various emotional states (modes) in themselves that can be very difficult to get into alignment, making it difficult to choose a clear personal direction. The art product often shows different, conflicting sides of the person, as various authors have pointed out throughout the years, from the early 1980s until now (e.g. Jádi & Trixler, 1980; Rankanen, 2016a). On the basis of one or several products, dialogues between these different sides can be stimulated, e.g. between the mild and the critical self. Exploring these states can eventually contribute to a less diffuse, more stable self, more self-compassion and positive self-esteem. When the art product does not reflect or poorly reflects the patient, this can be worked on to strengthen in the next art process.

In the **interaction** during the joint viewing focussed on self-regulation problems, the emphasis lies on investigating and determining the identity of the person and what personal direction one wants to follow. The conversation related to the art work is then about identity, authenticity and self-image.

Enduring and inflexible patterns of cognitions, emotions and behaviours

Personality disorder patients have enduring and inflexible intrapersonal patterns of cognitions, emotions and behaviours that lead to significant distress or impairments, with an impact on a broad range of personal situations (APA, 2013; WHO, 2015). In the **art process**, fixed patterns of cognitions, emotions and behaviours as well as the way the patient interacts with the art media (e.g. controlled perfectionistic, impulsive or affective behaviour) are visible according to many authors (e.g. Hinz et al.; Schweizer et al. 2009). Alternative behaviours can be practised with (e.g. from rationally stuck behaviour to more spontaneous, less controlled behaviour or from impulsive to more thoughtful). The art process can be then seen as a play/practise field with space for experiment. When aiming at changing enduring and inflexible patterns, the emphasis is on the art process itself, the interaction, and less on the art product. In the creative process, choices are made, artistic challenges are dealt with and improvisation is often needed. This process appeals to fine tuning and to becoming more flexible and more constructive. Practicing could result in improvement of problem-solving skills, as well as to come off from fixed patterns (Gussak & Rosal, 2016; Hinz, 2009). This would stimulate personality disorder patients to cope better with personal problems in different life areas. Art assignments, art techniques, imagination and play are used by the art therapist to make patterns visible, and then to offer challenges to induce behaviour change as described in handbooks (e.g. Gunther, Blokland-Vos, van Mook, & Molenaar, 2009; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2012). In art therapy, the threshold to practise and play may be reduced because challenges are offered within a safe, indirect situation with varied degrees of safety versus challenge built in by the art therapist (Smeijsters, 2008). Success experiences in the art work can stimulate the person to come to change feelings and thoughts; for example, 'I can do nothing well' can be changed

by success experiences in the art work to 'I can do this!' (Schnetz, 2005; Wilkinson & Chilton, 2013).

In the **interaction** based on the art process and **art product**, patient and therapist look back and evaluate with respect to the concrete work process: what is the perception of the patterns, what are inconsistencies and what are the development possibilities (e.g. affective material handling involved in the art process versus creating rationally distance in the communication afterwards). The communication on observed patterns can be about the origin, its function or meaning, the desired direction and what a first concrete step could be to lead to change.

Impairments in interpersonal functioning

Personality disorder patients also have problematic social patterns that lead to impairments in interpersonal functioning, especially focussed on empathy or intimacy (APA, 2013; WHO, 2015). Empathy can be problematic for example because perception of others is biased, one can be preoccupied with criticism or rejection and intimacy is often problematic because (close) relationships with others can be intense, unstable and conflicted or largely superficial to serve self-esteem regulation. The **art process** can be used as a social practise and playing field; art-making then is a social situation in which interactions with other patients take place via the art work, as described in different handbooks on art therapy (Gussak & Rosal, 2016; Schweizer et al., 2009). Art therapy can then be focussed on practicing effective behaviour in collaboration with others (practicing, for example, to ask for what you need, to say no and to deal with conflicts). Group-focussed art therapy may offer experiences focussed on contact, interpersonal connection, reciprocity, play and/or autonomy.

The **art product** always shows traces of how the interaction with others took place. The **interaction** is then also based on this interpersonal functioning. Personality disorder patients may experience cognitive distortions, and evaluating the concrete process can then offer a form of reality testing. Mentalization is also often difficult for personality disorder patients. This may be actively practised in the interactions with other participants as well as in the communication on the art work itself and the art experiences (Bateman & Fonagy, 2004a/b; Springham et al., 2012; Verfaille, 2016). Improved mentalization contributes to a better understanding for personality disorder patients of themselves and others in interactions. A better understanding of different perspectives in the interpersonal functioning may also contribute to more stable relationships or a better interpersonal functioning.

The mechanisms described above are supposed to be unique to art therapy. Only in art therapy, we find this specific use of the art process, art product and interaction regarding this art work in order to reach personal therapeutic goals. Art therapy emphasizes the experiential and acting in the here and now, more than verbal (psycho)therapies. Occupational or activity therapies often make use of art work but are aimed mostly at relaxation and/or day structuring but do not contribute to the personal (psycho)therapeutic goals. The art-therapy mechanisms described here seem not to be exclusive to the personality disorder target group:

the mechanisms could fit more diagnostic groups. Nevertheless, they seem to be well fitting the personality disorder problems.

How meaningful and attractive the above-described theories and ideas on art therapy (what it does and how it works) for personality disorder may be, these are based on evidence originating from *expert opinions*, *clinical expertise* and *patient preferences*. Therefore, this evidence on art therapy should be qualified as the lowest level in the evidence-based pyramid, level D (CBO, 2007). Furthermore, art-therapy interventions are often not described systematically and clearly in the literature. The question is, then, firstly: is art therapy indeed effective in working on personality disorder problems? And if so, are the mechanisms described here indeed how it works? What is examined so far, what do we know on the basis of quantitative empirical evidence?

QUANTITATIVE EMPIRICAL EVIDENCE

In this section, the existing quantitative empirical evidence level C and level B is briefly summarized.

A total of six non-comparative research studies have been found (**level C**; CBO, 2007) which will be described ordered by the year of publication from most recent to older. First, Eren, Öğünç, Keser, Bıkmaz, Şahin, and Saydam (2014) conclude, using a pre-/post-test study involving a psychodynamic art therapy in 17 patients with a personality disorder, that group art therapy contributes to improving global functioning by patients with personality disorders.

Second, Gatta et al. (2014) describe the effects of group art therapy in the setting of a residential rehabilitation centre for adolescents with personality disorders (N = 9). Although limitations of this study are the lack of a control group and the small sample considered, it provides some clues that, as part of a compulsory stay in a residential rehabilitation centre, group art therapy could have an added, aggregating value, helping the adolescents to combat the sense of solitude and self-centred isolation.

Third, a study (N = 6) of Springham et al. (2012) concerns a mentalization-based treatment programme for borderline personality disorder (BPD), with an art-therapy group as one of the programme's three components. This study combines quantitative and qualitative methods within a naturalistic practice setting. Evaluation shows positive results including increases in distress tolerance, lowered service use and two participants no longer meeting criteria for the BPD diagnosis. The study suggests that in anchoring mental content in an externalized form, art therapy offers the flexibility to slow down the process of explicit mentalization to a manageable pace. Limitations of this study are again the small sample size, the lack of a control group and the qualitative element being represented by a single case.

In a quantitative study by Haeyen (2011), patients diagnosed with a personality disorder B and C (N = 34) evaluated art therapy by answering the question: 'How much benefit did you

gain from art therapy?' on a five-point Likert scale (1 = not; 2 = little; 3 = slightly; 4 = rather much; 5 = much), with a mean score of 4. Also, the goals that were worked on in art therapy were evaluated. The goals that patients scored most as being targeted by art therapy are: 'expression of emotions', 'a more clear and stable self-image' and 'recognizing, understanding and changing patterns in feeling, behaviours and thoughts'.

In a small study (N = 5), Franks and Whitaker (2007) report the results of a combined 9-month treatment programme of an art psychotherapy group alongside individual verbal psychotherapy sessions for personality disorder patients. The authors conclude that the results from the used outcome measures suggest that the combination of treatments is effective with benefits sustained over time, measured with an 8-month follow up (n = 3). However, given the very small sample and the possible bias (intervention not sufficiently isolated), it is not possible to generalize these results.

Finally, another study by Haeyen (2007) reports the experiences regarding a one-session art therapy imagination assignment with a focus on schema modes of 48 patients diagnosed with a personality disorder cluster B/C; this study mentions effects such as insight in oneself and the own patterns, more contact with emotions, improved emotion regulation and a gained corrective experience.

All these non-comparative studies suggest some effects of art therapy in patients with personality disorders. This suggestion fits well with what has been described above, that art therapy is a means to get in touch with your own problems (with aims such as improved emotion regulation, a more clear and stable self-image or increased distress tolerance) and that art therapy has a possible added value.

Only three studies report evidence on **level B** (non-randomised, cohort studies, patient-control studies; CBO, 2007). However, all three have a moderate (weak) quality, have an insufficient size and/or are not always randomised.

First, Karterud & Pedersen (2004) report on components of a group-oriented, short-term day-care programme for treatment of personality disorders (N = 319). Most patients have a personality disorder (86%), mostly the avoidant or the borderline personality disorder. Treatment evaluation has been done by posing the question: 'how much benefit did you gain from therapy x?'. The benefits of the art-therapy group were scored significantly higher (p < 0.001) than that of all other groups, and the art-therapy group score correlated significant (p = 0.005) with the 'overall benefits' of the programme. The multiple regression analysis also indicates a stronger effect in the art-therapy group (b = 0.17; p = 0.008). Moreover, the more severely disturbed patients 'seemed to favour the pretend mode' of the art group therapy. Referring to the work of Bateman and Fonagy (2006), the authors propose that the art group therapy 'appears to be a safe method of exploring the mind in the presence of mentalizing self-objects' (Karterud & Pederson, 2004).

The second study was a pilot study, conducted by Van den Broek, Keulen-de Vos, and Bernstein (2011) (N = 10), and focussed on the extent to which SFT and drama, music and art

therapy (arts therapies) were able to provoke schema modes in forensic patients with a cluster B personality disorder. SFT is compared with treatment as usual (TAU) (i.e. cognitive behavioural therapy) and arts therapies versus psychotherapy. The comparison of psychotherapy versus arts therapies shows a significant effect concerning the healthy modes (d = 0.80). Patients report more healthy modes in arts therapies than in psychotherapy (T = 7.00; p < 0.05). Art therapy that is part of the TAU comes forward as the most effective form of intervention. The conclusion is that art therapy is probably effective in provoking experiences and feelings (mental states) and promoting a healthy adult attitude to these feelings and experiences.

The last of the three studies concerns a relatively old randomised controlled study by Green, Wehling and Talsky (1987) in which art therapy is compared with TAU in a population of chronic psychiatric patients with cluster A and cluster B personality disorder (N = 28). Compared with patients receiving TAU, the patients in the art-therapy condition (10 weeks) have improved on measures on self-esteem and social contact. The target group of this study, however, is broader than patients with personality disorders.

No studies on art therapy and personality disorders on **level A** were found. The results of the search do not involve a systematic review (meta-analysis) or more independently conducted randomised comparative clinical trials of good quality (randomised double-blind controlled trials) of sufficient size (≥ 20 subjects; a limit set by Lebwohl, Heymann, Berth-Jones, & Coulson, [2010] and consistency (CBO, 2007).

PROBLEM DEFINITION

The existing evidence for art therapy in the treatment of personality disorders is weak at best: no level A research, hardly any evidence on level B, only some studies on level C and, above all, most information does not exceed level D. The few available studies, often limited in sample size and quality, seem at best promising. Moreover, the involved art-therapy interventions for personality disorders have not been described systematically, clear and explicitly enough, especially not according to the steps needed to be taken to develop the interventions to a proven effective status (Spring, 2007; Veerman & van Yperen, 2007). Although art therapy is highly appreciated by personality disorder patients (Haeyen, 2011a; Karterud & Pedersen, 2004), there is a strong need for more evidence.

RELEVANCE OF THE PRESENT THESIS

At stake is an evidence gap that cannot be ignored. From an evidence-based point of view, we do not know whether art therapy really works and, if so, *how* it works. The main objective of this thesis is to substantiate and to develop knowledge about the effects of art therapy in patients

diagnosed with a personality disorder. In this thesis, I will report on a research programme in which the main research question will be: does art therapy have effect(s)? And if so, how large are the effects of art therapy, and what can be said about the nature of these effects?

First, experiences from patients will be explored in order to find an answer on what outcomes involved in art therapy are recognizable and relevant for patients. Next, a study will be reported in which a specific measurement tool for art therapy will be developed, aimed at monitoring the contribution of art therapy in multidisciplinary treatment programmes of personality disorders. In Chapter 4, a planned, systematic and theory-based art-therapy intervention will be constructed aimed at management of ineffective behaviours among patients with personality disorders. With this intervention, a trial will be performed to examine the efficacy of art therapy in individuals with a personality disorder cluster B/C. Outcomes will give insight in the effect sizes as well as the nature of these effects. In Chapter 6, the nature of these effects in terms of positive health and or reduction of negative symptoms will be focussed on. It will be investigated on which domain art therapy has most effect – on mental health or symptom reduction – with the aim to add evidence to the theoretical base of art therapy. In Chapter 7, we will further explore the psychometric properties of the measurement tool for art therapy. In the final Chapter, results are summarized and discussed in detail.

OUTLINE

This dissertation presents the results of a series of five studies on art therapy in patients diagnosed with personality disorders. For an overview, see Table 1.

Table 1. Overview of studies in this dissertation

	Research (sub)question	Goal of study	Design method	Sample
Chapter 2	What are the perceived effects of art therapy in treatment of adult patients with personality disorders cluster B/C?	Provide insight into the perceived effects of art therapy and constructing a theoretical framework.	Qualitative design. Literature study, individual and focus group in-depth interviews, data analysed using the Grounded Theory Approach.	29 patients diagnosed with a personality disorder cluster B/C.
Chapter 3	Can we develop an instrument to measure the contribution of art therapy in multidisciplinary treatment of personality disorders?	Construct and develop an instrument with adequate psychometric properties.	Structural validity (exploratory and confirmatory factor analysis), reliability, construct validity and sensitivity to change were examined.	Two independent databases (n = 335, n = 34) of patients diagnosed with a personality disorder cluster B/C.
Chapter 4	Can we construct a planned, systematic and theory-based art-therapy intervention aimed at management of ineffective behaviours among patients with personality disorders?	Develop an art-therapy intervention for patients with personality disorders based on empirical findings, theoretical models and clinical practice experience.	Intervention mapping was applied to guide the development and implementation of the art-therapy intervention.	
Chapter 5	What is the efficacy of art therapy in individuals with personality disorders cluster B/C?	Evaluate the effects of the art-therapy intervention on psychological functioning of patients with a personality disorder B/C.	Randomised controlled trial (RCT) comparing (1) a weekly group art therapy of 1.5 hours during 10 weeks and (2) a waiting list group. Outcome measures were assessed at pre-test, at post-test (10 weeks after baseline) and at follow-up (5 weeks after post-test).	57 patients diagnosed with a personality disorder cluster B/C (SCID-II).

Chapter 6	Does art therapy affect symptom reduction and/or positive mental health?	Provide insight in on which domain art therapy has most effect, with the aim to add evidence to the empirical base of art therapy.	Draws on RCT data (chapter 5). Effect sizes for mental health and mental illness, principal component analysis for each group of indicators, factor scores regression to examine the distinctiveness of the concepts.	74 patients diagnosed with a personality disorder cluster B/C
Chapter 7	What are the psychometric properties of the SERATS concerning validity and sensitivity to change?	Explore the convergent validity of the SERATS with a broader range of measures.	Convergent validity and sensitivity to change were examined.	32 patients diagnosed with a personality disorder cluster B/C who received art therapy

The first step, starting from scratch in the process to obtain insight in art-therapy effects, is an exploration of the patients' perspective. What effects do patients experience as stemming from art therapy? **Chapter 2** reports on the study *Perceived effects of art therapy in the treatment of personality disorders, cluster B/C: A qualitative study* (published in: The Arts in Psychotherapy, 2015). Patients' reports of perceived effects can help us to find rich information or reveal hidden variables that provide explorative information about possible patterns of effects that patients' experience in relation to art therapy as a part of a multi-intervention treatment programme. This first study is aimed to provide insight into the perceived effects of art therapy, to relevant outcome measures for further research. We report on interviews of patients diagnosed with a personality disorder in individual and focus-group in-depth interviews. Data are gathered and analysed using the Grounded Theory Approach in order to generate concepts and inter-related categories. This results in a theoretical framework of perceived effects of art therapy in treatment of adult patients with a personality disorder cluster B/C.

Next, the development of a specific measurement tool for art therapy will be reported, aimed to measure art therapy in multidisciplinary treatment of personality disorders. This will be done in **Chapter 3** *Measuring the contribution of art therapy in multidisciplinary treatment of personality disorders. The construction of the 'Self-expression and Emotion Regulation in Art Therapy Scale' (SERATS)* (published in: *Personality and Mental Health,* 2017a). The perceived effects (chapter 2) are used for the development of an assessment tool to examine the efficacy of art therapy and within clinical practice. This study is about the development of an art-therapy instrument: the Self-expression and Emotion Regulation in Art Therapy Scale (SERATS). The goal is to develop a short instrument to measure perceived effects of art therapy with good psychometric qualities, i.e. good internal reliability, clear construct validity; further, the instrument should be able to measure changes over time.

Because we want to measure the results of art therapy, we need to construct a planned, systematic and theory-based art-therapy intervention aimed at management of ineffective behaviours among patients with personality disorders. The study that focussed on this topic is described in **Chapter 4** *Development of an art-therapy intervention for patients with personality disorders: an intervention mapping study'* (published in: *International Journal of Art Therapy, 2107*). A planned, systematic and theory-based approach to test and possibly to increase the effectiveness of the art-therapy intervention for this target group is needed, aimed at management of ineffective behaviours among patients with personality disorders. Because current art-therapy interventions are based on practical beliefs or common-sense approaches, this has no solid basis in research results. The principles of intervention mapping are applied to guide the development, implementation and planned evaluation of the art-therapy intervention. Empirical findings, theoretical models and clinical practice experience will be combined to construct a practical programme tailored to the needs of the target group.

With this intervention, we performed a randomised clinical trial (RCT) to examine the efficacy of art therapy in individuals with personality disorders cluster B/C. This will be reported in **Chapter 5** *Efficacy of art therapy in individuals with personality disorders cluster B/C. A randomised controlled trial* (published in: *Journal of Personality Disorders*, 2017b). The goal of this RCT is to evaluate the effects of the art-therapy intervention as developed (see chapter 4) on psychological functioning of patients with a personality disorder. In this study, adult patients diagnosed with a personality disorder cluster B/C (SCID-II) were randomly assigned to (1) a weekly group art therapy of 1.5 hours during 10 weeks or (2) a waiting-list group. Outcome measures are focussed on personality disorder pathology, maladaptive and adaptive schema modes, experiential avoidance and mental health functioning (OQ45, AAQ-II and SMI). The outcome measures are assessed at pre-test, at post-test (10 weeks after baseline) and at follow-up (5 weeks after post-test).

Next, a study on the nature of the found effects will be reported. Is the nature of the effects on the domain of positive mental health by enhancing aspects such as well-being, flexibility or resilience as many experts think, or does it also reduce symptoms of mental illness? This is the focus in **Chapter 6** *Promoting Mental Health versus Reducing Mental Illness in Art Therapy with Patients with Personality Disorders: A Quantitative Study* (published in*: The Arts in Psychotherapy*, 2017c). We examine this issue with the aim to add evidence to the empirical base of art therapy.

In **Chapter 7**, *The Psychometric Properties of the SERATS. A Further Investigation* (manuscript submitted for publication), we will further investigate the psychometric properties of the SERATS to explore the convergent validity and the sensitivity to change of the SERATS with a broader range of measures.

In the final Chapter of this thesis, **Chapter 8** *Summary and General Discussion*, the overall results of the studies will be summarized. Limitations and considerations, as well as the implication of the results in relation to the background of the thesis, will be discussed.

CHAPTER 2.

Perceived effects of art therapy in the treatment of personality disorders, cluster B/C: A qualitative study

A Qualitative Study

Haeyen, S., Hooren, S. van & Hutschemaekers, G. (2015). Perceived effects of art therapy in the treatment of personality disorders, cluster B/C: A qualitative study. *The Arts in Psychotherapy*, 45, 1-10. doi:10.1016/j.aip.2015.04.005

ABSTRACT

Art therapy is frequently used in the treatment of patients diagnosed with cluster B/C personality disorders, but there is little evidence for its efficacy. This study aimed to provide insight into the perceived effects of art therapy. We interviewed 29 adult patients in individual and focus-group in-depth interviews, including a 'negative case', starting with a topic list coming from the literature study. Data were gathered and analysed using the Grounded Theory Approach in order to generate concepts and interrelated categories. The constructed theoretical model of effects of art therapy consisted of five core categories: improved sensory perception; personal integration; improved emotion/impulse regulation; behaviour change; and insight/comprehension. Compared to verbal therapy, patients experienced art therapy as an experiential therapeutic entry with a complementary quality next to verbal therapy and a more direct way to access emotions, which they attributed to the appeal of art materials and art making to bodily sensations and emotional responses. Art therapy was found to fit well the core problems of patients with personality disorders, to offer a specific pathway to more emotional awareness and constructive emotion regulation. The perceived effects give input for further development and research and the development of an assessment tool to examine the efficacy of art therapy and within clinical practice.

INTRODUCTION

Art therapy can be described as the therapeutic use of art making within a professional relationship by people who experience illness, trauma or challenges in living, or by people who seek personal development. The purpose of art therapy is to improve or maintain mental health and emotional well-being. Art therapy utilises drawing, painting, sculpture, photography and other forms of visual art expression (Malchiodi, 2005).

Art therapy is frequently used to treat people with personality disorders who are struggling with serious emotional and self-regulation problems (APA, 2013). Therapists believe art therapy is a powerful intervention in the treatment of personality disorders, and patients report that art therapy has beneficial effects in daily clinical practice. Nevertheless, art therapy is not usually the first-choice treatment according to the basic principles of evidence-based medicine. This is because there is little empirical evidence for its efficacy, and the available evidence is not focussed on the unique value of art therapy itself but on multidisciplinary treatment programmes, in which art therapy is important but plays only a secondary role. The specific effects of art therapy have not been isolated in these studies (e.g. Bateman & Fonagy, 1999, 2004a; Gatta, Gallo, & Vianello, 2014; Karterud & Urnes, 2004; Wilberg, Karterud, Urnes, Pedersen, & Friis, 1998). There seems to be a discrepancy between the limited evidence for art therapy and the fact that it is considered to be promising in practice. Since that is the case, why is art therapy used so often?

Until now, we have relied on the clinical expertise of art therapists and their collective sense of profession. Experts describe a large variety of effects that art therapy can have on the recovery process of a patient with a personality disorder. First, they have noted that art therapy improves emotion and impulse regulation (Eren et al., 2014; Haeyen, 2005, 2007; Morgan, Knight, Bagwash, & Thompson, 2012). Art therapy seems to stimulate the regulation of overwhelming and poorly adapted emotional experiences by allowing the patient to express emotional themes in the artwork and to handle materials that appeal to different emotional responses. Art therapy uses experiential techniques and effectively provokes mental states connected with `child modes' and improves the `Healthy Adult mode' known from Schema Focussed Therapy (Van den Broek, Keulen-de Vos, & Bernstein, 2011). In addition, experts stated that patients learn to reduce their tension and/or stop when their emotions become too overwhelming, to structure chaotic behaviour and to rethink behaviour before acting on it. This results in strengthened control, improved self-structuring skills and more positive behaviour (Eren et al., 2014; Haeyen, 2005, 2007; Zigmund, 1986). Lack of self-control and structuring skills are typical behavioural problems for many patients with a personality disorder, especially with a Borderline personality disorder (Linehan, 1996).

The second effect mentioned by experts concerns stabilising and strengthening identity. Many art therapists and a few researchers have described the effect of strengthening identity: a more positive self-image (Chrispijn, 2001; Haeyen, 2007; Johns & Karterud, 2004;

Morgan, Knight, Bagwash, & Thompson, 2012; Neumann, 2001) and an increase in 'self-cohesion' (Levens, 1990; Robbins, 1984). According to researchers and art therapists with many years of clinical experience, art therapy leads to increased self-awareness, improved self-perception, improved reflective abilities and self-insight (Bateman & Fonagy, 2004; Haeyen, 2007; Haeyen & Henskens, 2009; Jádi & Trixler, 1980; Levens, 1990; Ouwens et al., 2007; Waller, 1992). Many patients with a personality disorder experience serious identity problems, also known as self-regulation problems. They suffer from a damaged or poor self-image, which consists of polarities. Various experts have stated that art therapy increases contact with one's own emotions, body and experience. In other words, intra-psychological integration is stimulated through artwork and the art-making processes, possibly resulting in a corrective emotional experience (Bateman & Fonagy, 1999; Goodwin, 1999; Gunther, Blokland-Vos, van Mook, & Molenaar, 2009; Haeyen, 2007; Haeyen & Henskens, 2009; Lefevre, 2004; Lev-Wiesel & Doron, 2004; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2008). As Bateman and Fonagy (2004) described, in art therapy, experience and feeling are placed outside the mind and into the world, a process that facilitates explicit mentalizing. They further stated that art therapy creates transitional objects and that the therapist needs to work at developing a transitional space. The created objects can be used to facilitate expression while building stability of the self (Bateman & Fonagy, 2004a; 2006). By creating playful safe transitional objects and space, identity may be strengthened and stabilised by the patients' investigation of their own basic preferences and needs.

The third effect mentioned by literature is about learning to express emotions more effectively. Many art therapists and a few researchers have mentioned that, by moving from images to words, patients learn to express themselves in a more implicit way through which explicit expression and mentalization can emerge. During art therapy, patients examine feelings without words, pre-verbally and sometimes less consciously (Eisdell, 2005; Haeyen, 2005; Johns & Karterud, 2004; McMurray & Schwarz-Mirman, 2001; Milia, 1998; Springham, Findlay, Woods & Harris, 2012). In this way, art therapy is said to contribute to the process of gaining insight and understanding about the patient's problem. art therapy potentially offers a different therapeutic entry than regular verbal therapies. Art therapists emphasise that, since this entry is indirect, art therapy breaks down barriers (Haeyen, 2005; Hartwich & Brandecker, 1997; Robbins, 1994). Through art therapy, expression is used to improve communication and initiate contact (Daszkowski, 2004; Gatta, Gallo, & Vianello, 2014; Haeyen & Henskens, 2009; Johns & Karterud, 2004; Karterud & Pedersen, 2004; Springham, Findlay, Woods & Harris, 2012; Zigmund, 1986). Expression of intra-psychological conflicts and traumatic experience during art therapy gives the patient the opportunity to experience (instead of avoid) and reframe these conflicts, which art therapists believe may be highly effective for trauma processing (Eastwood, 2012; Engle, 1997; Hitchcock Scott, 1999; Jádi & Trixler, 1980; Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007; Morgan, Knight, Bagwash, & Thompson, 2012; Moschini, 2005; Pifalo, 2006; Van der Gijp & Kramers, 2005). Karterud and Pedersen (2004) also mentioned that the effect

of learning to express emotions more effectively could explain the results of a quantitative study among 319 patients with personality disorders. That study found that patients valued art therapy more highly than other treatment elements, such as verbal therapy and other therapy groups. The authors explained the high value assigned to art therapy as related to the 'as-if situation' that offers patients a safe way to explore their perception of feelings and emotions, express them and give them meaning by means of self-objects in the shape of works of art. As described by Fonagy, Gergely, Jurist, and Target (2002), AT adheres to a 'pretend mode' by using fantasy and imagination.

The fourth effect to consider is about dealing with limitations and vulnerability by accepting limitations and using more effective coping skills. Experts have mentioned that acceptance, support and recognition are some of the effects of art therapy related to learning to deal with and accept one's own expression or artwork and that of others (Haeyen, 2007; Gunther, Blokland-Vos, van Mook, & Molenaar, 2009; Springham, Findlay, Woods & Harris, 2012; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2008). Dealing with personal expressions validates vulnerabilities that are present in the art therapy process and product, and challenges coping skills. Entering new experiences in art therapy and having indirect experiences by working together on artistic assignments lead patients with a personality disorders to experience positive effects on self-acceptance, higher self-esteem and improved social functioning. Long-term psychodynamic art psychotherapy decreased symptoms of self-mutilation, suicidal attempts, self-harm behaviours (Eren et al., 2014).

The expert opinions and evidence from multidisciplinary treatment studies suggest that art therapy may be promising. Coordinating treatment modalities may offer patients more therapeutic possibilities than one treatment modality may offer alone (Heckwolf, Bergland, & Mouratidis, 2014; Springham, Findlay, Woods & Harris, 2012). This is also stated in recent publications on art therapy that describe contemporary personality disorder treatment modalities combined with art therapy. Examples are: art therapy combined with Dialectical Behaviour Therapy, Mentalization-based treatment or with Schema Focussed Therapy (Haeyen, 2007; Heckwolf, Bergland, & Mouratidis, 2014; Springham, Findlay, Woods & Harris, 2012; Van den Broek, Keulen-de Vos, & Bernstein, 2011; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2012).

However, we do not know the differential effects of art therapy compared to verbal therapy and to what degree patients recognise the supposed effects of art therapy. Literature provides us with many patient testimonies, most of which describe positive experiences with art therapy (Eisdell, 2005; Gatta, Gallo, & Vianello, 2014; Haeyen & Henskens, 2009; Moschini 2005). Patients bring their own personal and unique concerns, expectations and values to art therapy. However, in those testimonials, little attention is paid to the difference between art therapy and verbal therapy. In addition, they do not provide a systematic view of the uniqueness and added value of art therapy.

This study aimed to provide a systematic investigation of the patients' experience of the benefits of art therapy. In addition to existing expert literature, this study could give a

complete image of the effects of art therapy in treatment of adult patients with personality disorders cluster B/C and develop a theoretical framework that is grounded in patients' daily art therapy experiences. This framework would contribute to the theoretical formation of art therapy and also lead to a clarification of the possible specific qualities of art therapy compared to verbal therapy.

METHOD

This qualitative study was performed with the Grounded Theory Approach (GTA) (Corbin & Strauss, 2008). In-depth interviews were used to collect the data, because we wanted to focus on what patients report when absorbed in genuine art therapy experiences in the context of a natural setting, in order to examine the experience without preconceived notions or expectations. GTA was used to gather and analyse the data to generate concepts and interrelated categories, because there has been little research into the effects of art therapy experienced by patients with personality disorders and because the GTA focusses on the experience processes of personality disorder patients in art therapy.

Procedure

We conducted participant sampling according to the principles of theoretical sampling, in which new cases were chosen in each step to compare with those that had already been studied (Corbin & Strauss, 2008). Step 1 was an individual interview phase that started with interviews of three patients who were just finishing their treatment. Next, we interviewed five more patients of different ages, sex, settings and modes of treatment. This process is a form of theoretical sampling (Strauss & Corbin, 1998). Then we included three more patients who had ended their treatment between one month and six years ago (time sampling); they were added because they might evaluate art therapy differently than patients who were still involved with the treatment and therapists. Finally, we also interviewed a patient who might not approve of the results so far, a so-called 'negative case'(Corbin & Strauss, 2008). We analysed all the interviews by open coding, resulting in a code tree. This process of data gathering came to a point of information saturation when no new codes emerged (155 codes).

In Step 2, we conducted three focus-group interviews in order to focus more specifically on the added value of art therapy and for additional dialogue to deepen the developed concepts. The respondents were given the opportunity to interact and discuss things with each other. We interviewed 17 more patients in these focus groups; the results of these interviews were analysed by axial coding. This process reduced the number of codes to 54 and resulted in main and subcategories (five main categories and 28 subcategories). In Step 3, we performed selective coding based on the main and subcategories found in the axial coding. All interviewed patients were asked to read the summaries that emerged from the data analysis and to give

feedback. This feedback confirmed the analysis, so no new content was added to conceptualise the categories.

The continuation of these three steps was an iterative process of data gathering and data analysis. In this process, new data were compared with previous data and previous data were repeatedly compared with new data. The iterative process and 'constant comparison' are key aspects of Grounded Theory methodology (Corbin & Strauss, 2008). Fig. 1 outlines the three main steps of data collection and data analysis in this study. The dotted lines represent the constant comparison.

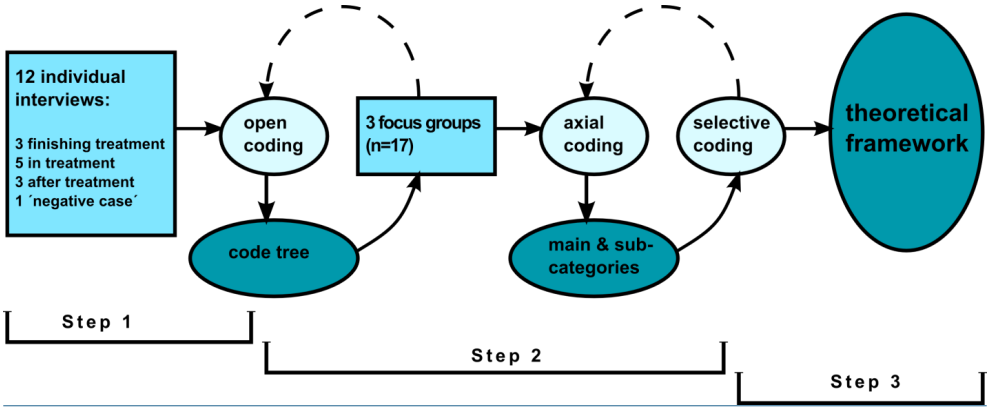

Figure 1. Steps in the iterative process of the study.

Participants

Participants were recruited through departments of a mental health care centre that focussed exclusively on personality disorders. We interviewed 29 patients about the effects of art therapy that they had experienced. Participants were adult patients (27 female and two male) with at least one personality disorder, cluster B/C diagnosis. The most frequent diagnosis was a 'personality disorder not otherwise specified'. Other participants were diagnosed with evasive, borderline, dependent, obsessive-compulsive and narcissistic personality disorders and/or traits. The largest group had a GAF score of 55, meaning moderate symptoms or moderate difficulty in social, occupational or school functioning. The participants received art therapy as part of a multidisciplinary treatment programme or were specifically referred for art therapy by a psychologist or psychiatrist.

An inclusion criterion for this study required that participants had received at least 15 sessions of art therapy. All respondents received verbal therapy in addition to art therapy. We interviewed 25 participants during or at the end of their treatment process and for some time after receiving art therapy (varying from one month to six years after art therapy). We individually interviewed 12 patients; 17 more were interviewed in a focus group.

Interviews

The group of 29 respondents was interviewed in 12 individual (*n* =12) and three focus groups (*n* =17). These interviews were open in-depth interviews, proceeding inductively and using an unstructured format and a topic list coming from the literature study. The starting point for both the individual interviews and the focus groups was a general instruction that determined the sequence of the conversation: to talk about what they experienced (emotions, interactions and consequences) as an effect or benefit of art therapy and what they experienced as helping or obstructing conditions relating to the art therapist, the circumstances and their own basic needs in art therapy. The topic list was used to prevent important topics from being neglected and to bring fluency to the conversation if necessary. Participants were also asked to articulate the characteristics of art therapy as compared to verbal therapy and the specific effect of the art-making process based on their 'most important' art product. These 'most important' art products chosen by the respondents were present at the time of the interview, which helped the conversation remain concrete and specific. Each interview lasted about one hour and each respondent was interviewed once.

Data analysis

As already mentioned, we used GTA to analyse the data and to generate concepts that could then be integrated into a theoretical framework about the effects of art therapy with interrelated categories and their properties. The data were analysed using Kwalitan, a computer program for qualitative data analysis (Peters, 2000). Consistent with the principles of the Grounded Theory method, we applied three coding steps (i.e. open, axial and selective coding) to the interview analysis (Fig. 1) (Corbin & Strauss, 2008). First, we prepared all the interviews by fully transcribing the audio recordings. In the open-coding phase, concepts were identified and their initial properties and dimensions were discovered. In this study, the open coding in Step 1 started after the first three interviews. In this step, we used 'in vivo codes' as much as possible, which means that the text fragments were labelled using the words of the respondents themselves (Corbin & Strauss, 2008). In vivo codes included 'conflict with myself', 'to get out of the "thinking" mode' and 'symbols'. All the codes were summed up in a code tree (i.e. a list of codes). All the text fragments from the following interviews that shared the same characteristics were given the same code. Through comparative analysis, we renamed existing codes to develop them more fully. Consequently, the code tree expanded as the open coding progressed and until no new codes emerged. At the end of this process, the code tree contained 155 codes.

In Step 2, the axial coding phase, it became clear that codes could be grouped together into categories based on their more overarching similarities. The number of codes was then reduced to 54. Similar codes were grouped by making connections between categories at the property and dimension levels (Corbin & Strauss, 2008). For example, we grouped several codes ('to show myself', 'metaphors (used to symbolise oneself)', 'identity' and 'express/ portray feelings from the past') into the category 'self-expression'.

Through this process, it became possible to determine main and subcategories. This was guided by the number of patients who talked about a category, the frequency with which a category was mentioned and the importance it was given. This process resulted in five core categories and 28 subcategories.

In Step 3, selective coding connected the categories in order to create and refine an integrating theory (Corbin & Strauss, 2008). In this process, five core categories of effect emerged to which all subcategories could be linked. Although these steps seem to be sequential, this process of analysis required constant comparison of all the interviews (see Fig. 1).

Quality criteria

Several techniques were used to meet the quality criteria of 'trustworthiness' to ensure the rigor of this research (Guba, 1981; Krefting, 1991; Lincoln & Guba, 1985). Credibility strategies to establish trustworthiness were `prolonged engagement' in which informants were accustomed to the researcher. The threat of responds based on social desirability rather than on personal experience was countered by the facts that numerous interviews were held, in different social contexts and by talking in the presence of their own artwork in order to stay close to the actual experience. Other strategies were time sampling and triangulation of data methods and data sources (different social settings for data collection – individual and focus groups, theoretical sampling of respondents on gender, age, diagnosis and from different wards). Reflexivity was used to satisfy the criteria of credibility, dependability (i.e. the findings can be repeated) and conformability (i.e. the findings are grounded in data and not biased by the investigator's motivation or interest). A field journal was kept to be sensitive of our own subjectivity, for auditability and self-reflection. Writing memos was used to document considerations and insights, and to make constant comparisons during the process of data collection and analysis. Another way of looking for truth value of the findings that we performed was including a disconfirming or 'negative case' (Corbin & Strauss, 2008). A negative case is a respondent who would not approve previous findings, i.e. the positive results of art therapy we found so far. We selected a respondent, who showed resistance to art therapy and avoidance of experiences in art therapy. Member checking was performed on two occasions to ensure that the researcher accurately represented the respondents' opinion. All respondents mentioned that they recognised not only their experiences but also those of others. Peer examination was performed with other researchers and field experts to ensure the honesty of the researcher and deeper reflexive analysis by checking coding and categories developed from the data, for reaction and to discuss hypothesis. The whole process was audited/coached by research experts and a senior lecturer in art therapy for inspection and verification. These last two strategies and the description about informants and setting to identify whether data are typical contribute to the dependability and transferability of this study. Transferability is also strengthened by the fact that this study is conducted in a naturalistic setting, i.e. an mental health care expert centre for specialized treatment of personality disorders with different treatment programmes.

RESULTS

Core categories

We found five core categories related to the effects of art therapy (see Table 1).

Table 1. Core categories and subcategories of art therapy effects

Core categories	Subcategories
1 Improved sensory perception and self-perception	– discovering/experiencing materials and possibilities – discovering new opportunities and gaining consciousness of individuality/authenticity – emotional reaction to materials – perception/awareness of one's own feelings – experiencing the present moment – body awareness/perceiving the body/physical signals
2 More personal integration	– seeing one's emotional experience through visual images/ design – exploring, recognising and acknowledging feelings – portraying identity/self-image – portraying feelings of past and present – differentiating and clarifying feelings and thoughts – differentiating one's own patterns concerning feelings, thoughts and behaviours – differentiating between inner conflicts/themes
3 Improved emotion and impulse regulation	– emotionally expressing personal themes – improving regulation skills – acting out and 'living through' emotions/feelings and directing this process – anchoring feelings/experiences
4 Behaviour change	– applying alternative behaviour in dealing with oneself and one's own emotions – experiencing emotional contact with others – advancing social cooperation skills – adequately coping with social conflicts – giving/receiving social recognition and emotional support – improving feedback skills (giving and receiving)
5 Stronger insight and comprehension	– improving the verbal expression of experiences – improving transcending thinking on the product/ process – ameliorating understanding of one's own patterns regarding intra-psychic functioning – ameliorating reflection on one's own patterns in relation to others – drawing, transcending and connecting conclusions about this

Core category 1: Perception and self-perception

Perception concerns the base of the experienced effects of art therapy. It is defined as discovering materials, feeling the accompanying physical effects and exploring possibilities and choices, which results in more self-awareness and a sense of individuality. Patients stated that working with art is an experience that one can enter into and that this experience leads to experiencing the present moment, to emotional responses and to more emotional and body awareness. Patients also indicated that, at first, they sometimes felt worse when they gained full perception of all their mutable, often negative, emotions and feelings and the accompanying destructive behaviour. They noted that this process consisted of starting to experience and recognise the actual burden of negative feelings, while simultaneously experiencing that they had so far made little progress in dealing with these feelings. Avoidance of negative feelings came forward in the interviews as a core problem for people with personality disorders. Perception was the first step in this process of experiencing, recognising and validating emotions, as can be seen in the following quote:

> 'I start with a heavy, big piece of clay .... I am an analyser in my profession, but this I do by intuition ... and I need to use my force to get it in the first rough shape. I like to beat the clay .... I feel it's actually about power and aggression for me ... but as the art process progresses, I need to be more careful, more refined and vulnerable in my actions.' (Respondent 8, a 60-year-old male)

This perception was a base for further therapeutic exploration and actions and for exploring changes in patterns of feelings, behaviour and thoughts.

Core category 2: Personal integration

'Personal integration' is defined as the ongoing self-definition in which the integration of contradictive polarities in oneself leads to more self-coherence and self-acceptance. The patients mentioned that they could express and portray their personal issues, emotional experiences and identity or self-image in art therapy. They felt that their identities became visible, which led to an ongoing self-definition in which identity and self-image could be strengthened and become more positive. The patients noticed that another characteristic of art therapy is that the artwork confirms what is already there and that their development in the therapy process became visible in the work of art. They spoke of how a more coherent, more stable self-image and more self-acceptance arose. By expressing emotions through their artwork, they could further investigate and unravel their thoughts, patterns and inner conflicts. The following quote emphasises how art work can contribute to becoming aware and more accepting of oneself.

Image 1: 'I am scared stiff every time I see what I draw. I do tend to play down things .... I look at it and I often get a bit of shock, because how trapped or how unsafe I felt comes to the surface.... Really intense emotions are revealed. ... Through becoming conscious, feelings can be integrated.' (Respondent 27, a 21-year-old female)

The patients also stated in the interviews that, in the artwork, they examined, expressed and processed inner struggles closely connected to traumatic experiences from the past by giving them form. This investigational art process helped patients differentiate between emotions, thoughts, patterns and inner conflicts or contradictory feelings. Personal integration and more self-coherence were facilitated by bringing conflicting emotions, thoughts and behaviours into one coherent image. The following quote illustrates this integration process.

Image 2: '... the two emotions are integrated in such a way that they exist beside each other and that they can become unified ... by working with contrast and material such as chicken wire and sheep wool, symbolising contrasting emotions ... together in one work of art. ... Both are possible; at the same time, it was such an eye-opener for me ... as if things have come together. Before, I was such a mess; my feelings were rushing through each other. ... I got more of a grip on myself.' (Respondent 2, a 44-year-old female)

Core category 3: Emotion and impulse regulation

Regulation of emotion involves modifying the emotion after it is felt. Patients got in touch with or really experienced their emotions by means of works of art. They learned to allow these emotions and to let them go or turn them off as well. Patients who were able to do this during art therapy experienced more freedom and developed more grip on the intensity of their emotions. The next quote shows how a tendency for self-harm can be countered in the art work:

> 'It is also good to be able to draw feelings of self-destruction. Because then you are dealing with it, with the emotion itself, but not by putting the knife in your body .... That is the difference.' (Respondent 16, a 27-year-old female)

Patients basically learned to dose and regulate their emotions. The artwork and the art-making process offered an experiential space in which patients could experiment, act out, experience and portray. Before art therapy, their emotions were more uncontrolled or over-controlled, which resulted in feeling unsafe. The patients learned to cope with their emotions instead

of being overwhelmed and unable to reframe or intervene effectively, as can be seen in the quote accompanying image 3. Patients could organise feelings and thoughts during art therapy because the process of creating art demands structure of perception and thoughts. As a result of the improvement in their emotion-regulation skills, they felt more confident that they could guard their own sense of security.

Image 3: 'And I'm thinking, "oh well, I will see what comes", and I was splashing around with some ink, and the red was like blood for me, and everything was boiling inside, I just got really cross, I felt really anxious and I had to distance myself, it was so important to me, because I usually push away the anger inside of me ...; it became clear to me how angry I actually am, that is something I really had to face here. ... My husband said: "You will get through the rest, but this had to be brought up". For me, it was a real turning point. I also realised that by being in contact with the group about this, a lot of emotion could break loose. ... at that moment I realised that I do have control of it.' (Respondent 9, a 54-year-old female)

Core category 4: Behaviour change

Behaviour changes consist of two aspects: the behaviour of the patients towards themselves and their behaviour towards or in cooperation with others. A number of patients stated that they learned to change their behaviour patterns. Patients mentioned that creating requires the ability to be self-directed, because they have to make a number of choices about what to do and how to do it. The product and process trigger different emotional states and reactions. Therefore, experiments in art therapy can help patients practise alternative behaviour.

During the interviews, we found ample indications that the patients learned to find social support from others. Even though they often found teamwork exercises to be unpleasant and difficult, the patients often stated that these exercises ultimately resulted in important experiences. In the art therapy group, they learned to develop self-respect and to balance this

with reaching their goals and managing their relationships by looking for solutions together with others. During art exercises in which social behaviour was studied and challenged, patients learned to know the behaviour patterns that they used in contact with others.

> 'I still remember that one time we all had to draw on one piece of paper. I didn't like it at all. I wasn't going to use the whole paper so to say, you don't want to begrudge the others their space, but you notice that someone else is going over what you drew (uh...). I couldn't really deal with that so well. ... I have been giving myself more space ..., let others see more of who I am and if someone crosses my boundaries, then I let them know.' (Respondent 3, a 35-year-old female)

Core category 5: Insight and comprehension

Insight and comprehension is defined as the ability to understand oneself and others, which underlies overt behaviour by perceiving and interpreting behaviour. This leads to insight about oneself and others. The patients often talked about how they learned to put into words their non-verbal experiences in art therapy. They mentioned that they experienced an inner dialogue that guided their choices while working on the art product. This dialogue was also present after the art-making process, by distancing themselves from the artistic process and the artwork and by transcending thinking on the product/process by naming and giving meaning. They developed insight and comprehension by looking at their emotions, thoughts and behaviour through artistic means. They also developed a better level of understanding or insight into their own patterns on an intra-psychological level and in relation to others. Through this, they came to a more generalised self-insight and reflection by naming their own processes and drawing transcending and connecting conclusions about them. Self-reflection and self-insight were established in a judgement-free atmosphere, helped by the therapist and the group. The next two quotes show how art therapy stimulated insight and comprehension:

> 'I was not aware of how much of a perfectionist I was, and that it was limiting me so much. This is something I realised in art therapy.' (Respondent 21, a 23-year-old female)

> '... an art work confirms things and it helps to work towards things. To realise what you've got ... I have a really good foundation ... while I was making this artwork, that is when I really woke up.' (Respondent 28, a 56-year-old female)

Towards a model of the core categories of art therapy effects

On the basis of the above data, we constructed a model (Fig. 2) consisting of five core categories: one as a base and four categories on top of it that show a certain overlap. Core category 1, 'Perception', formed the base upon which intensely felt experiences can lead to

what the patients reported to be therapeutic effects. Improved perception of physiological reactions to external or internal stimuli was the first step towards experiencing the present moment, recognising emotions, naming and validating them, and taking steps to express them constructively or change them. Patients stated that they experienced perception as a basis for experiencing other effects.

The four other categories can be summarised as follows. Core category 2, 'personal integration', is important for patients with personality disorders because it concerns the effect of experiencing oneself as more of a whole person, more balanced and less divided, conflicted, unstable and/or dependent. Core category 3, 'emotion and impulse regulation', concerns the effect of handling one's own emotions/impulses and not being the victim of these emotions/impulses. Core category 4, 'behaviour change', concerns the effect of handling the way a patient deals with him/herself and/or others, by learning to accept or by developing different behaviour. Core category 5, 'insight and comprehension', concerns the effects of being able to better understand yourself and others, and of being able to make yourself understood by others, instead of isolating yourself and feeling misunderstood and alienated.

This theoretical framework contributes to the theoretical formation of art therapy in the treatment of patients with personality disorders. Categories 2 through 5 showed overlap; they did not appear to have a particular order and concerned more or less autonomous concepts. They also influenced each other: an effect on one concept influenced the development of another effect, as can be seen in the following quote, which mentions effects on perception, self-insight and personal integration.

> '... a lot of short-tempered rage was bothering me .... I have really learned to stand still, examine it and name it, and see what it does with you.... That is something I really did in art therapy ... examining my feelings, becoming conscious. ... and if I act effectively, I will not get this wrath anymore and the feelings can be integrated into my thoughts and my actions.' (Respondent 1, a 39-year-old female)

The importance of each category depended on the individual patient, on his or her personal therapeutic process and the focus of this process. A satisfactory result could be based upon the presence of one or more effects with their own degree(s) of intensity. In order to deliver the right conditions for the development of therapeutic effects, patients mentioned that the therapy should be well attuned to the patient's basic needs to be seen and heard, and should establish a good balance between feelings of controlled safety and freedom.

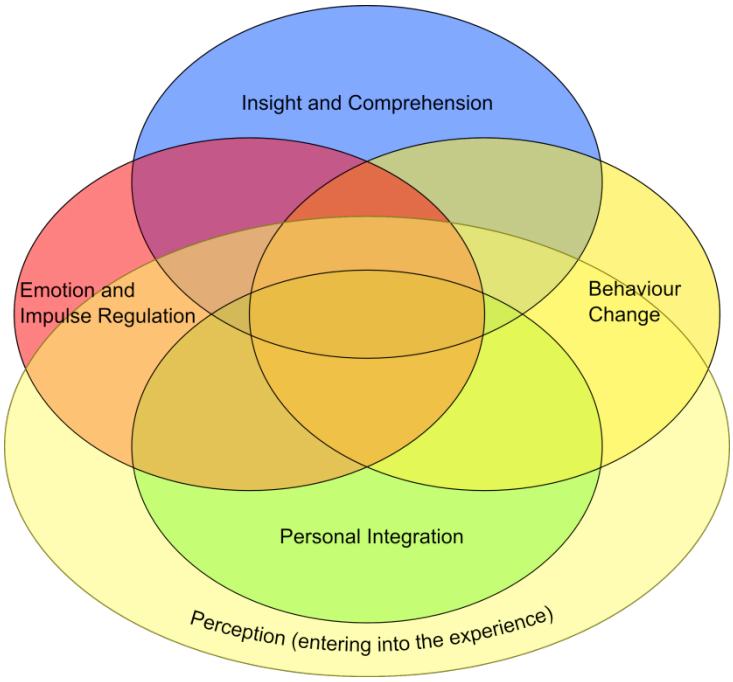

Figure 2. Model of core categories of art therapy effects.

The perceived core of art therapy in comparison to verbal therapy

According to many of the patients, art therapy was, mainly, a more direct way to access less-conscious, less-aware or non-framed emotions through a working method that was essentially based on experience. Art therapy confronted them with themselves and their own patterns of feelings, thoughts and actions within a fairly safe situation. Many patients even stated that for them, compared to verbal therapy, art therapy was the better, safer and better-paced way to explore their emotions in their therapeutic development. However, some patients find art therapy more difficult than verbal therapy because they fear emotions and loss of control, as was seen in the negative case. This case showed explicitly that, whenever the course of art therapy becomes difficult, the patient might experience resistance against feeling what is going on. Patients also indicated that, in art therapy more than in verbal therapy, one could really find out and practise how to act differently. The following quote shows how different emotional levels can be reached in art therapy:

> 'Yes, words are in a manner of speaking my survival position, that talking and that thinking ... usually it is because I want to stay away from something emotional that

> I don't want to feel or experience … in art therapy, you do come closer to yourself. Verbally, things need to be faster, … in art you have more time and possibility to work within your boundaries and to really think or feel … that is the difference; because of this, it becomes calmer and … you reach the emotional levels easier that you simply pass over in talking. It is all so fast … from your head more into your body.' (Respondent 3, a 35-year-old female)

Patients often mentioned that they experienced a different dynamic in art therapy compared to verbal therapy: art therapy was more gradual, less rapid and more concentrated on the self. More gradual because in verbal therapy interactions follow each other rapidly and thoughts about the communication itself can take up concentration. More concentration on the self and the possibility of more 'undisturbed' inner dialogue were also mentioned as characteristics of art therapy. Because of this, patients stated that they felt to have more overview and control. They were able to perceive less-conscious processes and to allow less-conscious feelings to become more conscious. Patients sometimes feared emotions and loss of control exactly because of this experiential emotion-focussed appeal. The positive effect of having improved contact with less-conscious feelings was a more stable self-image and 'an improved felt contact with the self and others', as was stated often.

The patients often associated talking in verbal therapy with being rational, with cognitions being in the foreground and also with avoiding emotions and sometimes with 'whining'. The patients sometimes found words to be too direct. The alternative therapeutic entry of art therapy felt like a less controlled and a more lived-through experience. Many of the patients stated that they found it characteristic as well as safe that, in art therapy, communication happens via the image, as a result of the work of art. Art therapy offers a situation that is aimed at experiencing and that also has a playful character, a combination of pleasant and serious, which was found to be characteristic of art therapy. According to the patients, images were revealing, direct and confrontational as well as concealing, protective and grounding. Many patients mentioned that characteristics of art therapy and verbal therapy complemented each other. Processes that started in one therapy could be continued in the other. The next quote shows how a therapeutic process that was avoided in verbal therapy came to development in art therapy:

Image 4: 'Art therapy has really helped me to work on things or to get things going. This project was actually a starting point of me facing a lot deeper problem that I had been avoiding in verbal therapy until then ... about the (um...) sexual abuse in my past. ... I made photos of symbols that stand for me and for a part of my life. ... I put them in cigar boxes, they each represent a certain moment in my life ... and I wrote a poem to go with each part.' (Respondent 18, a 27-year-old female)

DISCUSSION

In this study, we developed an integrated theoretical model of the effects of art therapy based on the personality disorder patients' experiences. This model consists of five core categories: (1) perception; (2) personal integration; (3) emotion and impulse regulation; (4) behaviour change; and (5) insight and comprehension. Improved perception (1) is the first step towards experiencing the present moment and seems to be the basis upon which other therapeutic effect categories lean: to experience oneself more as a whole person and be more balanced (2), to handle one's own emotions/impulses (3), to accept or develop different behaviour towards oneself and others (4) and to better understand oneself and others (5). Categories 2 through 5 appear to have no particular order and to influence each other. Core problems for many

patients with personality disorders – managing emotions, adequately processing information about experienced emotions, lower emotional awareness, having problems identifying their own and others' emotions (Levine, Marziali, & Hood, 1997; Linehan & Heard, 1992; Westen, 1991) – are all addressed in art therapy, as was stated by the personality disorder patients. According to them, the added value of art therapy in relation to verbal therapy is that they experience art therapy mainly as a more direct way to access more unconscious emotions because art materials and art making appeal to bodily sensations and emotional responses.

To a large degree, the patients' experiences were in line with the expert knowledge. Experienced art therapists describe the effects of art therapy as improving emotion- and impulse-regulation skills, stabilising and strengthening identity, learning to express emotions and dealing with limitations. The patients mentioned almost all the effects mentioned by experts. Experts and patients agree that the artwork facilitates personal integration by bringing together conflicting emotions, thoughts and/or behaviours into one coherent image. Both also emphasise the specific possibility in art therapy to fall back on the visual process that is visible in the single art product, in traces of actions and in the chronological line of the different artworks made over time. As a result, personal changes become visible in the artwork and self-reflection is challenged. Finally, experts and patients agree that art therapy improves emotion-regulation skills. Some patients in art therapy experienced a change from overly controlled to more spontaneous handling of emotions, while other patients experienced a change from impulsive to more felt control.

So experts and patients agree to a large extent. However, there are some nuances. Some differences between expert knowledge and patients' opinions were also brought forward by this study. Experts emphasise more than patients that it is important in art therapy treatment to come to verbal expression and they emphasise more the importance of trauma processing. This could be explained by the fact that most respondents had group therapy focussed on general psychological personality disorder problems and that these themes were not the focus point of the interviews. The most important difference seems to be that experts define the therapeutic entry of art therapy as indirect, as a playful 'as-if situation', and they emphasise that art therapy breaks down barriers because of this. Patients, however, noted that art therapy is not always 'a safe way to explore the perception of feelings and emotions'. Because of the indirect emotion-focussed therapeutic appeal of art therapy, this entry is sometimes even more threatening to patients than entry through verbal therapy. Art therapists in practice should be very aware of this aspect and not easily assume that art therapy is always accessible and playful. To counteract this fear of loss of control, it is important that art therapists focus on the specific needs of the client by arranging a safe balance between the offered structure, in order to provide direction, and the offered freedom, in order to meet the need for autonomy.

The added value of art therapy in personality disorder treatment as comes forward in our findings is that art therapy not only fits well the core problems of personality disorders and the goals to go with them, it also offers a specific experiential level with different aspects

that provides therapeutic access to these problem areas. The added value of the specific experiential level of art therapy comes forward in the findings of this study, because personality disorder patients explicitly experience art therapy as a more direct way than verbal therapy to access more unconscious emotions; this is because art therapy appeals to bodily sensations and emotional responses. Patients stated that art therapy confronted them with themselves and their own patterns of feelings, thoughts and behaviours, going further than a conscious, rational level and leading to more emotional awareness. Looking further into the different aspects concerning this experiential level of art therapy, patients state that in art therapy they practise alternative coping behaviour more directly and actively than in verbal therapy and that art therapy also has a different dynamic than verbal therapy: it is more gradual, with relatively more concentration on the self and more 'undisturbed' inner dialogue. This may result in a psychological overview and a feeling of control. Because of the experience-based approach, in which patients can come to development using their internal dialogue, tempo, expression and self-reflection, art therapy can be especially useful for people who tend to rationalise, avoiding emotional inputs, and for people who are weak on the personal integration level. However, although art therapy matches well the goals that go with the core problems of art therapy, it is essential that the art therapist should tune in soundly on the core problems of personality disorders with art therapy interventions in a way that offers a balance between emphasis on emotional expression, on experience and at the same time with an eye on the personal integration.

The art therapy effect of increasing emotional awareness by providing experiential situations may be an answer for the 'experiential avoidance' phenomenon described in literature about personality disorders (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996), which refers to a broad range of potentially problematic behaviours that are used to avoid aversion/unpleasant experiences. Experiential avoidance is a way of acting to avoid painful experiences that can cause different kinds of acting out or self-destructive behaviour. Decreasing experiential avoidance is an important aim in the treatment of personality disorders (Berking, Neacsiu, Comtois, & Linehan, 2009). This study shows that experiential avoidance could be linked with art therapy, because art therapy provides stimulating experiential situations that result in more felt emotional awareness. Improved awareness in art therapy stimulates 'affect tolerance' or experiential acceptance (i.e. differentiation of mixed valenced feelings and constructive emotion regulation). This may yield a more stable self-image and can improve contact with the self and others. In clinical practice, art therapists should focus in on this strong side of art therapy by developing art therapy interventions specifically directed on emotion-regulation skills and by developing specific art therapy emotion-regulation treatment modules with a strong link to experiential awareness and acceptance. Furthermore, this should also have implications for future research, by including experiential awareness and acceptance as an outcome measure in future studies on the effectiveness of art therapy.

Art therapy could also be effective for patients who struggle with integration on an intra-psychic level, who are sometimes considered to be therapy resistant. The concept of 'personal integration' has also been articulated in this study. Patients with personality disorders have difficulties with personal integration, and art therapy seems to have potency in making therapeutic progress with it. Patients with a personality disorder are often able to use language, metaphors and/or visual symbols in art and poetry, but they are unable to connect this expression to their experience. Being able to connect and integrate this expression to their affective, physical and relational experiences is necessary for developing a coherent self-image and continuity of experience (Gregory & Remen, 2008). This study shows that art therapy utilises the ability of patients with personality disorders to express themselves in images, symbols and metaphors and that art therapy helps them link this expression to affective experiences, thoughts and words. The art therapist is the guiding coach in this process, and he or she prevents that a patient is only at a symbolic or cognitive level, not making connection with the experiential, sensory level.

Several techniques were used to meet the criteria of 'trustworthiness' during the course of this research (see Methods section). There are limitations of this study despite these efforts to enhance quality. A limitation of this study is that we did not take into account the treatment phase of the interviewed patients. Interviewed patients had had at least 15 sessions of art therapy, in different phases of treatment and also post-treatment. It may be that patients beginning treatment experience different effects than patients who have finished art therapy treatment. Although peer review showed recognisability of the findings, another limitation could be that the group of respondents may be selective in terms of motivation/willingness, self-insight and treatment access. The respondents felt some need for treatment and were willing for specialised treatment. The group of personality disorder patients in practice is broader than that, often having self-destructive, impulsive behaviour or often having difficulties in the therapeutic alliance. Further exploration and development of the theoretical framework may require the inclusion of a wider range of personality disorder patients. Several techniques were applied to focus on reflexivity to counter subjectivity. Besides the review of peers and expert auditors, the interviewer also practised skills to keep the neutral role which is necessary for the interviews to ensure that respondents felt free to say what they wanted to say, being aware of the possible bias coming from her profession, i.e. art therapist (S.H.). Intervision also helped to prevent possible bias.

A strength of this study is its systematic way of examining the effects of art therapy according to a representative number of patients in a naturalistic setting, which led to a transferable and practice-based overview of art therapy effects. In addition, it included a 'negative case' which is a respondent who would not approve the previous findings (Corbin & Strauss, 2008). Because this negative case could be explained, the general interpretation was strengthened. The concepts that we found are integrated into a theory with interrelated

categories. Because of the rich information and the point of saturation that we reached, we assume that these findings are applicable, usable and transferable.

This study gives also rise to examination of whether it is possible to quantify the effects of art therapy. The effects found may form the basis for developing a tool to make these effects measurable during art therapy. Future research could include monitoring art therapy processes or randomised controlled trials with pre- and post-measurements. In addition, future studies could investigate if and how the effects that we found show up in the formal aspects in the visual art work during art therapy. For example, can we see personal integration be developed and on what level, in the formal aspects of art work, in the images and/or in symbols? Formal aspects and changes in the art work could be connected to the levels as mentioned by Hinz (2009) in the Expressive Therapies Continuum. Specific art therapy modules with interventions or methods that specifically fit the effects that we found could also be tested in further research on the effectiveness of art therapy with outcome measures as experiential awareness and acceptance. In this way, art therapy can be developed to a higher quality standard.

Our final conclusion is that this study provides a systematic overview of art therapy effects in the treatment of personality disorders. The framework that we developed contributes to the theoretical substantiation of art therapy. The main finding of this study about the added value of art therapy seems to be the direct way to emotions, and the possible potency of art therapy on active improvement of emotion regulation, experiential acceptance and integration on an intra-psychic level. Through this direct, active experience and its outcomes in the form of art products, different goals that are directly addressed by specific art therapy methods can be achieved: more emotional awareness; constructive emotion regulation; a more stable self-image; contact with the self and others; psychological overview and a feeling of control; integration of emotions/feelings; and possible insight (into self and others) and comprehension. Practitioners should realise the strength of the fact that art therapy is an experiential therapeutic entry that offers opportunities to gain more emotional awareness and that has a complementary quality next to the relatively more cognitive quality of verbal therapy. A strong recommendation for clinical practice is that practitioners should be aware of and make full use of the experiential aspect of art therapy and make a fruitful therapeutic combination with verbal therapy in personality disorder treatment.

CHAPTER 3.

Measuring the contribution of Art Therapy in multidisciplinary treatment of Personality Disorders

The construction of the Self-expression and Emotion Regulation in Art Therapy Scale (SERATS)

Haeyen, S., Van Hooren, S., Van der Veld, W.M., & Hutschemaekers, G. (2017a). Measuring the contribution of Art Therapy in multidisciplinary treatment of Personality Disorders. The construction of the Self-expression and Emotion Regulation in Art Therapy Scale (SERATS). *Personality and Mental Health*. doi:10.1002/pmh.1379

ABSTRACT

Despite the use of art therapy in clinical practice, its appreciation and reported beneficial results, no instruments are available to measure specific effects of art therapy among patients with Personality Disorders cluster B/C in multidisciplinary treatment. In the present study, we described the development and psychometric evaluation of the Self-expression and Emotion Regulation in Art Therapy Scale (SERATS). Structural validity (exploratory and confirmatory factor analysis), reliability, construct validity and sensitivity to change were examined using two independent databases (n = 335, n = 34) of patients diagnosed with Personality Disorders cluster B/C. This resulted in a nine-item effect scale with a single factor with a high internal reliability and high test–retest reliability, it demonstrated discriminant validity and sensitivity to change. In conclusion, the SERATS is brief and content valid and offers objective and reliable information on self-expression and emotion regulation in art therapy among patients with Personality Disorders cluster B/C. Although more research on construct validity is needed, the SERATS is a promising tool to be applied as an effect scale and as a monitoring tool during art-therapy treatment.

INTRODUCTION

Patients diagnosed with personality disorders have significant impairments in self (identity of self-direction) and interpersonal (empathy or intimacy) functioning, and have one or more pathological personality trait domains (i.e. negative affect, detachment, antagonism, disinhibition, and psychoticism (APA, 2014; Linehan, 1993). Personality pathology is characterized by a pervasive pattern of emotional instability, impulsivity and disturbed relationships (APA, 2014; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). These patients are among the most challenging patients to treat and are often referred to specialized inpatient settings that often concern intensive multidisciplinary treatment programs (Verheul & Herbrink, 2007). Art therapy often contributes in such programs because art therapy provokes experiences and feelings (mental states) by the targeted therapeutic use of various art materials (e.g., clay, drawing and painting material, wood), techniques and forms of work (individual and in collaboration) in which material-interaction and personal expression are central (van den Broek, Keulen–de Vos, & Bernstein, 2011; Haeyen, 2015; Johns & Karterud, 2004). Patients appreciate art therapy and experience beneficial results (Eren, Öğünç, Keser, Bıkmaz, Şahin, & Saydam, 2014; Haeyen, van Hooren, & Hutschemaekers, 2015; Karterud & Urnes, 2004). Group (art) therapy may address important avoidant interpersonal strategies of personality disorders or that the ability to tolerate, mentalize and manage social interactions can be improved by dealing with interpersonal challenges and encounters within the group in the long run (Kvarstein, Nordviste, Dragland, & Wilberg, 2017; Springham, Findlay, Woods, & Harris, 2012).

Despite its use in clinical practice, its appreciation by clients and reported positive outcomes, very little empirical studies substantiate this intervention. The studies on effects of art therapy are poor at best (ZiN [Zorginstituut Nederland], 2015). Several reasons could be brought forward to enable understanding of this lack of evidence: art therapy hardly has a research tradition and is offered mostly in combination with other forms of therapy, making it complex to isolate its effects (Reynolds, Nabors, & Quinlan, 2000). Moreover, empirical studies examining the effects of art therapy or treatments that include art therapy use instruments focusing on symptoms, personality or coping skills that do not yield much information on its specific effects. To our knowledge, no instruments are available to isolate and measure the effects of art therapy in multidisciplinary treatment programs. The few available diagnostic scales in art therapy, such as the Diagnostic Drawing Series (Fowler & Ardon, 2002) or the Art-Based Intervention self-report questionnaire on the art-making experience (Snir & Regev, 2013), are assessment tools and not specifically suited to measure the effects of art therapy treatment. In general, there is need for further evaluating treatment approaches for patients with personality disorders (Chakhssi, Janssen, Pol, van Dreumel, & Westerhof, 2015). To do so for art therapy, what it is needed are specific scales for monitoring and measuring the contribution of art therapy in multidisciplinary programs (Slayton, D' Archer, & Kaplan, 2010;

Snir & Regev, 2013). Such scales will stimulate the quality of art therapy and stimulate insight in the contribution to the treatment process as such.

Our aim is to develop an instrument to measure perceived effects of art therapy among personality disorder patients with emotional and self-regulation problems. The instrument should be short so as not to become a burden for the patient. A short easy-to-use instrument to be completed repeatedly is not expected to be of great interference on the often unstable therapeutic relationships with personality disorder patients. The instrument should have adequate psychometric qualities, i.e., internal reliability, clear construct validity; further, it should be able to measure changes over time. In this article, we describe the development of the Self-expression and Emotion Regulation in Art Therapy Scale (SERATS).

STUDY 1: SCALE DEVELOPMENT AND CONFIRMATION

In this first study, our aim was to construct an instrument measuring specific effects of art therapy on patients with a personality disorder cluster B/C. We focussed on patients with personality disorders cluster B and/or C, because these personality disorder clusters are the most prevalent (APA, 2014) and common group-based treatment programs for personality disorders often recruit poorly functioning patients covering a range of personality pathology (Kvarstein, Nordviste, Dragland, & Wilberg, 2017). A large part of the art therapists work with this target group and despite the consensus on this, there is little evidence about the added value. Based on the result of a previous study on the perceived effects of art therapy (Haeyen, van Hooren, & Hutschemaekers, 2015) we constructed an item pool, with as goal to develop an instrument with an adequate internal structure and a small number of items. Internal structural validity was analysed by exploring the factor structure as described in the consensus-based standards for the selection of health-measurement instruments (Mokkink, et al., 2010). In a second analysis, we tried to confirm this structure.

METHOD

Participants and procedure

A total of 335 adult patients with at least one diagnosis of a personality disorder cluster B/C from five different mental health centres in the Netherlands participated in this study. All patients were from specialized personality disorder services. Main diagnoses were Borderline personality disorder (16.9%), Unspecified personality disorder (41.4%) and Avoidant personality disorder (16.5%). Less frequent diagnoses were Dependent personality disorder (4%), Obsessive–compulsive personality disorder (3.2%) and Narcissistic personality disorder (0.7%). The age of the participants varied from 18 to 61 years with a mean of 34.5 years (SD =

9.8 years); 251 participants were female (75%), 84 were male (25%). All participants received art therapy as part of a multidisciplinary treatment program of personality disorders. Besides art therapy, this program consisted of cognitive based therapy, individual as well as in a group, sometimes psychomotor therapy, music therapy and/or rehabilitation counselling. All patients who agreed to participate signed an Informed Consent form, and they were asked to fill in the questionnaire.

Materials

In a previous study, the authors explored the perceived effects of art therapy in the treatment of personality disorders, cluster B/C (Haeyen, van Hooren, & Hutschemaekers, 2015). In this qualitative study we applied the method of grounded theory, e.g. by applying unstructured interviews and focus groups, to assess what personality disorder patients experienced as a result of art therapy. Based on this study a conceptual framework on art therapy effects among patients with personality disorders was constructed. This conceptual framework incorporated improved sensory perception, personal integration, improved emotion regulation, behaviour change and insight/comprehension. Based on this framework content-valid statements were formulated, resulting in an initial pool of 26 items.

An evaluation of this set was performed in two feedback panels with the aim to assure content validity and usability. The first panel consisted of seven experts working with the patients with personality disorders (i.e., four art therapists and three psychologists). This panel was asked to evaluate the possible ambiguities in the items, as well as the readability, comprehensiveness and relevance for art therapy evaluation. As a result, we decided to re-word five items, by changing statements from negative to positive and removing multi-interpretable wording. The revised set of items was presented to the second panel that consisted of nine persons (i.e., two research professionals, one professional test designer and six patients, four female, two male, aged 22–55 years, from the intended target group). This panel was asked to evaluate the items with the focus on usability in clinical practice, readability and clarity of formulation. This resulted in small grammatical changes to three items, making them more clear and unambiguous. Both panels shared the opinion that the items sufficiently represented the perceived effect of art therapy. Based on the advices of the feedback panels, we had a pool of 26 items with a five-point Likert scale defined as "1. Never true," to "5. (Almost) always true" with positive and negative formulated items.

Analysis

We performed factor analysis out of the pool of 26 items. The analysis consisted of two steps: exploratory and confirmatory factor analyses. Because carrying out exploratory factor analyses (EFA) and confirmatory factor analysis (CFA) on the same data is not appropriate, we randomly split the sample (n = 335) in two sets of approximately 50% of the cases. Random selection was done without replacement; hence, there was no overlap in the two sets.

In step 1, we performed EFA to find out how many factors were present in the data and to limit the amount of items. The model was estimated with SPSS 22 (IBM Corp., 2013) with as method VARIMAX rotation. We performed three analyses. First, we tested for the number of factors by inspection of the scree plot; second, we forced that number of factors on the data. Items with factor loadings below .7 were deleted to develop a short instrument with a small number of items and an adequate internal structure. Third, we analysed the subset of items again, to find out whether all factor loadings were above .7 and whether we could maintain the original factor structure.

In step 2, we performed a CFA using LISREL 9.2 (Jöreskog & Sörbom, 2010) in order to test the conclusions from the EFA. The model parameters were estimated with the full information maximum likelihood method (FIML) in LISREL. The factor models were evaluated with the chi-square test (CHI2) and the root mean square error of approximation (RMSEA). A model with a p-value, for the CHI2, higher than .05 was considered to be a suitable model. In addition, a model with RMSEA less than .08 is generally regarded as an acceptable model (Hu & Bentler, 1999; MacCallum, Browne, & Sugawara, 1996). If a model did not fit, we searched for the model modification that improved the fit most, using the modification index. We modified the factor model, until an acceptable – in terms of fit – model was found. When an item had a factor loading less than .7, the item was removed and the CFA was started from scratch.

RESULTS

Exploratory factor analysis

The sample of 335 patients was automatically at random divided into two sets. In dataset 1 (n = 159), the first EFA (done on 26 items) resulted in a scree plot that showed a breaking point at the second component. The eigenvalue (EV) of the first component was 11.9, while the five subsequent components had an EV of respectively 1.5, 1.2, 1.0, 1.0 and 0.9. This indicated one underlying component, which accounted for 45.93% of the variance. Selection of items with a loading higher than .7 resulted in 10 items. We performed a second EFA on these items. Again, the scree plot indicated one underlying component. This component explained 64.6% of the variance. The lowest loading was .72 and the highest loading was .86.

Confirmatory factor analysis

For the CFA, we used the other random half of patients (n = 176). We estimated a single factor model with the 10 items, assuming a simple structure (no correlated errors). We rejected this model on the basis of the fit measures, CHI2 (df = 35) = 102.25, p = .000, RMSEA = .105. Next we ran three models and added the following correlated errors (one-by-one): between item 9 and item 10, between item 2 and item 8, and between item 2 and item 4. Despite its poor fit, CHI2 (df = 32) = 57.27, p = .004, RMSEA = .067. We accepted the third model, because the

poor fit was probably due to the high power to detect misspecifications. Saris, Satorra, & van der Veld (2009) showed that the power to detect misspecifications in factor models with high factor loadings (i.e., >.8) was high with a larger chance to be rejected. The factor loadings in the estimated model ranged from .58 to .84. We removed item 10 because the factor loading of this item was lower than .7 (.58). Next, the analysis was repeated. That fit of the third model was acceptable (Saris, Satorra, & van der Veld, 2009): CHI2 (df = 24) = 24.75, p = .022, RMSEA = . 062. The item names, item formulations and the estimated standardized factor loadings are shown in Table 1. The factor loadings ranged from .71 to .90. The correlated errors were all small, the largest being .12.

It followed from the EFA and CFA that the scale had 9 items with one underlying factor; see Table 1 for item formulations and loadings for this factor.

Table 1. Results of the final[a] CFA on nine items of the Self-expression and Emotion Regulation in Art Therapy Scale[b]

Item	Item formulation [b]	Loading
01	I get in touch with my feelings through the process of making art	.83
02	I am able to depict my feelings in art therapy	.84
03	Through the process of making art, I am able to discover what is at play within me	.79
04	I am able to express my feelings through the process of making art	.90
05	I am able to make things fall into place in the art	.79
06	Making art is a kind of outlet for me	.72
07	A piece of art I have created can help me hold on to a particular feeling	.73
08	I apply the new behaviour that I have been experimenting with in art therapy outside of the therapy setting	.71
09	I gain greater insight into my psyche through art therapy	.86

[a] This model had three correlated errors: between item 2 and item 8, between item 4 and item 9, and between item 6 and item 9.
[b] The instrument translation process included back-translation (Maneesriwongul & Dixon, 2004).

DISCUSSION

Based on the EFA and the CFA, we have constructed a brief nine-item scale with one underlying dimension. The content of the final items is focussed on experiencing, becoming aware and expressing feelings, regulating emotions/feelings (letting out, making fall into place or holding on to) by applying new behaviour and gaining insight, all in relation to the art therapy experience. These items are linked to important difficulties of personality disorders e.g. identity of self-

direction, emotional instability, impulsivity and pathological personality trait domains such as negative affect, detachment, or disinhibition, (APA, 2014; Linehan, 1993; Lieb et al., 2004). Because the main focus of the scale is self-expression and emotion regulation we named the scale the SERATS.

STUDY 2: SCALE RELIABILITY AND VALIDITY

In study 2, we assessed the internal consistency, the test–retest reliability and the construct validity of the nine-item SERATS. In the exploration of construct validity, we focussed on a general questionnaire of mental health complaints (Outcome Questionnaire 45 [OQ45]) and a specific outcome questionnaire on acceptance and experiential avoidance (Acceptance and Action Questionnaire-II [AAQ-II]). Art therapists consider both outcome measures as relevant. However, if the SERATS has adequate construct validity, its scores should not be identical to the outcomes of the OQ45 and the AAQ-II. The choice for the OQ45 was based on the fact that it is one of the ten instruments most frequently used by practitioners in the USA to measure clinical outcomes (Hatfield & Ogles, 2004) and is often used in clinical outcome research for a broad target group for measuring general symptoms and distress (de Jong, Nugter, Polak, Wagenborg, Spinhoven, & Heiser, 2007). The AAQ-II seemed an interesting measure because of its possible link between the unique experiential situation in art therapy and the concept of experiential acceptance (vs. avoidance). Experiential avoidance is considered to play a central role in the course and development of psychopathology, including personality disorders (Chakhssi et al., 2015; Jacob, Ower, & Buchholz, 2013).

METHOD

Participants and procedure

We used the original sample from study 1 (n = 335), and constructed two subsamples (selection on base of sequence of entry). The first subsample consisted of 75 patients who were invited to complete the same questionnaire twice within a short period of 1 to 3 weeks to examine the test–retest reliability. The age of these participants varied from 19 to 61 years with a mean of 36.03 years (SD = 11.4 years); 62 participants were female (83%), 13 were male (17%). The second subsample consisted of 64 participants. This subsample of patients completed not only the SERATS, but also the OQ45 and the AAQ-II (construct validity). The age of these participants varied from 19 to 55 years with a mean of 32.9 years (SD = 8.69 years); 45 participants were female (70%), 19 were male (30%). These data were collected during a 4-month period.

Instruments

The AAQ-II (Jacobs, Kleen, de Groot, & A-Tjak, 2008) is a self-report questionnaire used to measure acceptation and experiential avoidance. Experiential avoidance is avoiding unpleasant inner experiences, such as thoughts, feelings and physical sensations. Psychological flexibility is the current and overarching term to describe this model, defined as the ability to contact the present moment and the thoughts and feelings it contains without needless defense, and, depending upon what the situation affords, persisting or changing in behaviour in the pursuit of goals and values (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). The AAQ-II consists of 10 items (e.g., "I'm afraid of my feelings" or "I am in control of my life") with a Likert-scale from 1 (never true) to 7 (always true), with higher scores indicating greater levels of psychological flexibility. The internal consistency is good (Bond, et al., 2011; Fledderus, Oude Voshaar, ten Klooster, & Bohlmeijer, 2012; Jacobs, Kleen, de Groot, & A-Tjak, 2008).

The OQ45 (de Jong et al., 2007; Lambert et al., 1996;) was used to measure general mental health functioning with a total score (0-180) and four sub domain scores: "symptom distress", "interpersonal relations", "social role" and "anxiety and somatic distress" . The OQ45 consists of 45 items (e.g., "I get along well with others" or "I blame myself for things") scored on a five-point scale. A high score suggests a high degree of symptoms. Reliability and validity estimates is good (de Jong et al., 2007).

Analysis

The nine-item SERATS was evaluated on the internal consistency (i.e., Cronbach's alpha and the test–retest reliability using Pearson's r correlation coefficient). Next, the sum scores of the SERATS were correlated to the total scores on the AAQ-II and the OQ45. These analyses were performed with SPSS 22.

RESULTS

Reliability analysis

We evaluated both the internal consistency (with Cronbach's alpha) and the test–retest reliability. For the estimation of the internal consistency, we used the total sample (n = 335). Cronbach's alpha of the nine items was .94. This could not be improved by removal of one of the items. The test-retest correlation (n = 75) was r = .96.

Construct validity

The correlations between the SERATS on the one hand and the AAQ-II and the OQ45 total score on the other were small (n = 64) (see Table 2).

Table 2. Pearson correlations between the SERATS, the AAQ-II and the OQ45

	AAQ-II	OQ45				
		Symptom distress	Interpersonal relations	Social role	Anxiety and somatic distress	Total
SERATS	.136	-.212	-.015	-.398	-.147	-.224
Sig. (2-tailed)	.28	.09	.90	.00	.25	.08

AAQ-II = Acceptance and Action Questionnaire-II; OQ45 = Outcome Questionnaire 45; SERATS = Self-expression and Emotion Regulation in Art Therapy Scale.

The overall small correlations indicated that the SERATS measured something else than the OQ-45 as well as the AAQ-II. The only significant correlation concerned a negative correlation between the SERATS and the OQ45 "social role" subscale (r = -.398, p < .00). Higher scores on the SERATS correlated with lower scores on social role, meaning less difficulty in social roles.

DISCUSSION

The SERATS had a high internal consistency and high test–retest reliability and demonstrated adequate construct validity in relation to the AAQ-II and the OQ45, meaning it demonstrated discriminant validity with the AAQ-II and the OQ45 total score. This indicated that the SERATS has added value; it seems to measure a concept with only some similarity. The SERATS does not measure exactly the same as general mental health functioning nor "acceptance and experiential avoidance." A possible explanation for this is that the OQ45 focus on general mental distress that the AAQ-II items focus mainly on cognitive processes (negative thoughts, worries, remembrances, felt control in life and reactions to feelings), whereas experiential activity in art therapy is much less cognitive; it is often less conscious and focussed on acceptance of feelings as well as here-and-now awareness (van den Broek, Keulen– de Vos, & Bernstein, 2011; Haeyen, van Hooren, & Hutschemaekers, 2015; Horn et al. 2015). The comparison between a specific measure (linked to the intervention of art therapy) and a more general measure can be complicated.

The only significant correlation found between the SERATS and the OQ45 "social role" subscale. Less difficulty in social roles correlated to a higher score on the SERATS . This could mean that improved self-expression and emotion regulation are related to fewer conflicts, a more balanced regulation of stress in social roles.

The main finding here is that the SERATS measured something unique. More research is needed to examine the exact spectrum of the SERATS and its specific aspects of mental health.

STUDY 3: SENSITIVITY TO CHANGE

The objective of study 3 was to evaluate whether the SERATS is sensitive to monitor individual changes over time in individuals who participated in art therapy.

METHOD

The design of the study was a pretest–posttest design without control group. In between the pretest and posttest, participants received art therapy, lasting for 13 weeks. The art therapy intervention program consisted of a weekly session of art therapy of 1–1.5 hours, described in an art therapy manual: "Don't act out, live through" (Haeyen, 2007). This art therapy program was based on dialectical behaviour therapy (Linehan, 1996) and schema focussed therapy (Young, 1994). To test the hypothesis that scores on the SERATS changed over time, a paired samples t-test was performed in SPSS 22.

Participants and procedure

Thirty-four patients diagnosed with (at least one) personality disorder from the B/C cluster agreed to participate in this study (informed consent). Recruitment took place in an expert centre for treatment of personality disorders. All patients whose treatment would last at least another 3 months were asked to participate. These patients were either involved in day-clinic treatment or outpatient treatment, which involved art therapy. Six patients dropped out during this study, only two of them with reasons related to the questionnaire itself: not willing to fill in or did not return the questionnaires. The age of the participants (n = 28) varied from 20 to 60 years with a mean of 37.1 years (SD = 12.68 years).

RESULTS

The difference between the pretest (M = 3.42, SD = .59) and the posttest (M = 3.72, SD =. 51), was t (27) = 3.13, p < . 004. The effect size (d = .60) was large (Field, 2009).

DISCUSSION

The SERATS was sensitive to change. Patients in art therapy reported at the start of their treatment poorer scores than after 12 weeks. Moreover, the results showed a large effect size, suggesting that the change is reliable. The sensitivity to change indicated that this scale can monitor art therapy over time. Based on this finding as well as on this first experiences

in practice, the timing of when to ask patients to complete the SERATS would be at the start of art therapy (session 1 – 3) and then with terms of 12 weeks each until finishing art therapy treatment. The full clinical relevance has yet to be evaluated because patients in this sample had been exposed to art therapy previously and art therapy was part of a larger treatment program which both may have influenced the results. Nevertheless, this analysis examined the sensitivity to change of the SERATS and not the effect of art therapy. Further research will be needed to fully explore the clinical utility of this scale.

GENERAL DISCUSSION

In a series of analyses, we have developed and tested the psychometric properties of the SERATS. The focus of the scale is on self-expression and emotion regulation. The SERATS appears to be a brief, content-valid, unidimensional nine-item scale with high internal consistency and high test–retest reliability. The SERATS could be completed at the start of art therapy (session 1 – 3) and then with terms of 12 weeks each until finishing art therapy treatment. The SERATS demonstrates adequate construct validity and is sensitive to change. All the statistics are promising: the SERATS could be potentially a powerful instrument in measuring and monitoring perceived effect of art therapy during treatment.

The items of the SERATS are explicitly related to art therapy in order to isolate perceived effect of art therapy with this questionnaire. The focus of the scale on self-expression and emotion regulation is relevant for personality disorder patients as these are main difficulties for these patients who have significant impairments in self and interpersonal functioning, and have one or more pathological personality trait domains (APA, 2014; Linehan, 1993). Self-expression concerns the authentic expression of one's own personality and feelings, in painting, poetry or other creative activity (Kraus, Chen, & Keltner, 2011). Art therapy for personality disorder patients is focussed on discovering, improvising, and intuitively acting during the art process, envisaging the own artwork as self-product and active reflection on the art process and product (Haeyen, van Hooren, Dehue, & Hutschemaekers, *manuscript submitted for publication*; Lusebrink, 2010). The analogy between the art process and product with functioning in daily life can be examined (Pénzes, van Hooren, Dokter, Smeijsters, Hutschemaekers, 2014) and a mindful self-dialogue can be stimulated by self-expression in art (Rubin, 2001; Schweizer et al., 2009). Emotion regulation implies the recognition and acceptance of emotions, problem solving and reappraisal, which appear to be protective against psychopathology (opposite of dysregulation: suppression, avoidance and rumination) (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Gross, 1998; Koole & Rothermund, 2011). The regulation of emotion in art therapy is partly intentional and explicit because cognitive control and reflection can take place during and after the art-making process. At the same time, the process is also implicit and less conscious because unintended personal themes are being

triggered in the process of art making. Material interactions can bring up emotional responses on often less-conscious levels. Contradictive feelings and ineffective modes can become visible in the artwork, after which the artwork is replaced or edited according to preferred feelings and effective modes, giving meaning through objects in the form of pieces of artwork and explicitly reflecting on it (e.g. van den Broek, Keulen–de Vos, & Bernstein, 2011; Haeyen, van Hooren, & Hutschemaekers, 2015; Verfaille, 2016). These strategies stimulate reappraisal, acceptance and integration of these feelings, corrective experiences, increased insight and decision-making (e.g. Huckvale & Learmonth, 2009; Van Vreeswijk, van Broersen, Bloo, Haeyen, 2012; Springham, Findlay, Woods, & Harris, 2012). The added value of art therapy in multidisciplinary treatment programs may be especially this *implicit* self-expression and emotion regulation process.

This study has several limitations. First, the exploration of the construct validity of the SERATS is rather weak because we compared our results only with the OQ45 and the AAQ-II. We presume that the SERATS measures something else and that changes over time on the SERATS are an indication of the progress the patient has made in art therapy. Both assumptions need more research. Second, the SERATS does not offer a zero measurement: the patient is questioned about his or her experiences in art therapy and has to experience this at least during one or two sessions. Also, the SERATS cannot be used among patients not receiving art therapy, because the items refer to art therapy. The strength of this study is that we developed and tested our scale in and with the effort of the target group of patients with a personality disorder in specialized mental health care practice. Experienced effects of art therapy as reported by patients are present and recognizable in the content of our scale, and this makes it usable and promising in art therapy research and practice.

Concerning the content of our instrument, some questions need further exploration. Future research should examine whether the SERATS indeed measures self-expression and emotion regulation in art therapy, as main difficulties for personality disorder patients (Linehan, 1993). We have to determine whether changes during therapy imply real and wanted treatment effects, distinguishable from satisfaction or the experienced quality of the therapeutic relation. It is also possible that the scale is measuring attitudes or experiences regarding art making. To initially explore these first questions about what the SERATS is measuring we performed some additional analyses. We examined correlations between the SERATS and specific items of the former item pool with content related to experienced benefits of art therapy (overall benefit and daily, emotional, and social functioning), relationship with the therapist and the familiarity with the art media. The SERATS correlated most with overall benefit of art therapy and improvement of emotional functioning. There was no correlation between the SERATS and the items about the relationship with the therapist and the familiarity with the art media. The nine items of the SERATS seem to be focussed on getting in touch with feelings, to learn to express these feelings, to gain insight and understanding and, developing and practicing new behaviour. In the SERATS the patient scores the level to which he succeeds to express, understand and regulate emotions and behaviour through art therapy. The question remains

if the SERATS functions as an effect measure or as an evaluation of art therapy. We need to examine whether the SERATS indicates changes unique to art therapy. Finally, more research is needed to set up standards indicating whether individual scores should be considered high or low and whether those scores have clinical relevance, helping therapist and client to monitor the course of therapy. If all the mentioned questions will get positive and empirically straightforward answers, we may conclude that the SERATS is relevant to be used to evaluate progress in art therapy in multidisciplinary treatment programs and identify aspects in therapy that need amelioration and to improve the quality of the treatment program as a whole.

The implications and considerations for practitioners in personality disorder services for the use of the SERATS can be found on different levels. For the art therapist it can be a tool for reflection on his/her therapeutic efficacy and discussing the outcomes and the progress with the patient. The use of feedback in treatment can empower patients because of an increased sense of ownership of their own change process and it may result in faster progress, or may be especially effective for `not on track' patients (de Jong et al., 2007). Discussing the results with the patient may stimulate the therapeutic relationship and have a positive impact on the insight of his or her own problems. This might be of importance for personality disorder patients who often lack a sense of ownership due to self, emotion and behaviour regulation problems. For personality disorder patients discussing results with their therapist may stimulate self-insight and `reframing' their very often-negative self-image (Finn & Tonsager, 1997). Therapist alliance, engagement and confidence within the group setting are basic elements in a group therapy process. Monitoring therapy experience is a central issue in personality disorder treatment (Kvarstein, Nordviste, Dragland, & Wilberg, 2017). Poor treatment adherence is an often described central challenge of Borderline personality disorder (Barnicot, Katsakou, Marougka, & Priebe, 2011).

Using the SERATS promotes the participation of the patient and can lead to adjustment and acceleration of the therapy (Lambert, Whipple, Hawkins, Vermeersch, Nielsen, & Smart, 2003; Sapyta, Riemer, & Bickman, 2005). Some of the patients and art therapists involved in these studies shared their first experiences with the use of the SERATS through a survey. They mentioned that the SERATS meets the standards of clarity and readability, is specific for personality disorders and art therapy and, is usability in practice. The preferred frequency of using this instrument was three months; both groups of users stated that more frequent use would interfere with the therapy and less frequent seemed less useful. The art therapists mentioned that the SERATS was helpful in the evaluation of their patients. Discussing the results with patients was most helpful with patients who did not speak out easily or with who the therapeutic relationship was difficult. Art therapists mentioned that it stimulated awareness and reflection in the personality disorder patients which matched well the treatment goals of the personality disorder patients. A possible limiting factor therapists mentioned was the involved time investment. We stress the need for future research on the SERATS. When art therapists want to use the SERATS in personality disorder treatment we recommend to discuss

the result with the individual patient to stimulate the therapeutic relationship and to stimulate personality disorder patients in healthy interpersonal functioning and cooperation in decision making concerning their own treatment process.

In short, we developed the SERATS as a specific art-therapy instrument measuring self-expression and emotion regulation in patients with personality disorders cluster B/C. Measuring outcomes of art therapy is important for several reasons and the SERATS offers objective, reliable and valid information, although more research is needed. As an external assessment on art therapy it offers an therapeutic value in practice when making use of the feedback in the therapeutic relationship, it makes it possible to monitor art therapy and contribute to quality improvement of art therapy. Doing so, the SERATS contributes to the improvement of mental health care aimed at a healthy emotional functioning for patients with severe self-expression and emotion regulation problems.

CHAPTER 4.

Development of an Art Therapy Intervention for Patients with Personality Disorders: an Intervention Mapping Study

An Intervention Mapping Study

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ABSTRACT

Art therapy for people diagnosed with personality disorders cluster B/C seems valuable to explore dysfunctional patterns in managing emotions. Current art therapy interventions are based on practical beliefs or commonsense approaches, without a sound basis in research results. To increase the effectiveness of art therapy for this target group, a planned, systematic and theory-based approach is needed. The principles of Intervention Mapping were applied to guide the development, implementation, and planned evaluation of the art therapy intervention. Empirical findings, theoretical models, and clinical practice experience were combined to construct a programme tailored to the needs of the target group. A structured 10-session art therapy intervention programme for patients was developed, aimed at: experiencing a (more) stable and positive sense of self, being able to express and regulate emotions, understanding emotions, thoughts and behaviours, using improved social and problem solving skills. Implementation took place and evaluation of the intervention is being carried out. The systematically developed art therapy intervention seems to be promising for personality disorder patients in learning to deal with their problems. The results of the evaluation study may contribute to the knowledge about the use of art therapy for personality disorder problems.

INTRODUCTION

Patients diagnosed with personality disorders cluster B/C usually receive a cognitive-oriented psychotherapy or verbal therapy as a first choice. In addition to verbal therapies, multidisciplinary treatment for personality disorder patients often consists of art therapy. Art therapy focusses on individual treatment goals with the aim of development, stabilisation, or acceptance on emotional, cognitive, social, or physical level in the patient (Schweizer et al., 2009). The experiential process of art making (drawing, painting, sculpture and other forms) and the art products of personal expression arising from this are used by the art therapist within the therapeutic relationship. Art therapy is seen as a playful situation in which freedom, individuality, and self-direction can be experienced as well as sensory perception, expression of emotions and a way of structuring meaning. Art therapists consider the art processes as a way to understand one's own life narrative and meaning (Schweizer et al., 2009).

Patients diagnosed with personality disorders cluster B/C mention that art therapy is valuable because of its perceived effects of art therapy, i.e. improved sensory perception, personal integration, improved emotion regulation, behaviour change, and insight/comprehension (Haeyen, Van Hooren, & Hutschemaekers, 2015). It seems a suitable intervention because a personality disorder consists strongly of dysregulation of emotions and instability of the self, and art therapy could be helpful for insight, positive development, stabilization, or acceptance of these aspects. Social functioning is often a problem area for personality disorder patients, and art therapy can focus on interpersonal goals during social interactions in the present moment, with possible links to previous experiences in life. Art therapy makes patterns in feelings, behaviour, and thought visible and tangible, and it appeals directly to mindfulness and (self-) perception skills that offer a basis to develop behaviour (Schweizer et al., 2009). Horn et al. (2015) conclude that art therapy is a better entrance for many personality disorder patients to explore their dysfunctional patterns compared with the more cognitive verbal therapies. Nevertheless, as literature shows, the art-therapy interventions that currently exist for this target group are diverse and often based on practical beliefs or commonsense approaches, without a sound basis in research results.

A theoretically sound and evidence-based intervention is needed and should provide a description of what works, under what circumstances, and for whom, with a thorough insight in the relevant determinants of behavioural change, the theoretical methods to affect these determinants, and the translation of the theoretical methods into practical intervention strategies. In this study, we will describe the systematic and theory-based development of the art-therapy intervention, aimed at supporting people's self-regulation of personality disorder patients cluster B/C, using the Intervention Mapping (IM) protocol (Bartholomew, Parcel, Kok, Gottlieb, & Fernández, 2011).

METHOD

IM is a systematic method for the development, implementation, and evaluation of health interventions by constructing programmes grounded both in theory and empirical data (Bartholomew et al., 2011). This method is applied in mental health care and also in contexts of people with psychological problems. IM proceeds according to the following steps. Step 1: needs assessment through a review of the scientific literature by analysing the target population, the environmental conditions, as well as determinants of behaviour that promote mental health. Step 2: the determinants of the mental health behaviour are used to set objectives for behaviour change, divided into broad performance objectives and concrete change objectives in terms of what a person needs to learn to change his or her behaviour. Step 3: assessment of theoretical foundations and empirically evaluated methods and strategies for behaviour change. Step 4: translation of methods and strategies into an organised intervention. Step 5: planning of the adoption, implementation, and sustainability of the intervention. Step 6: formation of an evaluation plan. All these six steps were applied in order to develop a systematic, theory-based art-therapy intervention for people with personality disorders to promote their self- and emotion regulation.

Steps 1, 2, and 3 were carried out by performing a comprehensive review of the literature on art therapy and personality disorders. The CINAHL, ERIC, PUBMED, SCIENCEDIRECT, and WEBOFSCIENCE databases were searched for English articles published until 2016. Search terms were: `personality disorder*' or `personality patholog*,' `art therap*' or `arts therap*' or `creative therap*,' or `emotion regulation.' In Step 2, qualitative (individual and group interviews), quantitative (survey), and focus groups were used to gain a broad perspective of perceived effect of art therapy among patients with personality disorders cluster B/C (Haeyen et al., 2015). In Step 3, we performed a theoretical analysis of art-therapy methods and consensus-based strategies in which the important and changeable determinants of behaviour of personality disorder patients were addressed. In Step 4, the theoretical art-therapy methods and strategies resulted in a practical and organized intervention, described in a manual. In Step 5, the intervention is implemented and supervised. An extended manual and an intervention protocol were written to transfer the intervention. In Step 6, the intervention was assessed in daily practice, and an evaluation plan was provided and carried out.

RESULTS

Outcomes of the IM process will be described according to the six steps.

Step 1: needs assessment

A personality disorder is not always recognised right away because it concerns deeper lying patterns of feelings, actions, and thoughts. A personality disorder is an enduring and inflexible pattern concerning difficulties in cognition, emotiveness, interpersonal functioning, or impulse control that leads to significant distress or impairment and impacts a broad range of personal and social situations (American Psychiatric Association [APA], 2013; World Health Organization [WHO], 2015). It emerges in late adolescence and is not due to use of substances or another medical condition. People with a personality disorder have significant impairments in self (identity of self-direction) and interpersonal (empathy or intimacy) functioning, and have one or more pathological personality trait domains (i.e. negative affect, detachment, antagonism, disinhibition, and psychoticism; APA, 2013). The extent of the emotional and behavioural problems experienced by people with personality disorders varies considerably. Some are able to sustain some relationships and occupational activities. People with more severe forms of personality disorder experience very high levels of emotional distress. They have repeated crises, which can involve self-harm and impulsive aggression. They also have high levels of other diagnoses, including other personality disorders, and are frequent users of psychiatric and acute hospital emergency services (National Institute for Health and Clinical Excellence [NICE], 2009). Although our understanding of the influence of environment on genes and vice versa increases, the research in the field of people with a personality disorder diagnosis in recent decades, has been troubled by the dichotomy in our thinking with regard to the involvement of genes versus environmental factors on the development of difficulties. It is becoming increasingly clear that nature and nurture are not mutually exclusive categories, e.g. nature comes to expression by the influence of nurture. We know by now that in the development of personality disorders, multiple genes, but also multiple environmental influences are involved (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008).

The DSM-5 lists 10 personality disorders, grouped into three clusters, i.e. cluster A (Paranoid, Schizoid, and Schizotypal personality disorder), cluster B (Antisocial, Borderline, Histronic, and Narcissistic personality disorder) and cluster C (Avoidant, Dependent, and Obsessive-compulsive personality disorder). Many people with personality disorders have a long history of previous treatment of different problems with varying degrees of success (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008). In general, people with personality disorder meet the diagnostic criteria for more than one disorder, e.g. depression, addiction or post traumatic stress disorder. There are hardly any studies looking into the effects of an additional disorder on the symptomatology and treatment of a personality

disorder. Most of these studies are from the perspective of the concurrent disorder (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008).

The estimated prevalence of personality disorders is 9.1% to 15% in the general population (APA, 2013). In 60.4% of psychiatric patients and 56.5% of the users of addiction services, at least one personality disorder can be diagnosed (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008). This makes personality disorders the most frequently diagnosed disorder of all psychiatric diagnoses. In the personality disorder population, people with cluster C disorders are the most common (44.7%), closely followed by people with cluster B disorders (27.3%). People with cluster Cluster A disorders are clearly the least prevalent (7.7%). This is without the people classified with an unspecified personality disorder. We focus on people with personality disorders cluster B and/or C, because these personality disorder clusters are the most prevalent.

Behaviour characteristics of cluster B consist of dramatic, emotional, or erratic behaviour, often also described as impulsivity. Usually there are impulsive and destructive behaviours and instability in the area of emotions, identity, and interpersonal relationships. Behaviour characteristics of cluster C consist of tense or anxious behaviour. The main features of people with cluster C personality disorders are fear and vulnerability. This leads to problems in several life areas such as close relationships, well-being, and work relations. Both cluster B and C consist of an instable and/or negative self-image and instable affects, attention-seeking behaviour, feelings of inadequacy and dependency, or perfectionism. Adjustment to social environment can be a problem because experiences and behaviours of people with personality disorders cluster B/C differ from societal norms and expectations, and interpersonal (empathy or intimacy) functioning is difficult (Eurelings-Bontekoe, Verheul, & Snellen, 2009; Ingenhoven, Van Reekum, Van Luyn, & Luyten, 2012).

Central determinants of the behavioural characteristics of personality disorders are emotion regulation problems and emotional vulnerability. Emotion regulation refers to the processes by which we influence which emotions we have, when we have them, and how we experience and express them (Gross, 1998). Emotion-expressive behaviour plays an important role in social interactions (Gross, 2002). Emotional vulnerability is characterized by a very large sensitivity to emotional stimuli, a very strong response to emotional stimuli after emotional stimulation, and a slow return to the emotional basic level (Linehan, 1996). These two central determinants, emotion regulation problems and emotional vulnerability, have different appearances for each diagnostic group, which can be seen as more specific determinants that can cause serious problems in various areas of life. These specified determinants are shown in Table 1.

Table 1. Specific determinants of ineffective personality disorder behaviour per diagnostic group (APA, 2013)

Diagnostic group (prevalence in general population)		Specific determinant
Cluster B	Antisocial personality disorder (0.2–3.3% [a])	Pervasive pattern of disregard for and violation of the rights of others, lack of empathy, bloated self-image, manipulative and impulsive behaviour
	Borderline personality disorder (1.6–5.9% [b])	Pervasive pattern of instability in relationships, self-image, identity, behaviour, and affects often leading to self-harm and impulsivity
	Histrionic personality disorder (1.84%)	Pervasive pattern of attention-seeking behaviour and excessive emotions
	Narcissistic personality disorder (0–6.2%)	Pervasive pattern of grandiosity, need for admiration, and a lack of empathy
Cluster C	Avoidant personality disorder (2.4%)	Pervasive feelings of social inhibition and inadequacy, extreme sensitivity to negative evaluation
	Dependent personality disorder (0.49%/0.6%)	Pervasive psychological need to be cared for by other people
	Obsessive-compulsive personality disorder (2.1–7.9%)	Characterised by rigid conformity to rules, perfectionism, and control to the point of satisfaction and exclusion of leisurely activities and friendships (not the same as and quite different from obsessive-compulsive disorder)

[a] In rehabilitation clinics, jail, and forensic institutes >70%

[b] In mental health institutions up to 20%

Step 2: matrix of change objectives

Next, important and changeable objectives of behaviour were chosen. For personality disorder patients of both cluster B and C, determinants taken from Table 1 are summarized and translated into general therapeutic change objectives: 1. Experiences a (more) stable and positive sense of self; 2. Is able to express and regulate emotions; 3. Understands own emotions, thoughts, and behaviours; 4. Uses improved social skills; and, 5. Uses improved problem-solving skills. These general change objectives were translated into more concrete performance objectives to be identified in art therapy (see Table 2).

The general change objectives can be described as follows.

A (more) stable and positive sense of self. This means the ability to self-validate and have a more stable and positive idea about self – i.e. about one's goals, values, interests, and emotions. A more stable and positive sense of self could be helpful regarding several specific determinants in personality disorders cluster B/C, i.e. the pervasive psychological need to be cared for by other people, rigid conformity to rules and perfectionism, a bloated self-image, or a pervasive pattern of instability in self-image and identity often leading to self-harm.

Increased emotion regulation. This means that the person has the ability to recognise, validate, and regulate their own emotions. The capacity for emotion regulation is stronger when a person has learned how to label and regulate emotional arousal, how to tolerate emotional distress, or when to trust his or her own emotional responses as reflections of valid interpretations of events (Linehan, 1996). This is a change objective because of determinants such as emotion dysregulation, excessive emotions, emotional vulnerability, extreme sensitivity, and impulsive, avoidant, or attention-seeking behaviours.

Understanding emotions, thoughts, and behaviours. This means that the person has insight in thoughts and reaction patterns based on awareness and evaluation of behaviour in interactions with others. This is a change objective because of determinants concerning troubles with empathy and pervasive patterns in behaviours and feelings.

Improved social skills. This means that the person is able to interact with others in a balance between autonomy and collaboration, to deal with conflict, to give and receive feedback, and to be able to ask for what one needs as well as to say no to what one does not want. This an important change objective because of determinants such as instability in relationships, pervasive pattern of disregard for and violation of the rights of others, lack of empathy, manipulative and impulsive behaviour, pervasive pattern of need for admiration or feelings of social inhibition and inadequacy, a psychological need to be cared for by other people, and exclusion of friendships.

Improved problem-solving skills. Problem-solving skills can be defined by the ability for creative thinking and acting, finding more than one solution, thinking dichotomously and using flexible strategies and improvising, and being flexible in the search for another direction in emotion, thought, and action. This is a change objective because of determinants concerning pervasive patterns in behaviour and thought, e.g. characterised by impulsivity, dependent behaviour, negative evaluation or rigid conformity to rules, perfectionism, and control to the point of satisfaction and exclusion of leisurely activities.

Table 2. Matrix of general change objectives and performance objectives in art therapy for personality disorder patients cluster B/C

Target group and determinant (selected)	General change objectives	Performance objectives in art therapy
Cluster B - Lack of empathy - Instability in relationships - Instability of self-image, identity - Instability of behaviour (impulsivity) and affects (excessive emotions)	1. Experiences a (more) stable and positive sense of self 2. Is able to express and regulate emotions 3. Understands own emotions, thoughts, and behaviours 4. Uses improved social skills 5. Uses improved problem-solving skills	1. Patient tries to understand other patient's actions and expressions in art work 2. Patient integrates feeling, acting, and thinking on the level of individual and group art processes 3. Patient develops observation skills and positive thinking about own and other's actions and art products 4. Patient experiments with self-expression and structuring art processes 5. Patient becomes aware, reveals identity in a situation of felt control 6. Patient develops a new perspective on his self-image (more positive) 7. Patient frames/integrates the experiences by reflective verbalisation 8. Patient dares to participate and experiment with behaviour on the level of individual and group art processes 9. Patient experiments with self-expression and spontaneous art processes 10. Patient becomes aware, reveals identity in a situation of reduced control
Cluster C - Feelings of social inhibition and inadequacy - Dependent or avoidant behaviour and anxiousness (suppressed/avoided emotions) - Extreme sensitivity to negative evaluation - Psychological need to be cared for by other people - Rigid conformity to rules, perfectionism, and excessive control		

Step 3: theoretical methods and practical strategies

In Step 3, general change objectives coming from Step 2 were translated into practical strategies by selecting theory-based intervention methods. Theoretical foundations and empirically evaluated methods and strategies for these change objectives were obtained by literature review.

The theoretical foundations in order to achieve the change objective consist of principles of the dialectical behaviour therapy (Linehan, 1996), mentalization-based treatment (Fonagy & Bateman, 2005), analog process model (Pénzes, Hooren, Dokter, Smeijsters, & Hutschemaekers, 2014)), expressive therapies continuum (Lusebrink, 2010), gestalt art therapy (Rhyne, 2001), and schema therapy (Young, Klosko, & Weishaar, 2003). In line with these theoretical principles, practical strategies were selected for each change objective. These practical strategies focus on discovering, improvising, and intuitively acting during the art process, envisaging the own artwork as self-product and active reflection on the art process and product (Lusebrink, 2010). A strategy of the analog process model is to examine the analogy between the art process and product with functioning in daily life (Pénzes, Hooren, Dokter, Smeijsters, & Hutschemaekers, 2014). Strategies also concern exploration of the conflicting inner world, reminiscence, trauma image processing (Haeyen et al., 2015; Malchiodi, 2012), mindfulness techniques, (guided) imagery techniques, gestalt art-therapeutic techniques, and making artistic symbolisation of life experiences in the past (Haeyen, 2007; Rubin, 2001). Another practical strategy is making contradictory feelings and ineffective modes visible through the artwork, after which the artwork is replaced or edited according to preferred feelings and effective modes, giving meaning through objects in the form of pieces of artwork and explicitly reflecting on it (e.g. Gunther, Blokland-Vos, van Mook, & Molenaar, 2009; Haeyen et al., 2015; Verfaille, 2016). Fantasy and play are used as an `as-if situation,' which offers a space for experiment and practise (Fonagy & Bateman, 2005). Strategies for the change objective to improve social skills include exploration of oneself during behavioural experiments in interactions with other people while focusing on autonomy versus collaboration, dealing with interpersonal conflict, experimentation during the process of group artwork, and reflection on this process and the artwork (Eren, Öğünç, Keser, Bıkmaz, Şahin, & Saydam, 2014). A strategy for the change objective to improve problem-solving skills is using creative problem solving. In addition, playful strategies activate patients to explore and develop alternative patterns in acting, thinking, and feeling (Schweizer et al., 2009).

These strategies stimulate a mindful self-dialogue, expression of feelings in the present moment, self-awareness and self-agency (Rubin, 2001; Schweizer et al., 2009), change in behaviour, thoughts, or feelings, reflection on (contradictory) feelings and reappraisal, acceptance and integration of these feelings, corrective experiences, increased insight (Huckvale & Learmonth, 2009; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2012) understanding oneself in interactions with others, personal growth, and making decisions (e.g. Franks & Whitaker, 2007; Karterud & Pedersen, 2004; Springham, Findlay, Woods & Harris, 2012).

Offering the art therapy in a group situation makes it possible to experience and explore similarities and differences in relation to individual processes of other patients and to introduce communication, feedback, and verbal reflections of group members on the meaning of the art process and the artwork (Haeyen et al. 2015; Johns & Karterud, 2004).

Step 4: intervention

In Step 4, the theoretical models and methods of Step 3 are translated into a manual for the intervention. The manual is based on information from Steps 1 to 3, the literature review and discussions with 18 experienced art therapists (> 10 years of experience) for the national guidelines for multidisciplinary treatment of personality disorders (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008) and 29 service-using patients who participated in previous research (Haeyen et al., 2015), years of experience of the first author (SH) with art-therapy assignments developed and used in practice of personality disorder treatment by many art therapists using assignments from a larger workbook (Haeyen, 2007). Final decisions for this 10-session intervention protocol were made in the research group. We concluded that an intervention programme should focus on: (1) a clear generic treatment structure; (2) the change objectives that fit the patient's goals; (3) a therapeutic style that fits these objectives; (4) a routine monitoring of the progress in art therapy; and (5) support for art-therapy professionals. The program is directed on patients with personality disorders cluster B/C motivated to investigate and change their patterns in feelings, thoughts, and behaviours. Inclusion criteria are: adults (18+ years) with a primary diagnosis of at least one Axis II Personality Disorder cluster B and/or C or a personality disorder not otherwise specified (American Psychiatric Association, 2013), an IQ > 80. Exclusion criteria are acute crisis, psychosis, actual and serious suicidal behaviour and/or thought, and/or severe brain pathology. Patients participate on a voluntary basis and will be actively involved in setting their specific personal goals within the programme, based on an explicit, joint understanding of the potential benefits of the programme.

Generic structure: 10-session art-therapy intervention model.

We introduce a fixed structure for the treatment protocol of 10 sessions of 90 minutes group art therapy, each based on the change objectives, to be located in a specialist personality disorder service. Before participation an intake takes place with the art therapist in which specific personal goals within the protocol are determined. The context of the therapy should be clear and safe, and there should be a possibility to rely on professional crisis intervention when needed. Moreover, the therapeutic group situation should be feasible, meaning that the patient can benefit from the therapy group and also has the ability to constructively collaborate with others. It is an open rolling group. When appropriate, a patient can repeat the 10-session cycle two times. Each session starts with some minutes for tuning in and explaining the experiential assignment and the goals for the session. The sessions end with discussion and

reflection based on the art process and art product. The atmosphere of the sessions should be one of respect, validation, empathy, and understanding, with a primary emphasis on the need to sustain communication, to keep the channels of communication open (Fonagy, Luyten, & Allison, 2015). When a patient ends the therapy, it is advised to discuss further therapy or what to do after therapy, with a treatment coordinating mental health care professional from the specialist personality disorder service (mostly a psychiatrist or psychologist).

The description of the art-therapy programme. First, we describe how each change objective is addressed in the 10-week intervention protocol as a whole. Second, we describe the content per session separately. The art-therapeutic content fits the personality disorder patients' goals based on the change objectives from step 2 and the theoretical methods and practical strategies from step 3.

Targeting change objective 1: A (more) stable and positive sense of self. The patient develops a more stable and positive sense of self by means of stimulating a non-judgmental self-awareness and self-reflection related to the art process and product. Self-awareness is stimulated by a focus on the experience in the "here-and-now" promoting increased conscious sensory and affective perception of art materials and increased exploration of the qualities of various expressive materials offered by the art therapist such as pastels, clay, and paint. In order to get the patient to enter into the experience of the present moment, the art therapist uses techniques such as relaxation, mindfulness exercises, and guided imagery. Self-reflection is stimulated by focusing and reflecting on aspects such as: (1) the formal elements of the characteristics of the art product (e.g. line, form, shape, space usage, colour), (2) self-images, expressed symbols, and the personal meaning for a patient and others, (3) the course of the art process, and (4) the behaviour, thoughts, and feelings during this process. It is important that increasing self-awareness and self-reflection is practised with descriptive mindful attention, with acceptance, and with the help of validating interventions of the art therapist or the group members.

Targeting change objective 2: increased emotion regulation. The patient develops increased emotion regulation by means of an artistic, visual, and communicative expression of emotions and, doing so, externalising these emotions in the artwork. This is a foundation to improve the ability to cope with difficult emotions and reconcile emotional conflicts using visible and tangible artwork. The art therapist stimulates expressive use of materials to explore individual art expressions. She or he intervenes by providing materials and processes that encourage the uncovering or disclosing of personalized emotion regulation goals. Also, characteristics of art materials and themes are used to trigger inner images, experiences, and feelings of the patient, which can take place on different levels (emotional/sensory/affective or rational/perceptual/symbolic). Themes are, for instance: feeling competent versus vulnerable, being self-critical versus self-helping. The interventions of the therapist are focussed on enhancing personal expression, strengthening and handling the experience in the present moment, or positively influencing the present emotions by means of, for instance, an opposite

action. The art therapist gives space to the patient's child needs, and authentic art expressions are welcomed as an effective way to oppose ineffective parent modes. A major aim of the art-therapy intervention is to recognise contradictory emotions and find balance in and integration of these emotions (see also descriptions of sessions 6 and 9).

Targeting change objective 3: understanding emotions, thoughts, and behaviours. A better understanding of and insight in emotions, thoughts, and behaviours is achieved by verbal reflections and communication that clarify meaning of the patient's artwork during and after the making of that artwork. In this respect, it is again important that both the patient as well as the art therapist and group members take a non-judgemental, `not-knowing,' validating, and respectful attitude. Understanding is challenged on the individual as well on the group dynamic level. On the individual level, the focus is on emotional exploration of meaning, as well as organising and structuring the expression of emotions, thoughts, and behaviour. On the interpersonal level, the focus is on exploration and understanding of and insight in interaction patterns.

Targeting change objective 4: improved social skills. Social skills are explored, challenged, and practised by interactive exercises in the group, in which patients collaborate and are stimulated to react to each other in the active art-making experience and afterwards in the verbal evaluation by giving feedback on each other's behaviour after collaborative assignments. Alternative effective interpersonal behaviour can be practised. Skills that are practised are, for instance, to be effective in asking what one needs, to say no, and to be able to deal with conflicts.

Targeting change objective 5: improved problem-solving skills. Patients' problem-solving skills are challenged during the creative process and the dynamic process in the group. During the art process, patients need to make choices and deal with artistic challenges; this stimulates being flexible, thinking divergently, and exploring solutions. The art therapist makes targeted use of materials, as well as of assignments that ask for improvisation, flexibility, and new behaviours with materials and themes. The problem-solving skill that is also practised is to be able to distract oneself temporarily from unpleasant emotions during stressful situations. Distraction can be found in working with pleasant art materials and in using relaxing ways of art-making that nurture senses, with relaxation, focussed attention, and encouraging images. In this way, self-soothing is actively practised as an opposite action to painful emotions.

Below, the content of each session will be described. A short overview of this content and the linked change and performance objectives are summarised in Table 3.

Table 3. The art-therapy 10-session intervention protocol based on theoretical models and empirically validated methods

Number	Art assignments	Change objectives	Performance objectives
1	Warming up: verbal exploration of emotions Assignment 1: exploring basic emotions (fear, angry, happy, sad) in abstract using sensory/motoric vs. symbolic art using pastels Assignment 2: `*Three sheets of paper working towards each other*' (autonomy vs. collaboration, with paint; interpersonal effectiveness) Evaluation: reflection	1, 2, 3, 4	1, 2, 3, 7, 8, 9
2	Warming up: exploring present emotions with pastels (`What & How skills'; observe, describe, participate & non-judgementally, one-mindfully, effectively) Assignment: `*Above and below surface*' with coloured ink (emotion regulation, dialectic theme) Evaluation: reflection	1, 2, 3, 4	1, 2, 3, 4, 5, 7
3	Warming up: relaxation and `*Personal weather message*' with drawing materials Assignment: `*Life line*,' displayed in line, form, and colour (emotion regulation) Evaluation: reflection	1, 2, 3	1, 2, 3, 4, 5, 7
4	Warming up: exploring clay; sensory, motoric and affective (mindfulness skills) Assignment: two clay figures; `*Big self & little self*,' what does the child need? (exploring own schema modes) Evaluation: dialogue between clay figures; exploring internal dialogue, reflection	1, 2, 3, 5	1, 2, 3, 4, 5, 6, 7, 9, 10
5	Warming up: material experiment (`What & How skills') Assignment: `*Emerging painting*' (improving the moment) Evaluation: titles for each other's work, reflection	1, 2, 3, 4	1, 3, 4, 6, 7, 8, 9, 10
6	Assignment: `*The tormentor*' (exploring negative feelings and thoughts/ helping symbol; opposite action) Evaluation: reflection	1, 2, 3, 5	1, 2, 3, 4, 5, 6, 7
7	Warming up: imagination (improve the moment) Assignment: `*Clay monsters*' (exploring anger and fear; emotion regulation) Evaluation: putting the monsters together, making up sounds and texts, reflection	1, 2, 3, 5	1, 2, 3, 4, 5, 7, 10
8	Assignment: `*Group painting*' and role-play (interpersonal effectiveness, active schema modes) Evaluation: reflection	1, 2, 3, 4	1, 2, 3, 7, 8, 9

9	Warming up: mindfulness exercise Assignment: `*Image of emotional pain*' and soothing reaction; distress tolerance, opposite action to painful emotions, self-soothing Evaluation: reflection	2, 3, 5	1,3,4,5,6,7
10	Assignment: `*Emotion in clay and other material*' (emotion and experience acceptance) Evaluation: reflection	1, 2, 3	1, 2, 3, 4, 7, 8, 9, 10

Extra assignment 1: `Introduction collage,' for a starting group member.
Extra assignment 2: `Choose your most important art work,' for a leaving group member.

The sessions

Session 1

Warming up: Short verbal exploration of primary and secondary emotions.

Assignment 1: Exploring basic emotions (fear, angry, happy, sad) in two different ways using pastels: abstract, sensory/motoric versus symbolic, figurative. What's the difference in experiencing the emotions?

Assignment 2: `*Three sheets of paper painting toward each other*' (autonomy versus collaboration, with paint; interpersonal effectiveness). Make an abstract painting based on the present emotion, each on opposite sides of the paper strip, working towards the joint middle paper. Interpersonal interaction is challenged with this collaborative exercise in pairs in which autonomy versus collaboration is explored.

Evaluation: In the evaluation at the end of this session, social skills are actively practised by stimulating reactions to each other's artwork and by giving feedback on each other's behaviour in the collaborative assignment. Did you manage to concentrate on yourself and to tune in at the joint part?

Session 2

Warming up: Exploring present emotion(s) with pastels by choosing two colors, experimentally drawing lines, wiping with fingers/hands, and choosing one spontaneous word based on this experience. Observe, describe, participate non-judgmentally, one-mindfully, and effectively to get into the present moment.

Assignment: Make a drawing on the theme `*What is above and below surface*' with colored ink using a horizontal line. This assignment focusses on being more open, communicative about revealed versus concealed emotions and thoughts, and finding balance between contradictory aspects of these emotions and thoughts (dialectic theme) and towards integration.

Evaluation: Personal reflections.

Session 3

Warming up: Relaxation exercise and guided imagery on the theme a `*Personal weather message*' based on your present mood. Make a quick drawing of this mood image with drawing materials.

Assignment: Draw a personal `*Life line*' to express your personal experiences in your history of life from birth until now using line, form, and color. This assignment focusses on emotional organising and structuring of life experiences by transforming these into a creative expression, using a line, shapes, and colors for important events.

Evaluation: Personal reflections.

Session 4

Warming up: Exploring clay focusing on sensory, motoric, and affective aspects to get into the present moment and into the experience of clay (mindfulness skills).

Assignment: Making of two clay figures – "Big self & little self" – as symbolisation of when feeling competent and strong, and when feeling small and vulnerable. Place these two figures in relation to each other. Add some other material to soothe the little self-figure. This assignment is focussed on the exploring of different self-images, schema modes, and polarities in the person, e.g. adult mode versus child mode, and on the active search for the relation between these two modes in order to integrate polarities.

Evaluation: Description of the two figures and the characteristics of each. Making up a dialogue between the clay figures to explore the relation between the modes, to explore the internal dialogue between different parts of oneself and to reflect on this (gestalt art technique).

Session 5

Warming up: Material experiment, practising `What' (observe, describe, participate) and `How' skills (non-judgementally, one-mindfully, effectively) by actively searching for multiple ways of working with paint using different tools and exploring what is pleasant and what is not (nurture of the senses).

Assignment: `*Emerging painting*,' an abstract start of applying opaque paint, using the process to make an image emerge. This assignment is focussed on improving attention to the present moment. Creative problem-solving techniques are used in explicit and implicit ways by making choices during the art process (flexible, divergent thinking, exploring solutions).

Evaluation: Feedback exercise in which titles for each other's artworks are formulated and shared. Personal reflections.

Session 6

Assignment: Drawing of a personal `*Tormentor*' to explore and to depict negative thoughts using fantasy. Add text balloons showing the patient's thoughts to this figure. Next, make a `helping symbol' for a feature or skill to develop and stimulate an opposite action to these

painful, negative thoughts and emotions. This symbol is made on a laminated `flash card,' which serves as a transfer tool, to be taken home as a reminder for the helping feature or skill, which is visual, tangible, and present outside the therapy setting.
Evaluation: Personal reflections.

Session 7
Warming up: Relaxation exercise to get into the present moment, and guided imagination to explore feelings of anger in the past months.
Assignment: Make a `*Clay monster*' as horrible as possible, as a symbolisation of anger, also using other supplementary materials. This assignment focusses on exploration, regulation, and integration of this emotion. The monster is a kind of self-image that represents a part or a polarity of the person that is often avoided.
Evaluation: Personal reflections. Putting the monsters together, making up sounds and texts.

Session 8
Assignment: Making a `*Group painting*' using finger paint and role play (interpersonal effectiveness, active schema modes) and experiment with new behaviour (exaggerate or contrast action in the second term). Interpersonal interaction and cooperation is challenged to explore personal patterns, to practise interpersonal effectiveness, and to deal with conflicts.
Evaluation: Self-reflection and reactions to each other's way of working together, giving feedback on each other's behaviour during the group painting.

Session 9
Warming up: Mindfulness exercise focussed on breathing to get into the present moment.
Assignment: Making an `*Image of emotional pain*' to transform this experience into an external form in clay and another material to symbolise this emotion in an image of shape, color, and fantasy. This sense of self is present and validated in the artwork. Next, change something to this image to introduce mildness to develop and actively practise self-soothing, distress tolerance, and an opposite action to painful emotions.
Evaluation: Personal reflections.

Session 10
Assignment: Make a present `*Emotion in clay and other material.*' The emotion is the starting point, and the use of a combination of materials by the patient is challenged. This assignment is focussed on emotion, sensory aspects, and experience acceptance. The idea is to use the materials in a way that fits the present emotion(s). The patient is challenged to improvise to make explicit and implicit choices during the art process (flexible, divergent thinking, exploring solutions).
Evaluation: Personal reflections; making up titles for each other's work and sharing these.

Extra assignment 1: `*Introduction collage,*' a starting ritual for a starting group member to share something about oneself.
Extra assignment 2: `*Choose your most important art work,*' a farewell ritual when a group member leaves the group. Reflection on this choice. Both assignments are important for emotion regulation and interpersonal effectiveness.

Qualifications of the therapist. It is required that this intervention is carried out by an officially trained and registered art therapist with specific expertise in the understanding and management of people diagnosed with personality disorders cluster B/C. Regarding the therapeutic style, the art therapist balances between emotional closeness and distance and has a coaching, validating, inquisitive, or `not-knowing' stance and supporting style, which stimulates autonomy and responsibility of the patient, but also provides structure (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008). For instance, the art therapist is `limited reparenting' by offering soft materials and supportive art assignments and taking a comforting role in the cooperation but keeping the patient responsible (Gunther et al., 2009; Haeyen, 2015; Van Vreeswijk et al., 2012). The art therapist works in partnership with the personality disorder patients to develop autonomy and promote choice. An optimistic and trusting relationship is important, to work in an open, engaging and non-judgemental manner, and be consistent and reliable, developing mentalization, using the group therapy situation for connecting interpersonally. The art therapist sometimes also applies psycho-education in verbal reactions to a patient's personal patterns and characteristics in the art process and artwork. Because the therapist works through the use of material and experimental techniques and methods, the therapeutic relationship is developed, stimulated, and maintained in a triangular relationship between client – materials – therapist (Schweizer et al., 2009), and if art therapy is conducted in a group, this adds even more layers of interaction to the process (Karkou & Sanderson, 2006).

Routine monitoring of the progress in art therapy. There are specific questionnaires on personality disorder symptomatology and other questionnaires that measure relevant concepts, e.g. self-image, emotion regulation, and social skills. Based on our former research, we developed a questionnaire focusing on Self-expression and Emotion Regulation in Art Therapy Scale (the SERATS) for patients with personality disorders cluster B/C in order to measure the perceived effect of art therapy (Haeyen, Van Hooren, Van der Veld, & Hutschemaekers, 2017a). This is a brief, content-valid questionnaire that offers objective and reliable information about the therapeutic change of the patient in art therapy, however, further research on the construct validity is needed, before we can decide on the usefulness of the SERATS.

Support for art therapists. The application of this art-therapy programme for personality disorder patients places high demands on art-therapeutic and general-therapeutic skills. Art therapists who use this intervention programme should have intervision (inter collegial consultation) and/or supervision regularly. The target group is often experienced as

`difficult,' and inter-collegial support and advice is needed for each professional working with this group. Therefore, it is preferable to collaborate with other therapists or trainers who also offer interventions to the same (kind of) patients.

Steps 5 and 6: implementation and evaluation

The manual was written and first used within one mental health care institution. Scientific evaluation of the intervention was part of the implementation process. A study was designed to investigate the feasibility/efficacy of this intervention. In this randomised controlled trial (RCT), patients indicated for outpatient treatment aimed at personality problems were assigned randomly to an experimental group (receiving art therapy) or a control group (no intervention/waiting list). Informed consent was obtained from all participating patients. The trial was registered and approved by the Medical Ethical Committee of the Radboud University Nijmegen, The Netherlands (METC) (CCMO register: NL44394.091.13 and Dutch Trial Register: NTR3925). The results of this trial are reported in a separate article (Haeyen, Van Hooren, Van der Veld & Hutschemaekers, 2017b) and showed that this art therapy intervention was an effective treatment with mainly large to very large effect sizes (e.g. impulsivity Δd = -1.66, detached emotional state Δd = -1.31, `happy child' state $\Delta d$ = 1.55, `healthy adult' state Δd = 1.60; symptom distress Δd = -1.94).

DISCUSSION

In this paper, we have described the systematic development of an art-therapy intervention programme aimed at people with personality disorders cluster B/C, carried out by art therapists. By following the steps of the IM process, we have developed a tailored intervention programme. The recommended attitude of the therapist is described, as well as boundary conditions and advices for use. Implementation has taken place through a written manual, we developed the Self-expression and Emotion Regulation in Art Therapy Scale (the SERATS), and we carried out an RCT. To our knowledge, this is the first time that a number of potentially effective methods has been combined into one, ready-to-use programme tailored for this patient population.

This developed intervention has some strengths. First, in developing, implementing, and evaluating a systematic approach, the IM approach is used. In the process of developing the intervention, empirical evidence, theories, guidelines, and recommendations from general personality disorder and art-therapy literature were used to build a solid framework aimed at change objectives that are central for personality disorder patients. Second, the intervention programme is short, containing only an intake and 10 sessions, which matches the aim of mental health care practice to provide effective interventions that are short when possible. Third, the interventions and art-therapy assignments of this programme have been developed and were used in practice over many years and have been exposed to various rounds of feedback from

researchers, practitioners, and patients. These measures, to our belief, have greatly increased the validity of the art-therapy intervention programme. Fourthly, the intervention showed very good results. For some patients this programme might be sufficient to stabilise. For others this could be the beginning of a needed process for deeper personal change.

This study also has limitations. First, large-scale research into art therapy with personality disorder patients is lacking, and there is little research available to isolate effects of art therapy in a multidisciplinary treatment. Therefore, we have to rely on other studies outside the field of art therapy as well as small art-therapy studies with various quality, although the IM method places high demands on selecting effective theory-based intervention methods. Second, the degree of effectiveness of this art-therapy intervention may depend on the skill, experience, and style of the art therapist who carries out the intervention. Therefore, we recommend to put effort in developing a good knowledge base on both art therapy and personality disorder pathology and to organise collegial support or intervision.

In conclusion, the art-therapy intervention programme seems to be promising for patients with personality disorders cluster B/C in learning to deal with their problems with change objectives such as: experiencing a (more) stable and positive sense of self; being able to express and regulate emotions; understanding emotions, thoughts and behaviours; and using improved social skills and problem-solving skills. It could offer a valuable contribution to the treatment of people with personality disorders by provoking experiences and feelings, by developing self-regulation skills, and by enhancing a healthy adult attitude towards the faced problems. If our intervention works, this could indicate that art therapy contributes to the process whereby the patient experiences more grip, more self-direction in what happens to him or her, and thereby more autonomy. The results of the evaluation study may contribute to the knowledge about how to use art therapy for problems of this target population. The results can be used as input for other art-therapy interventions aimed at personality problems. If that study points out that the intervention is effective in its purpose, we have a more solid base for the use of this intervention.

CHAPTER 5.

Efficacy of Art Therapy in Individuals with Personality Disorders Cluster B/C

A Randomised Controlled Trial

Haeyen, S., Van Hooren, S., Van der Veld, W., & Hutschemaekers, G. (2017b). Efficacy of Art Therapy in individuals with Personality Disorders cluster B/C: a Randomised Controlled Trial. *Journal of Personality Disorders*. doi: 10.1521/pedi_2017_31_312

ABSTRACT

Multidisciplinary treatment programs for patients with personality disorders often include art therapy but the efficacy of this intervention has hardly been evaluated. The objective of this study is to evaluate the effects of an art therapy intervention on psychological functioning of patients with a personality disorder. In this randomised controlled trial, 57 adult participants diagnosed with a personality disorder cluster B/C (SCID-II) were randomly assigned to (1) weekly group art therapy (1.5 hours, 10 weeks) or (2) waiting list group. Outcome measures OQ45, AAQ-II and SMI were assessed at baseline, at post-test (10 weeks after baseline), and at follow-up (5 weeks after post-test). The results show that art therapy is an effective treatment for personality disorder patients because it not only reduces personality disorder pathology and maladaptive modes but it also helps patients to develop adaptive, positive modes that indicate better mental health and self-regulation. Trial registration: NTR3925; CCMO register: NL44394.091.13.

INTRODUCTION

Multidisciplinary treatment programs for patients with personality disorders often include art therapy. Art therapy is an experiential intervention that focusses on individual treatment goals by the therapeutic use of personal expression using art materials (e.g. clay, drawing and painting material, wood, metal). In art therapy, patients examine feelings without words, pre-verbally and sometimes less consciously (Eisdell, 2005; Haeyen, 2007, 2011; Johns & Karterud, 2004; McMurray & Schwarz-Mirman, 2001; Milia, 1998; Springham, Findlay, Woods & Harris, 2012). Art materials and art-making appeal to both bodily sensations and emotional responses. Art therapy is often seen as a more direct and less cognitive therapeutic entrance compared with verbal therapies to explore their dysfunctional patterns in managing emotions (Bernstein, Arntz & de Vos, 2007; Haeyen, van Hooren, & Hutschemaekers, 2015; Horn et al. 2015; Levine, Marziali, & Hood, 1997; Linehan & Heard, 1992; Westen, 1991).

Despite frequent use of art therapy for personality disorder patients, its efficacy has hardly been evaluated. The available studies show promising results, but their number is very small; moreover, most of the studies do not isolate effects of art therapy. For example: in a recent pilot study, patients with personality disorders show significantly healthier emotional states in art therapy sessions than in verbal psychotherapy (Van den Broek, Keulen-de Vos & Bernstein, 2011). Karterud and Pedersen (2004) have shown that more severely disturbed patients with personality disorders favor the 'pretend mode' of art group therapy, as a safe method of exploring the mind in the presence of mentalizing self-objects (Bateman & Fonagy 1999, 2006). The benefit of the art therapy group correlates significantly with the 'overall benefits' (Karterud & Pedersen, 2004). Similar positive results such as decreased destructive behaviour, a better global and social functioning, improved distress tolerance, emotional regulation and a reduction in scores on positive symptoms have also been found in other small studies, mostly without control group or using a qualitative design (Eren et al., 2014; Gatta, Gallo & Vianello, 2014; Green, Wehling & Talsky, 1987; Franks & Whitaker, 2007; Springham et al., 2012). According to personality disorder patients themselves, art therapy offers corrective (emotional) experiences and promoted effects such as sensory perception, personal integration, emotion awareness and emotion regulation, behaviour change and insight, and comprehension (Haeyen, 2007; Haeyen et al., 2015; Rankanen, 2014). Thus, existing studies show beneficial effects, but do not provide decisive evidence. Therefore, in this study, we examine the effects of art therapy on psychological functioning of personality disorder patients cluster B/C using a randomised controlled trial (RCT). We focus on psychological flexibility, mental health problems and schema modes because we expect that art therapy could have effects on these aspects.

METHOD

Design

In this RCT, patients with personality disorders were assigned randomly to an experimental group (receiving art therapy) or a control group (waiting list with no intervention). Both groups were assessed at baseline (pre-test), immediately after the intervention at 10 weeks (post-test) and after another five weeks (follow-up; 15 weeks after baseline). The trial was registered and approved by the Medical Ethical Committee of the Radboud University Nijmegen, the Netherlands (METC) (CCMO register: NL44394.091.13 and Dutch Trial Register: NTR3925, same as the ISRCT or NCT number).

Procedure

The participants were recruited from a waiting list of patients targeted for personality disorder treatment in a specialized outpatient treatment unit for personality disorders. Inclusion criteria were adult (18+ years) with a primary diagnosis of at least one Axis II Personality Disorder cluster B and/or C or a personality disorder not otherwise specified (APA, 2013), IQ > 80 and adequate mastery of the Dutch language. Exclusion criteria were acute crisis, psychosis, actual and serious suicidal behaviour and/or thought, and/or severe brain pathology. The required minimum sample was calculated based on the power of .80 and 5% α-level. The expected effect size (d = 1.91) is based on a study by Gratz & Gunderson (2006), who studied individuals with personality disorders with the Acceptance and Action Questionnaire (AAQ-II) in an RCT design. With this expected effect size, we need a sample size of 25 persons (rounded up to a full number). Perry, Banon, and Ianni, (1999) suggest that we can expect a dropout of 22%. Based on this percentage, the number of participants had to be 62. Therefore, our sample size had to be 31 per group, instead of 25. For more information, see our research protocol (Haeyen, van Hooren & Hutschemaekers, 2013).

Patients on the waiting list were invited by letter to participate, but only if they were expected to fit the inclusion criteria. The letter mentioned, among others, ethical aspects, such as voluntary participation, withdrawal during the research and time to re-think. One week after the letter was sent, patients were approached by telephone. Patients who agreed to participate signed the informed consent approved by the Medical Ethical Committee and were assigned randomly to the experimental or the control group, using a dice. Patients in the experimental group started with the treatment, while patients on the waiting list did not receive treatment during the RCT. After a patient agreed to participate, the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II, Dutch version by Weertman, Arntz & Kerkhofs, 2000) was administered.

Participants

The flowchart (Figure 1) provides an overview of the RCT. In total, 113 patients were selected from the waiting list. However, 39 patients refused to participate or had to be excluded for the following reasons: acute crisis, other treatment started, not the right primary diagnosis, fear for loss of control, rejection of group therapy, and other reasons. The remaining 74 participants filled in the questionnaires at pre-test, 63 patients at post-test and 57 patients at follow-up. Reasons for dropout at post-test and follow up were physical problems, mourning, fear of travel, crisis (psychological/drugs/alcohol), work related and 'unknown' or no contact.

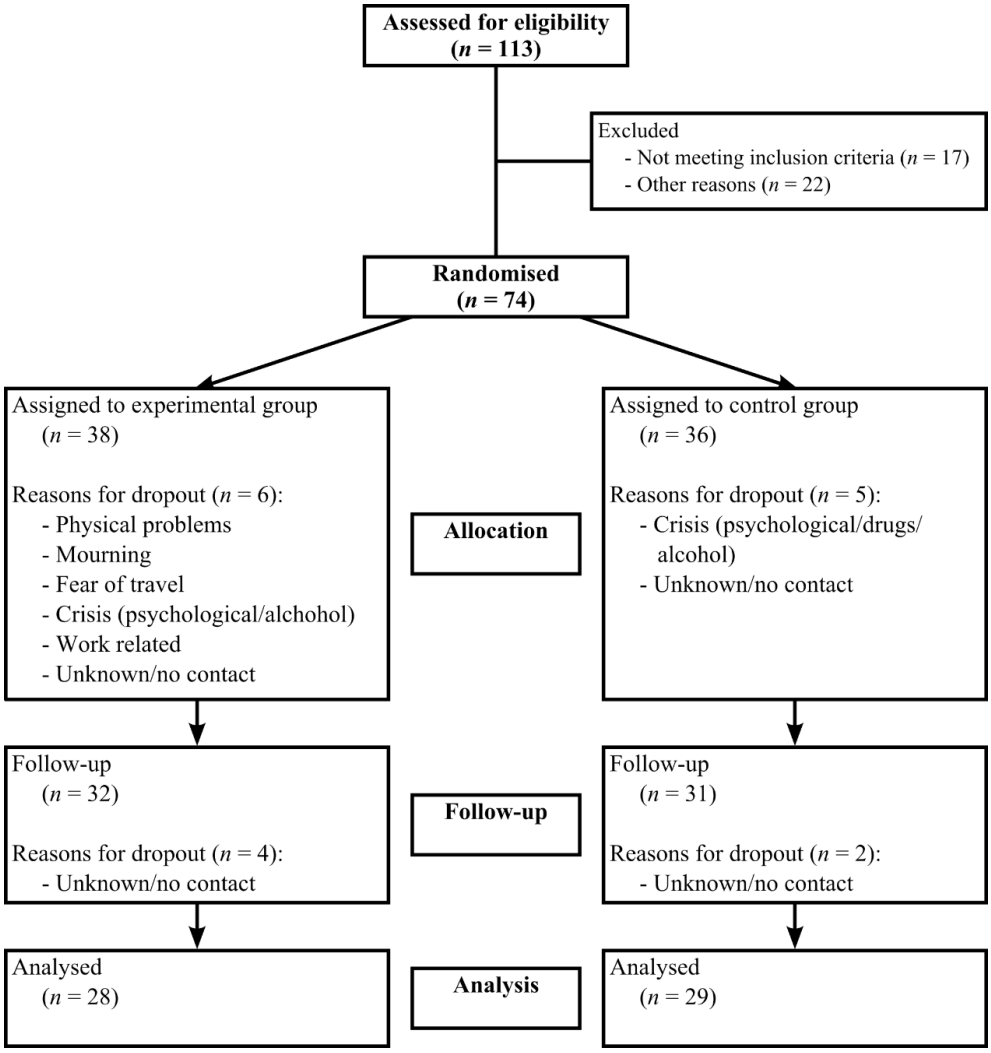

Figure 1. Patient flowchart.

Measures

Psychological flexibility is measured with the AAQ-II (Jacobs, Kleen, de Groot & A-Tjak, 2008). The AAQ-II consists of 10 items (e.g. "I'm afraid of my feelings" or "I am in control of my life") that are scored on a 7-point scale ranging from 1 (never true) to 7 (always true). The reliability of the Dutch version of the AAQ-II is good (Bond et al., 2011; Fledderus, Oude Voshaar, Ten Klooster & Bohlmeijer, 2012; Jacobs et al., 2008).

Global subjective mental functioning is measured with the Outcome Questionnaire 45 (OQ45; Lambert et al., 1996; De Jong et al., 2007). This questionnaire measures a total score and three sub domains: Symptom distress, Interpersonal relations, and Social role. The OQ45 consists of 45 items (e.g. "I get along well with others" or "I blame myself for things") that are scored on a 5-point scale ranging from 0 (never) to 4 (always). The reliability and validity for the Dutch version are good (De Jong & Nugter, 2004; De Jong et al., 2007).

The schema modes are measured with the Schema Mode Inventory (SMI version 1.1; Young et al., 2007), which are based on the Schema-Focussed Therapy for personality problems (Young, Klosko & Weishaar, 2003). The SMI measures 14 different schema modes. Each mode represents a state of mind that a patient may experience for a shorter or longer period, e.g. the vulnerable child, the raging child, the compliant surrender, the punitive parent and the healthy adult. The inventory contains 124 items (e.g. "I often feel alone in the world" or "I feel listened to, understood and validated") that are scored on a 6-point scale ranging from 0 (never or almost never) to 5 (always). The reliability of the Dutch version is good (Lobbestael, van Vreeswijk, Spinhoven, Schouten & Arntz, 2010).

The intervention: Art therapy

We designed a protocol for 10 weekly art therapy sessions (1.5 hours) in which the content of each session is described. This structured art therapy intervention protocol for patients with personality disorders can be requested at the first author. The intervention protocol consisted of specific art assignments extracted from the workbook 'Don't act out but live through' on art therapy for personality disorders (Haeyen, 2007) and were aimed at improving mindfulness, self-validation, emotion regulation skills, interpersonal functioning and insight and comprehension. The utilized art assignments concerned individual, duo and group assignments. Each session started with some minutes for tuning in and explaining the experiential assignment and the goals for the session. The sessions ended with discussion and reflection with the therapist together with the whole group, based on the art process and art product. This art therapy protocol made use of theoretical elements of Dialectical Behaviour Therapy (DBT) (Linehan, 1996), Schema-Focussed Therapy (SFT) (Young, 1994; Young, Klosko & Weishaar, 2003), Gestalt Art Therapy (Rhyne, 1970, 1973a, b), Creative Problem Solving (Osborn, 2011) and the Expressive Therapies Continuum (Hinz, 2009; Schweizer et al., 2009). The protocol was designed for an open group with a maximum of nine participants, meaning that participants could start at different times but always participated in a cycle of ten sessions and the number

of participants for each session varied. A senior art therapist and an art therapy student carried out the protocol.

Data analysis

Data were analysed with IBM SPSS 22 (IBM Corp., 2013). First, we evaluated the randomization by comparing the experimental and control group at the pre-test. Second, we evaluated whether dropout was random, by comparing (future) dropouts with completers at the pre-test. Finally, we tested whether art therapy is effective, using the general linear model (GLM) repeated measures procedure. In addition to the GLM, we also computed Cohen's *d* effect size to assess the effect of art therapy across time. Following Cohen (1988), effect sizes around .20 are small, effect sizes around .50 are medium, effects sizes around .80 are large and everything larger than 1.30 is very large.

RESULTS

Randomization

We compared demographic and clinical characteristics of the experimental and control group. The difference in age in the experimental group (M = 36.82, SD = 8.92) and the control group (M = 38.14, SD = 11.97) was not significant, $t(72) = -.54$, $p > .05$. The difference in gender distribution in the experimental group (71.1% women) and the control group (69.4% women) was not significant, X^2 (1, N = 74) = .54, $p > .05$. The descriptive statistics for the clinical characteristics are presented in Table 1. The main personality disorder diagnoses (in contrast to secondary diagnosis) have the same distribution in both groups, X^2 (6, N = 74) = .76, $p > .05$. The distribution of cluster B/C personality disorders is the same for both groups, X^2 (5, N =74) = .23, $p > .05$. The number of personality disorder diagnoses that patients have (one versus two or more) is not significantly different in both groups, X^2 (2, N =74) = .84, $p > .05$. And finally, the difference in OQ45 total scores was not significant, $t(72) = 2.10$, $p > .01$. There are no significant differences between the experimental and control group, which is an indication that the randomization has worked.

Table 1. Descriptive statistics for clinical characteristics at the pre-test.

	Experimental group (*n* = 38), %	**Control group (*n* = 36), %**
Paranoid Personality disorder	2.6	2.8
Narcissistic Personality disorder	2.6	0
Borderline Personality disorder	36.8	27.8
Obsessive Compulsive Personality disorder	10.5	8.3
Dependent Personality disorder	13.2	8.3
Avoidant Personality disorder	15.8	25.0
Unspecified Personality disorder	18.4	27.8
Cluster B	36.8	27.8
Cluster C	23.7	36.1
Cluster not otherwise specified	18.4	27.6
1 personality disorder	71.1	75.0
2 or more personality disorders	23.7	22.2

Drop out

Dropout must be analysed to make sure that the results of the GLM repeated measures are not an artifact of a special type of patient quitting the intervention. There are 17 (23%) patients who quitted and 57 (77%) who completed the intervention. We compared future dropouts with completers using observations from the pre-test. Dropouts did not significantly differ from completers on age [dropouts M = 40.35, SD = 10.03; completers M = 36.6, SD = 10.52, $t(72)$ = 1.31, p > .05], gender [dropouts 58.8% women, completers 73.7% women, X^2 (1, N = 74) = 1.38, p > .05], number of personality disorder diagnoses [dropouts 76.5% 1 personality disorder, 17.6% 2 personality disorders, completers 71.9% 1 personality disorder, 24.6% 2 personality disorders, X^2 (2, N =74) = .49, p > .05], the distribution of cluster B/C personality disorders [dropouts 41.2% B, 23.5% C, 17.6% Nos, completers 29.8% B, 31.6% C, 24.6% Nos, X^2 (5, N = 74) = 2.92, p > .05] and the OQ45 Total score [dropouts M = 84.41, SD = 16.73, completers M = 86.33, SD = 22.46, $t(72)$ = .33, p > .05]. These results indicate that dropout can be considered random and thus, will not bias the conclusions.

Repeated measures analyses

We analysed the following outcome measures, AAQ-II, OQ45 and the SMI, as well as three sub dimensions of the OQ45 and 14 modes of the SMI. The means and standard deviations of all outcomes are presented in Table 2. Overall, the change in the means indicate that patients improve during treatment; however, patients on the waiting list deteriorate over time on most outcomes.

Table 2. Means and standard deviation (in parentheses) of the outcomes across time.

	Experimental group (*n* = 28)			Control group (*n* = 29)		
	Pre-test	**Post-test**	**Follow-up**	**Pre-test**	**Post-test**	**Follow-up**
AAQ-II						
Total	30.5 (9.5)	41.61 (4.8)	40.57 (7.34)	35.4 (8.45)	43.52 (3.81)	30.93 (7.16)
OQ45						
Total	91.52 (23.61)	67.74 (18.39)	67.52 (19.61)	81.86 (20.99)	90.34 (17.96)	93.28 (18.11)
Symptom Distress	54.36 (16.13)	38.86 (12.49)	38.54 (13.38)	50.45 (13.98)	54.79 (13.35)	56.27 (13.33)
Interpersonal Relations	20.67 (6.72)	15.85 (4.78)	15.93 (5.09)	19.03 (6.61)	21.48 (5.12)	22.59 (5.55)
Social Role	17.61 (3.84)	13.68 (3.84)	13.75 (3.80)	14.07 (5.48)	15.93 (5.06)	16.24 (5.01)
SMI maladaptive modes						
Vulnerable Child	3.78 (.98)	2.81 (.79)	2.85 (.85)	3.20 (.96)	3.37 (.94)	3.45 (.93)
Angry Child	3.25 (.82)	2.68 (.64)	2.71 (.62)	2.93 (1.09)	3.18 (1.06)	3.21 (1.07)
Enraged Child	1.84 (.65)	1.48 (.51)	1.48 (.51)	1.59 (.53)	1.75 (.70)	1.77 (.71)
Impulsive Child	3.06 (.85)	2.15 (.58)	2.12 (.55)	2.45 (.72)	2.72 (.71)	2.85 (.75)
Undisciplined Child	3.13 (.89)	2.92 (.86)	2.90 (.82)	2.86 (.80)	2.97 (.77)	3.02 (.74)
Compliant Surrender	3.57 (.75)	2.93 (.72)	2.93 (.71)	3.14 (.97)	3.47 (.86)	3.56 (.90)
Detached Protector	3.07 (.85)	2.21 (.63)	2.24 (.61)	2.83 (.90)	3.06 (.97)	3.18 (.97)
Detached Self-Soother	3.62 (.94)	2.95 (.70)	2.97 (.72)	3.17 (.97)	3.52 (1.00)	3.60 (.99)
Self-Aggrandizer	2.89 (.76)	2.42 (.66)	2.37 (.63)	2.39 (.66)	2.57 (.77)	2.64 (.75)
Bully and Attack	1.99 (.65)	1.77 (.42)	1.75 (.41)	1.77 (.51)	1.91 (.52)	1.91 (.52)
Punitive Parent	2.81 (.84)	2.08 (.61)	2.07 (.63)	2.48 (.77)	2.70 (.78)	2.77 (.83)
Demanding Parent	4.19 (.89)	3.63 (.78)	3.61 (.78)	3.46 (.86)	3.72 (.85)	3.75 (.81)
SMI adaptive modes						
Happy Child	2.75 (.84)	3.64 (.67)	3.63 (.69)	3.07 (.93)	2.78 (.77)	2.69 (.73)
Healthy Adult	3.61 (.65)	4.33 (.57)	4.29 (.58)	3.77 (.80)	3.47 (.67)	3.39 (.67)

To test whether there is an effect of art therapy, we have analysed the data with GLM repeated measures. Time is the within subject variable (pre-test, post-test, follow-up) and Group is the between subject variable (Art therapy, Waiting list). The results of the GLM are presented in Table 3; degrees of freedom were adjusted if the Mauchly's test indicated that the assumption of sphericity had been violated. Table 3 also contains the standardized mean differences (SMD); however, they were computed in a separate analysis. The effect of time is significant for AAQ-II-Total score, $F(1.2, 64.4) = 11.09$, $p < .001$, OQ45-Total score, $F(1.3, 69.2) = 12.18$, $p < .001$, OQ45-Symptom Distress, $F(1.3, 71.4) = 18.88$, $p < .001$], OQ45-Social Role, $F(1.6, 86.2) = 3.63$, $p < .05$, SMI-Vulnerable Child, $F(1.3, 76.8) = 30.25$, $p < .001$, SMI-Angry Child, $F(1.3, 69.4) = 6.50$, $p < .05$, SMI-Enraged Child, $F(1.1, 61.0) = 5.20$, $p < .05$, SMI-Impulsive Child, $F(1.2, 66.4) = 16.71$, $p < .001$, SMI-Compliant Surrender, $F(1.2, 64.0) = 3.78$, $p < .05$, SMI-Detached Protector, $F(1.2, 64.6) = 20.39$, $p < .001$, SMI-Self-Aggrandizer, $F(1.2, 64.2) = 6.93$, $p < .01$, SMI-Punitive Parent, $F(1.2, 64.2) = 16.12$, $p < .001$, SMI-Demanding Parent, $F(1.2, 63.6) = 4.44$, $p < .05$, SMI-Happy Child, $F(1.2, 64.1) = 18.09$, $p < .001$ and SMI-Healthy Adult, $F(1.5, 80.6) = 11.17$, $p < .001$. The overall effect of Group is not as omnipresent; there is a significant effect of Group on the AAQ-II-Total, $F(1, 55) = 5.35$, $p < .05$, OQ45-Total, $F(1, 54) = 6.78$, $p < .05$, OQ45-Symptom Distress, $F(1, 55) = 8.15$, $p < .01$, OQ45-Interpersonal Relations, $F(1, 55) = 6.38$, $p < .05$, SMI-Detached Protector, $F(1, 55) = 5.92$, $p < .05$, SMI-Happy Child, $F(1, 55) = 6.26$, $p < .05$ and SMI-Healthy Adult, $F(1, 55) = 10.18$, $p < .01$. We are interested mostly, however, in the effect of the interaction between Time and Group. The effect of Time and Group is significant for all outcome measures: AAQ-II, $F(1.2) = 71.63$, $p < .001$, OQ45-total, $F(1.3) = 70.22$, $p < .001$, OQ45-Symptom distress, $F(1.3) = 72.42$, $p < .001$, OQ45-Interpersonal Relations, $F(1.2) = 41.50$, $p < .001$, OQ45-Social Role, $F(1.6) = 34.97$, $p < .001$, SMI-Vulnerable Child, $F(1.3) = 74.90$, $p < .001$, SMI-Angry Child, $F(1.3) = 47.18$, $p < .001$, SMI-Enraged Child, $F(1.1) = 39.41$, $p < .001$, SMI-Impulsive Child, $F(1.2) = 77.80$, $p < .001$, SMI-Undisciplined Child, $F(1.4) = 8.98$, $p < .01$, SMI-Compliant Surrender, $F(1.2) = 53.04$, $p < .001$, SMI-Detached Protector, $F(1.2, 64.6) = 81.34$, $p < .001$, SMI-Detached Self-Soother, $F(1.2) = 41.47$, $p < .001$, SMI-Self-Aggrandizer, $F(1.2) = 43.76$, $p < .001$, SMI-Bully and Attack, $F(1.2) = 23.54$, $p < .001$, SMI-Punitive Parent, $F(1.2, 64.2) = 67.60$, $p < .001$, SMI-Demanding Parent, $F(1.2) = 37.66$, $p < .001$, SMI-Happy Child, $F(1.2) = 89.82$, $p < .001$ and SMI-Healthy Adult, $F(1.5) = 85.46$, $p < .001$. To understand the interaction, we inspect the development of the means of the outcome variables in Table 2. The patients in the experimental group improve from the pre-test to the post-test, and they remain stable from post-test to follow-up. This pattern is about the same for all outcome variables. For the patients in the control group, the pattern is not the same for all outcome variables: sometimes patients deteriorate between pre-test and post-test, and sometimes they improve. Between the post-test and follow-up, the pattern is again the same for all patients: they deteriorate. If we ignore the post-test to simplify the interpretation, then patients in the experimental group improve over time, while patients in the control group deteriorate.

Effect sizes

To get an idea about the magnitude of the effect of the art therapy across time, we computed the change of the effect size (Δd) between the effect size at the post-test and the effect size at the pre-test. All effect sizes are SMDs (Lipsey & Wilson, 2001). Table 3 shows all the effect sizes between the experimental and control group at the pre-test, as well as at the post-test. Cohen's *d* at the pre-test should be small for all outcome variables, because of the randomization. However, the patients in the control group have better scores than patients in the experimental group. At the post-test, the situation is reversed; moreover, for all outcome variables, the effects are larger. The change in the Cohen's *d*, an indication of the effect of art therapy across time, is small to medium for the following outcome variables: AAQ-II-total (Δd = .11), SMI-Undisciplined Child (Δd = -.38) and SMI-Bully and Attack (Δd = -.68). The change in Cohen's *d* is very large for the OQ45-total score (Δd = -1.67) and its subscales OQ45-Symptom distress (Δd = -1.94), OQ45-Interpersonal relations (Δd = -1.39) and OQ45-Social Role (Δd = -1.25). The effect of art therapy on the adaptive schema modes is large to very large: SMI-Vulnerable Child (Δd = -1.24), SMI-Angry Child (Δd = -.90), SMI-Enraged Child (Δd = -.86), SMI-Impulsive Child (Δd = -1.66), SMI-Compliant Surrender (Δd = -1.18), SMI-Detached Protector (Δd = -1.31), SMI-Detached Self-Soother (Δd = -.82), SMI-Self-Aggrandizer (Δd = -.91), SMI-Punitive Parent (Δd = -1.29) and SMI-Demanding Parent (Δd = -.94). The effect of art therapy on the maladaptive modes is, as expected, in the opposite direction: SMI-Happy Child mode (Δd = 1.55) and SMI-Healthy Adult (Δd = 1.60).

Table 3. Results of the GLM repeated measures analyses and Cohen's d effect sizes.

	Time		Time*Group		Group		Cohen's *d*[a]		
	F	**(df1, df2)**	**F**	**(df1, df2)**	**F**	**(df1, df2)**	***d* (95% CI). Pre-test**	***d* (95% CI) Post-test**	***Δd***
AAQ-II									
Total score[b]	11.09***	(1.2, 64.4)	71.63***	(1.2, 64.4)	5.35*	(1, 55)	-.55 (-1.07, -.02)	-0.44 (-.97, .08)	.11
OQ45									
Total score[c]	12.18***	(1.3, 69.2)	70.22***	(1.3, 69.2)	6.78*	(1, 54)	.43 (-.90, .96)	-1.24 (-1.81, -.68)	-1.67
Symptom Distress[c]	18.88***	(1.3, 71.4)	72.42***	(1.3, 71.4)	8.15**	(1, 55)	.26 (-.26, .78)	-1.23 (-1.80, -.67)	-1.94
Interpersonal Relations[c]	2.84	(1.2, 67.1)	41.50***	(1.2, 67.1)	6.38*	(1, 55)	.25 (-.28, .77)	-1.14 (-1.70, -.58)	-1.39
Social Role[b]	3.63*	(1.6, 86.2)	34.97***	(1.6, 86.2)	.13	(1, 55)	.75 (.21, 1.28)	-0.50 (-1.03, .03)	-1.25
SMI maladaptive modes									
Vulnerable Child[c]	30.25***	(1.3, 76.8)	74.90***	(1.3, 76.8)	.69	(1, 55)	.60 (.07, 1.13)	-0.64 (-1.18, -.11)	-1.24
Angry Child[c]	6.50*	(1.3, 69.4)	47.18***	(1.3, 69.4)	.94	(1, 55)	.33(-.19, .85)	-0.57 (-1.10, -.04)	-.90
Enraged Child[c]	5.20*	(1.1, 61.0)	39.41***	(1.1, 61.0)	.44	(1, 55)	.42 (-.10, .95)	-0.44 (-.97, .09)	-.86
Impulsive Child[c]	16.71***	(1.2, 66.4)	77.80***	(1.2, 66.4)	1.80	(1, 55)	.78 (.24, 1.31)	-0.88 (-1.42, -.33)	-1.66
Undisciplined Child[c]	.51	(1.4, 75.7)	8.98**	(1.4, 75.7)	.03	(1, 55)	.32 (-.20, .84)	-0.06 (-.58, .46)	-.38
Compliant Surrender[c]	3.78*	(1.2, 64.0)	53.04***	(1.2, 64.0)	1.41	(1, 55)	.50 (-.03, 1.02)	-0.68 (-1.21, -.15)	-1.18
Detached Protector[c]	20.39***	(1.2, 64.6)	81.34***	(1.2, 64.6)	5.92*	(1, 55)	.27 (-.25, .80)	-1.04 (-1.59, -.48)	-1.31
Detached Self-Soother[c]	3.10	(1.2, 63.9)	41.47***	(1.2, 63.9)	1.25	(1, 55)	.47 (-.06, 1.00)	-0.35 (-.87, .18)	-.82
Self-Aggrandizer[c]	6.93**	(1.2, 64.2)	43.76***	(1.2, 64.2)	.02	(1, 55)	.70 (.17, 1.24)	-0.21 (-.73, .31)	-.91
Bully and Attack[c]	1.63	(1.2, 65.9)	23.54***	(1.2, 65.9)	.06	(1, 55)	.38 (-.15, .90)	-0.30 (-.82, .23)	-.68
Punitive Parent[c]	16.12***	(1.2, 64.2)	67.60***	(1.2, 64.2)	2.98	(1, 55)	.41 (-.12, .94)	-0.88 (-1.43, -.34)	-1.29
Demanding Parent[c]	4.44*	(1.2, 63.6)	37.66***	(1.2, 63.6)	.59	(1, 55)	.83 (.29, 1.38)	-0.11 (-.63, .41)	-.94
SMI adaptive modes									
Happy Child[c]	18.09***	(1.2, 64.1)	89.82***[(a)]	(1.2, 64.1)	6.26*	(1, 55)	-.36 (-.88, .16)	1.19 (.63, 1.75)	1.55
Healthy Adult[c]	11.17***	(1.5, 80.6)	85.46***[(a)]	(1.5, 80.6)	10.18**	(1, 55)	-.22 (-.74, .30)	1.38 (.80, 1.96)	1.60

* $p < .05$, ** $p < .01$, *** $p < .001$.

[a] This is a standardized mean difference (SMD) effect size, computed with David Wilson's web-based effect-size calculator (https://www.campbellcollaboration.org/escalc/html/EffectSizeCalculator-Formulas.php).

[b] Sphericity rejected, used Huynh–Feldt correction.

[c] Sphericity rejected, used Greenhouse–Geisser correction.

DISCUSSION

This efficacy trial has shown that art therapy effectively reduces pathology of personality disorders cluster B/C and general mental health symptomatology. The presence of early maladaptive schema modes typical for personality disorders has decreased (less impulsivity, detachment, vulnerability and punitive behaviour) and adaptive modes have strengthened (pleasant feeling and self-regulation). In addition, unpleasant inner experiences, such as thoughts, feelings and physical sensations are more easily accepted.

To what degree are our results in line with other comparable outcome studies? An unambiguous answer is difficult, because studies differ concerning patient population, kind of treatment and design. We first compare our results with studies with exactly the same target group, i.e. the same specific population of cluster B/C patients and comparable outpatient psychological treatment programs with the same duration (3 months) and the same intensity of weekly sessions. Horn at al. (2015) have found medium effect sizes on general psychiatric symptomatology with short-term inpatient psychotherapy based on Transactional Analysis, compared with a control group (non-randomised) consisting of 'other psychotherapies.' Van Vreeswijk, Spinhoven, Eurelings-Bontekoe & Broersen (2014) studied a short-term group schema cognitive-behavioural therapy and Renner et al. (2013) studied a short-term Schema Cognitive Behavioural Group Therapy; both report medium to large effect sizes using a pre–post-test design with only an intervention group (no control). In comparison with these studies, our results are at least equal but most of the time even higher. This is remarkable, given our more demanding design. In our second comparison group, studies are included with the same RCT design but a more restricted group of patients with a Borderline personality disorder (BPD). Stoffers et al. (2012) report two RCTs fitting our criteria (3 months, weekly sessions), the first on DBT skills training (Soler et al., 2009) and the second on Emotion Regulation Group Training (Gratz & Gunderson, 2006), both with 'treatment as usual' (TAU) as control group. In these studies, the effect sizes on total BPD symptom severity are large to very large results. Finally, a third study, an RCT with psycho-education compared with a waiting list condition (Zanarini & Frankenburg, 2008), has showed only small to medium effects. Taken together, we conclude that our findings are worthwhile and underpin the potential of art therapy as an effective treatment option (e.g. Van den Broek, Keulen-de Vos & Bernstein, 2011).

How to explain these remarkable effects of art therapy? Literature provides us with a number of possible explanations of this value of art therapy. Frequently mentioned are its experiential character and its focus on emotions (positive as well as negative). In art therapy, the experience of art materials and art-making appeal to bodily sensations and emotional responses, using imagination (Haeyen et al., 2015; Pénzes, van Hooren, Dokter, Smeijsters & Hutschemaekers, 2015; Schweizer et al., 2009). The experience takes place in the here-and-now, which strengthens awareness. The results of the present study show that experiential and emotional processes are addressed in art therapy with effect on a wide range of schema modes

and on reduction of the phenomenon 'experiential avoidance' (Hayes, Wilson, Gifford, Follette & Strosahl, 1996). The focus on emotions (positive as well as negative) can be especially suitable for personality disorder patients, because they tend to avoid emotional experiences and may have missed experiencing joy and play as key ingredients of their childhood (Lockwood & Shaw, 2012). Furthermore, art therapy is developed as a bottom-up strategy for emotion regulation, starting with experiences through actions using mental images, and then aimed at behaviour change and insight. In contrast, verbal therapy often has a complementary top-down strategy, by starting with cognitions to get a grip on emotional experiences. Mental images, increasingly regarded as central in the development and maintenance of different psychological disorders, could be targeted using experiential strategies to change negative emotions related with aversive childhood memories (Brewin, Gregory, Lipton & Burgess, 2010).

Art therapy has a possible differential effect in multidisciplinary treatment programs. The argument for the use of art therapy or other experiential therapies in multidisciplinary programs is often that these therapies are perceived as better entrances for many patients to explore their dysfunctional patterns compared with the more cognitive verbal therapies (Horn et al., 2015). In most current multidisciplinary treatment programs for personality disorder patients, verbal therapies and arts therapies are integrated and based on recent psychotherapeutic personality disorder intervention theories but without an explicit causal evidence base (Haeyen, 2007, 2015; Heckwolf, Bergland & Mouratidis, 2014; Horn et al., 2015; Springham et al., 2012; Van den Broek et al., 2011; Van Vreeswijk, Broersen, Bloo & Haeyen, 2012; Verfaille, 2016). Nowadays, experiential techniques are also more incorporated in cognitive behavioural therapies (e.g. Schema Therapy, Acceptance and Commitment Therapy and Compassion Focussed Therapy) but mainly in a supplementary way to a base of verbal interventions, while in art therapy, these experiential techniques are central. According to Arntz (2011, 2012) these techniques hold promise for modifying mental images but still need to undergo systematic empirical evaluation to test their effectiveness and to unravel underlying mechanisms of change.

Given the large effect sizes, it is important to keep in mind the limitations of this study. An important limitation could be the nature of the control. First of all, the control group was a waiting list group receiving no intervention. Therefore, effects in the experimental group could be due to non-specific therapeutic factors. Second, patients on the waiting list had to wait quite a long time (between five to seven months) and this may have affected the decrease of outcomes over time in this group. However, this is the first RCT that we know of on art therapy in patients with personality disorders; thus, in the design we used, we wanted to examine efficacy of this intervention, with specific as well as non-specific factors within. It would be an interesting next step to compare TAU with and without art therapy. Despite this limitation, to our knowledge, this is the first study to report on the results of art therapy in terms of improvement by using measures of symptom severity and demographic and clinical

characteristics of patients, and the findings are largely consistent with the studies as referred to earlier on short-term treatments for this population.

A second limitation is that the group of respondents may be selective in terms of motivation/willingness and treatment access and that this might have colored the results to some extent. Generalization to the wider population of personality disordered patients should be handled with caution. RCTs are generally criticized for their limited external validity because of the strictly controlled or experimental circumstances (e.g. Hodgson, Bushe & Hunter, 2007), and for this reason, they can overestimate an intervention's effect when implemented in clinical practice (Singal, Higgins & Waljee, 2014). Hence, we recommend effectiveness research on art therapy in everyday clinical practice to investigate whether the effects we found can be confirmed. This could be complicated because of the complexity to isolate art therapy results. A third limitation is that we used a rather short follow-up period (five weeks post intervention) due to logistic and ethical reasons; a longer follow-up would imply longer waiting time to start regular treatment.

A strength of the present study is that it is carried out among the intended target group. Demographic analysis showed that there were no significant differences between basic aspects of participants who dropped out and those who completed the protocol. Therefore we can assume that the results were not interfered by differences between the two groups.

This study showed some overall effects for personality disorder patients cluster B/C, but it would be interesting to distinguish which patients would benefit most. Future research should investigate for whom this treatment form best complements or is most needed. Based on the results of the SMI in the present study, personality disorder patients who are vulnerable, emotionally detached and self-critical could possibly benefit most.

CONCLUSION

Art therapy for personality disorder patients cluster B/C is effective. Art therapy not only decreases symptoms of psychopathology of personality disorders, maladaptive schema modes and experiential avoidance but also increases mental health functioning on positive measures on acceptation and adaptive schema modes; this means a more optimal personal performance, increased autonomy and self-acceptance. Compared with studies on other interventions with the same duration and intensity on the same population, we found effect sizes in the same, or higher range in the present study on this art therapy intervention. The value of art therapy could be the experiential character, the here-and-now awareness and the addressed emotional process (positive as well as negative). There is still a considerable need for research on art therapy. It would be interesting to replicate and validate current findings in everyday clinical practice and to examine which patients would benefit most from art therapy.

CHAPTER 6.

Promoting Mental Health versus Reducing Mental Illness in Art Therapy with Patients with Personality Disorders

A Quantitative Study

Haeyen, S., Van Hooren, S., Van der veld, W., & Hutschemaekers, G. (2017c). Promoting Mental Health versus Reducing Mental Illness in Art Therapy with Patients with Personality Disorders. A Quantitative Study. *The Arts in Psychotherapy*. doi: 10.1016/j.aip.2017.12.009

ABSTRACT

The distinction between mental health and mental illness has long been the subject of debate, especially in the last decade where there has been a shift in focus in mental health care from symptom reduction to the improvement of positive mental health. Art therapists have been influenced by this shift and in this study, we investigate: (1) whether art therapy improves mental health and/or reduces mental illness; and (2) what the relationship is between mental health and mental illness. We used secondary data (n = 74) from patients diagnosed with personality disorders from a pretest-posttest art therapy intervention, with 10 weeks in between the repeated measures. The indicators in the domains of mental health and mental illness we used were: symptom distress, flexibility, well-being, mindfulness, and schema modes. We used repeated measures ANOVA and effect sizes to examine the effects of art therapy and the Pearson correlation to examine the relationship between illness and health outcomes. Results indicated significant effects of art therapy in both domains. Furthermore, after creation of a single mental health and a mental illness score we found that the correlation between them was high. We conclude that art therapy both promotes mental health and reduces mental illness. The large correlation between these domains in patients with personality disorders suggests that we might be dealing with two sides of the same coin.

INTRODUCTION

Current evidence based approaches to mental health care focus almost exclusively on the reduction of mental illness symptoms, i.e. on the disease model of mental disorders. The term *mental disorder* refers to syndromes that are characterized by clinically significant disturbances in an individual's cognition, emotion regulation, or behaviour, that reflect dysfunctions in the psychological, biological, or developmental processes underlying mental functioning (APA, 2013). Art therapists, as being part of mental health care have been influenced by this approach and have described their interventions in terms of reducing the particular symptoms of specific mental disorders (e.g. Gussak & Rosal, 2016; Malchiodi, 2015; Schweizer et al., 2009).

In recent years signs of a shift in focus in mental health care can also be observed, from symptom reduction to the improvement of positive mental health (Seligman & Csikszentmihalyi, 2000) and to the strengthening of psychological flexibility (Kashdan & Rottenberg, 2010). This change is advocated by positive psychology (Snyder & Lopez, 2007) and follows changes in the definition of health. In the early years health has been defined as the absence of disease. Subsequently, the World Health Organization (WHO) has extended the definition to: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006; 2016). Huber and colleagues (2011) have suggested changing this WHO definition of health as 'the ability to adapt and self-manage in the face of social, physical and emotional challenges'. In their opinion, using the word disease signals illness, whereas the ability to adapt with these challenges is related to resilience and positive health (Huber et al., 2011). In mental health care practice, we see a comparable shift from symptom reduction to a recovery approach that emphasizes and supports a person's potential for recovery. This view is transdiagnostic in nature in that it appreciates mental problems outside the conceptual structure of diagnostic categories (APA, 2013). Many art therapists have embraced this change in focus of mental health care, because it reflects much better the major objectives of art therapy, i.e. improving or restoring a patient's optimal functioning and his or her sense of personal well-being on emotional, social and psychological levels (AATA [American Art Therapy Association], 2017). Aspects of psychological strength addressed in art therapy include: resilience, flexibility, adaptation, coping, personal efficacy, well-being, positive experiences, and living a meaningful life (e.g. Arts Council England, 2007; Chilton, 2013; Czamanski-Cohen & Weihs, 2016; Gussak & Rosal, 2016; Leckey, 2011; Malchiodi, 2015; Schnetz, 2005; Springham, Findlay, Woods, & Harris, 2012; Taylor, Fletcher, & Lobban, 2015; Wilkinson & Chilton, 2013).

The upcoming shift in focus in mental health care, from the disease model of mental disorders towards a transdiagnostic model, is built on the idea that mental illness and positive mental health are two distinct but related domains of personal functioning (e.g. Westerhof & Keyes, 2010). A person exhibiting (somatic or psychiatric) pathology is quite often capable of living a fruitful and happy life. Thus, pathology does not necessarily imply poor well-being/positive mental health. And, reversely, languish and struggle in life may occur despite absence

of mental disorders. The distinction between both domains well-being is based on studies with healthy populations (Westerhof & Keyes, 2010) . At the same time researchers argue that these two dimensions are not completely independent from each other; people with low well-being are more at risk to develop illness than people with high levels of well-being (Lamers, Westerhof, Glas, & Bohlmeijer, 2011; Wahlbeck, 2015). Studies on patient populations in mental health care are more hesitant about in the assumed a distinction between mental illness and mental health and even question the empirical evidence between mental health and illness (Lukat, Margraf, Lutz, Van der Veld, & Becker, 2016; Van Erp Taalman Kip & Hutschemaekers, 2017). Studies like these suggest that the dimensions of mental illness and mental health should be considered as a metaphor, mainly stressing different aspects of one and the same notion of health.

To what degree are effects of art therapy better described in terms of positive experiences with a focus on resilience, well-being or flexibility, than in terms of complaint reduction as prescribed by the disease model of mental disorders (e.g. Gussak & Rosal, 2016; Malchiodi, 2015; Schweizer et al., 2009)? The first aim of this study is to investigate whether the effects of art therapy are in the domain of mental illness, of positive mental health, or in both domains. The second aim is to study the relationship between mental health and mental illness. We examine these questions using data from a randomised controlled trial, which has been originally designed to evaluate the efficacy of art therapy in the treatment of personality disorders. In the present study we will use these data to better understand the benefits of art therapy and to contribute to the discussion of the nature of its effects in relation to the concepts of mental illness and positive mental health.

METHOD

Participants and procedure

This study used secondary data from a randomised controlled trial (RCT) conducted by Haeyen, Van Hooren, Van der Veld, and Hutschemaekers (2017b). In that trial, the effects of art therapy in patients diagnosed with personality disorders were investigated. The trial was registered and approved by the Medical Ethical Committee of the Radboud University Nijmegen, the Netherlands (CCMO register: NL44394.091.13 and Dutch Trial Register: NTR3925, same as the ISRCT or NCT number). For a full description of the RCT's design and procedure, see Haeyen, Van Hooren, Van der Veld, and Hutschemaekers (2017b).

Participants were recruited from a waiting list of patients indicated for treatment in an outpatient specialized treatment unit for personality disorders. Inclusion criteria were age (18+ years), IQ >80, adequate mastery of the Dutch language and a primary diagnosis of at least one Axis II Personality Disorder cluster B and/or C, or a personality disorder not otherwise specified (APA, 2013) as determined with SCID-II. Exclusion criteria were: acute crisis,

psychosis, actual and serious suicidal behaviour and/or thought, and severe brain pathology. After signing informed consent forms, 74 participants were randomly assigned to the weekly art therapy group (1.5 hours, 10 weeks) or the waiting list group.

The 10-week art therapy program consisted of a structured art therapy intervention protocol for patients with personality disorders. The principles of intervention mapping were applied to construct this program that was tailored to the needs of the target group (Haeyen, Van Hooren, Dehue, & Hutschemaekers, 2017). The protocol described the generic structure, the content of the sessions, the qualifications and therapeutic style of the art therapist, and the context including support for the therapist. The protocol consisted of assignments aimed at improving mindfulness, self-validation, emotion regulation skills, interpersonal functioning and insight and comprehension. The assignments were extracted from the workbook *Don't Act Out, but Live Through* (Haeyen, 2007). Examples of art assignments are: (a) Make a *"Clay monster"* as horrible as possible, as a symbolization of anger, also using other supplementary materials. This assignment focuses on exploration, regulation, and integration of this emotion. The monster is a kind of self-image that represents a part or polarity of the person that is often avoided. Or (b) make a "helping symbol" for a feature or skill to develop and stimulate an opposite action to painful, negative thoughts and emotions. This symbol is made on a laminated "flash card," which serves as a transfer tool, to be taken home as a reminder for the helping feature or skill, which is visual, tangible, and present outside the therapy setting. Other assignments are also in duo or group interaction.

The protocol was designed for an open group with a maximum of nine participants, meaning that participants could start at different times but always participated in a 10-session cycle and the number of participants for each session varied. Participants (N = 74) were on average 37.48 years old (SD = 10.45) and the majority (70.3%) were female. The most prevalent personality disorders were: borderline personality disorder (32.3%), avoidant personality disorder (20.4%) and unspecified personality disorder (23.1%).

Eleven patients dropped out between the pre-test and post-test: six from the experimental group and five from the control group. Reasons for drop out were psychological problems, mourning, fear of travel, crisis (psychological/alcohol), work-related problems and unknown (no contact). Post-test measures of the drop-outs were not available. However, in a drop-out analysis of pre-test measures, we did not find any significant differences between the groups' demographic and diagnostic characteristics.

Measures

To examine the effects of art therapy on mental health and mental illness, we used scales that are often used to operationalize mental health and mental illness. To measure mental health, we used the following indicators: the Acceptance and Action Questionnaire-II (Jacobs, Kleen, De Groot, & A-Tjak, 2008), the Dutch Mental Health Continuum-Short Form (Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011), the Mindful Attention Awareness Scale

(Schroevers, Nyklícek, & Topman, 2008) and the adaptive scales of the Schema Mode Inventory (Young et al., 2007). To measure mental illness, we used the following indicators: the symptom distress subscale and interpersonal relations subscales of the OQ45 (De Jong et al., 2007; Lambert et al., 1996), and the maladaptive scales of the Schema Mode Inventory (Young et al., 2007).

The Acceptance and Action Questionnaire (AAQ-II) measures the experiential avoidance, the opposite of acceptance and psychological flexibility. The AAQ-II consists of 10 items (e.g. "I'm afraid of my feelings" or "I am in control of my life") that are scored on a 7-point scale ranging from 1 (never true) to 7 (always true). The reliability of the Dutch version of the AAQ-II is good (Bond et al., 2011; Fledderus, Oude Voshaar, Ten Klooster & Bohlmeijer, 2012; Jacobs et al., 2008).

The Mental Health Continuum - Short Form (MHC-SF) measures emotional, social, and psychological well-being. The scale consists of 14 items (e.g., "During the past month, how often did you feel happy?" or "During the past month, how often did you feel that you had experiences that challenged you to grow and become a better person?") that are scored on a 6-point scale ranging from never (0) to every day (5). Emotional well-being is about satisfaction and positive feelings like happiness, interest and pleasure in life. Social well-being focuses on optimal functioning in society, such as social contribution and integration. Psychological well-being focuses on optimal personal performance and includes aspects such as autonomy and self-acceptance. The reliability of the MHC-SF is good (Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011).

The Mindful Attention and Awareness Scale (MAAS) measures receptive awareness of, and attention to, what is taking place in the present. The scale consists of 15-items, e.g. "I notice that I do things without paying attention", and "I find it difficult to stay focused on what's happening in the present". The items are scored on a 6-point scale ranging from almost always (1) to almost never (6). The test's reliability and validity are good (Brown & Ryan, 2003; Carlson & Brown, 2005).

The Outcome Questionnaire 45 (OQ45) measures global subjective mental functioning. This questionnaire contains three sub domain scores: 'Symptom distress,' 'Interpersonal relations' and 'Social role.' It consists of 45 items ("I get along well with others" or "I blame myself for things") that are scored on a 5-point scale ranging from 0 (never) to 4 (almost always). The reliability and validity for the Dutch version are good (De Jong & Nugter, 2004; De Jong et al., 2007). We excluded the 'social role' subscale because of less convincing internal consistency; disappointing values for Cronbach's alpha were found in the university, community and clinical samples (De Jong et al., 2007). In addition, social role functioning probably does not represent problematic behaviour (mental illness) in all items.

The Schema Mode Inventory (SMI version 1), measures 14 states of mind (modes) divided in two categories: adaptive and maladaptive schema modes, that a patient may experience for a shorter or longer period, e.g. the vulnerable child, the raging child, the

compliant surrender, the punitive parent and the healthy adult. The inventory contains of 124 items (e.g. "I often feel alone in the world" or "I feel listened to, understood and validated") that are scored on a 6-point scale ranging from 0 (never or almost never) to 5 (always). The reliability of the Dutch version is good (Lobbestael, van Vreeswijk, Spinhoven, Schouten & Arntz, 2010).

Statistical analysis

All data were analysed with SPSS 22 (IBM Corp, 2013). To examine the effect of art therapy in the domains mental health and mental illness, we used Repeated Measures ANOVA. In addition, we also calculated effect sizes (Cohen's *d*) to be able to compare the effects of art therapy. Effect sizes were calculated using David Wilson's web-based effect size calculator (Lipsey & Wilson, 2001). We were interested in the effect of art therapy on outcomes (not whether art therapy worked or not), therefore we analysed the pre- and post-test scores of the experimental group in the RCT (n = 32).

To examine the relationship between mental health and mental illness, we estimated the Pearson correlation between their factor scores. The factor scores were created by performing a principal component analysis (PCA) on the indicators of mental health and mental illness. In order to have a large enough sample size for the PCA, we used the pre-test data (not post-test data) and we included the control group; hence the sample size for this analysis was 74. We used the Kaiser rule (EV > 1) to determine the number of factors, and factor scores were estimated using the regression method.

RESULTS

We tested whether art therapy improved positive mental health and/or reduced symptoms of mental illness (see Table 1). We found that all indicators changed significantly over time, indicating that art therapy had an effect in both of the domains of mental health and mental illness. The effect of art therapy on the indicators of mental health ranged between d = .52 for the MHC-SF SW and d = 1.46 for the AAQ-II. For mental illness, the effect sizes ranged between d = -.82 for the OQ45 IR and d = -1.32 for the SMI maladaptive modes. The average effect of art therapy on indicators of mental health was d = 1.06 and on indicators of mental illness it was d = -1.09. Both were considered as large effect sizes and indicated that art therapy promoted mental health (mean d = 1.06) as well as reduced mental illness (mean d = -1.09).

Table 1. Results of the Repeated Measures ANOVA and the effect sizes (n = 32)

Indicators of	T1 Mean (SD)	T2 Mean (SD)	F	df	Sig.	Cohen's d^a
Mental health						
AAQ-II	30.44 (9.07)	40.03 (7.04)	60.00	1	.00	1.46
SMI adaptive scale	3.18 (.66)	3.98 (.56)	133.44	1	.00	1.31
MAAS	3.20 (.80)	4.14 (.69)	190.74	1	.00	1.26
MHC-SF EW	1.97 (1.13)	2.84 (.93)	52.25	1	.00	.84
MHC-SF SW	1.52 (.96)	1.99 (.86)	28.05	1	.00	.52
MHC-SF PW	1.86 (1.01)	2.78 (.85)	88.24	1	.00	.99
Mental illness						
OQ45 – SD	55.16 (15.48)	39.56 (11.84)	75.01	1	.00	-1.13
OQ45 – IR	20.67 (6.34)	16.13 (4.63)	27.83	1	.00	-.82
SMI maladaptive scale	3.09 (.47)	2.50 (.42)	109.85	1	.00	-1.32

AAQ-II = Acceptance and Action Questionnaire II; SMI = Schema Mode Inventory; MAAS = Mindfulness Attention Awareness Scale; MHC-SF = Mental Health Continuum – short form, EW = Emotional well-being, SW = Social well-being, PW = Psychological well-being; OQ45 = Outcome questionnaire 45, SD = Symptom distress, IR = interpersonal relations.

[a] This is a standardized mean difference effect size, computed with David Wilson's web-based effect size calculator (https://www.campbellcollaboration.org/escalc/html/EffectSizeCalculator-Formulas.php).

To examine the relationship between mental health and mental illness, we first performed a PCA on the indicators of mental health (MH). This resulted in one factor that explained 57.71% of the variance. The factor loadings varied from .55 to .89. A second PCA on the indicators of mental illness (MI) resulted in one factor that explained 77.08% of the variance. The factor loadings varied between .87 and .89. The strength of the relationship between mental health and mental illness was assessed by estimating the correlation between the two factors. The correlation between mental health and mental illness was significant and quite strong (r = -.75, p < .00). This result indicated that the empirical distinction between mental health and mental illness in this sample of personality disorder patients was poor at best.

DISCUSSION

The results of this investigation indicate that art therapy simultaneously reduces symptoms of mental illness and promotes positive mental health. Results show large to very large effects sizes for patients with personality disorders cluster B/C using an art therapy intervention protocol (Haeyen, Van Hooren, Dehue, & Hutschemaekers, 2017). As expected, art therapy is an effective treatment for ameliorating positive mental health, but it is also effective in reducing mental illness. Based on our findings, we conclude that art therapy effectively helps patients

with a personality disorders cluster B/C by decreasing symptoms of psychopathology and maladaptive schema modes, and at the same time by increasing positive mental health such as well-being, psychological flexibility, mindfulness and adaptive schema modes. These are eye-opening results. Art therapy-experts or other mental health care professionals often view the impact of art therapy to be mainly related to the domain of positive mental health. This view should be reconsidered. The effects of art therapy go beyond the scope of energizing, relaxing, or bringing relief on positive psychological aspects such as attention, autonomy, flexibility, social connection with others, emotional well-being, experiencing freedom, play and being self-directed. Art therapists should note that art therapy is also very effective in reducing specific symptoms of personality disorders.

One explanation of the working mechanisms of art therapy on *symptom reduction* of personality disorders is that art therapists focus on *emotion-regulation* problems of personality disorder patients using art therapy techniques for improving regulation of emotions, helping patients to express, explore and manage emotions. During this kind of art therapy intervention, patients may become aware of contradictory emotions and achieve dialectic emotional integration (Haeyen, 2007; Huckvale & Learmonth, 2009; Rubin, 2001). In addition, the use of experiential and imagining techniques in art therapy could provoke and transform experiences, feelings and mental states (e.g., vulnerability, loneliness, anger, impulsivity) in personality disorder patients (Haeyen, 2007, 2011; Keulen-de Vos, 2013; Van den Broek, Keulen-de Vos, & Bernstein, 2011). *Self-regulation* could be improved by working towards a more stable, positive self-image and to help explore, express and integrate conflicting sides of one-self. Art therapy techniques make these changes concrete and visible. *Enduring and inflexible patterns of cognitions, emotions and behaviours* characteristic of personality disorders could be recognized, and new feelings and behaviours challenged with the help of creating art. The process of art making could also help to defuse negative feelings and thoughts and allow patients to cope with them more effectively. Instead of regressive, inflexible and/or emotional impulsive behaviour, spontaneous and adult behaviour is encouraged (Schweizer et al., 2009; Van Vreeswijk, Broersen, Bloo, & Haeyen, 2012). *Interpersonal functioning* of personality disorder patients could be improved by art therapy interventions implicitly focusing on improving mentalizing skills. If so, art therapy might facilitate mentalization by giving meaning (to mentalize) through objects in the form of artwork (Bateman & Fonagy, 2006; Springham et al., 2012; Verfaille, 2016).

The simultaneous increase in positive mental health and decrease in symptoms of mental illness also might indicate that the distinction between both concepts is problematic. Our data do not support the assumption that the absence of symptoms is a prerequisite of well-being and positive health. Much stronger is the evidence for the hypothesis that health and illness are two sides of the same coin. Our results show a strong correlation between the two concepts suggesting that positive mental health and decreases in symptoms of mental illness are hard to distinguish empirically. These results are in contrast with the two continua-model

of Keyes (2005), in which the first continuum refers to well-being and the second to mental illness/(psycho)pathology and in which both states are relatively independent from one another (Keyes, 2005; Westerhof & Keyes, 2010). Our results are in line with recent findings from Van Erp Taalman Kip & Hutschemaekers (2017) that indicate at least very strong interdependences between well-being and psychopathology (see also: Bartels, Cacioppo, van Beijsterveldt, & Boomsma, 2013; Lukat, Margraf, Lutz, van der Veld, & Becker, 2016; Rogers, Hengartner, Angst, Ajdacic-Gross, & Rössler, 2014). Our data thus raises questions about the *theoretical* relevance of the concept of well-being in relation to psychopathology within the population of mental health patients.

In the case of personality disorders, the central symptoms are emotion regulation problems and emotional vulnerability with specific problems (e.g., pervasive patterns of instability in relationships, self-image, identity, behaviour) that affect impulsivity, attention-seeking behaviour and pervasive feelings of social inadequacy or rigidity. These central symptoms are not only characteristic of personality disorders, but they are also at the same time general adaptational and self-managerial problems, which could explain why interventions aimed at reducing psychopathology simultaneously increase well-being (Appelo & Bos, 2008; Vissers, Hutschemaekers, Keijsers, Van der Veld, & Hendriks, 2010). Based on our findings and those of others, psychopathology and mental health seem to be two sides of the same coin, not separate constructs.

Some limitations of this study need to be considered. First, we drew on data from our RCT which was not specifically designed to examine the concepts of mental health and mental illness. Second, the number of respondents was relatively small for the performed analyses. However, in the initial phase of the RCT a power analyses was performed that indicated that 28 patients in each group would ensure sufficient statistical power. Moreover, the empirical effects were large. Third, we only examined personality disorder patients. Further generalization of results would require patients from other diagnostic categories. Fourth, the choice of measures may not the best to operationalize the concepts of mental health and mental illness. For example, we used the OQ45 for mental illness, which is a very general questionnaire and not a specific measure of personality disorder pathology. However, the OQ45 is one of the 10 instruments most frequently used by practitioners in the USA to measure clinical outcomes (Hatfield & Ogles, 2004) and is often used in clinical outcome research to measure general symptoms and distress in diverse target groups (De Jong et al., 2007). Finally, positive mental health as a concept is not well defined. It is a diffuse concept unlikely to be operationalized by one factor.

CONCLUSION

This exploratory study has shed some light on the effects of art therapy in reducing symptoms of psychopathology and increasing positive mental health and well-being. The results indicate that art therapy is a powerful therapy for reducing psychopathology; as powerful as it is for enhancing well-being (increasing resilience and emotional adaptation). Therefore, we conclude that our view on art therapy should therefore be recalibrated: art therapy is not *mainly* or *only* a general procedure for improving well-being and quality of life. It also is a specific therapy, with interventions that reduce specific symptoms. Of course, this conclusion is based on our studied intervention, we do not know if other art therapy interventions also show these effects. Our results may help art therapists and other mental health care professionals develop greater awareness of the scope and efficacy of art therapy. Also, the quality of art therapy interventions can be improved by finding a balance between focusing on promoting positive mental health and reducing the symptoms of specific diagnostic target groups, depending on therapeutic goals, target groups and contexts.

It is our hope that this study contributes to the understanding of art therapy and its benefits, and provides insight into the scope of art therapy. Although more research is needed, the present study adds evidence to the empirical base of art therapy in patients with personality disorders cluster B and C and asks for a reappraisal of its symptom reduction quality next to the quality of enhancing positive mental health. In addition to the conclusions we can draw about art therapy, we also conclude that positive mental health and symptoms of mental illness are closely related. In this way, this study also contributes to the general discussion about mental health versus mental illness.

CHAPTER 7.

The Psychometric Properties of the SERATS

A Further Investigation

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ABSTRACT

The Self-Expression and Emotion Regulation in Art Therapy Scale (SERATS) was developed because art therapy lacked outcome measures to monitor the specific effects related to art therapy. The scale showed adequate several psychometric properties but lacked convergent validity. In this study we examined the validity of the SERATS in more detail using a broader range of measures and if the change in SERATS score was uniquely attributed to art therapy.

Using data from the RCT, we examined results of patients with cluster B/C personality disorders receiving art therapy treatment (n = 32). Convergent and discriminant validity was evaluated by inspection of the Pearson correlations between the SERATS and the AAQ-II, the MAAS, the MHC-SF, the OQ45, and the SMI at post-test. We used GLM analysis to compare scores on base-line and post-test, we also estimated the effect size of the change using Cohen's d. The SERATS was indeed sensitive to change, supported discriminant validity, but lacked convergent validity, meaning that it measured something empirically unique. In the absence of convergent validity, we are obliged to advice against use of the SERATS as an outcome measure for art therapy, at the moment. More research is needed.

INTRODUCTION

In *"Measuring the contribution of art therapy in multidisciplinary treatment of Personality Disorders"* (Haeyen, van Hooren, van der Veld, & Hutschemaekers, 2017a), we reported on the development of the Self-Expression and Emotion Regulation in Art Therapy Scale (SERATS). This instrument was developed because art therapy lacked outcome measures to monitor the specific effects related to art therapy (Snir & Regev, 2013; Regev & Guttmann, 2005; Slayton, D'Archer & Kaplan, 2010). We developed the SERATS on the patients' experiences with art therapy, expressed during individual and focus group interviews. Factor analysis resulted in a nine-item scale (see Table 1), which, on face validity measured self-expression and emotion regulation in art therapy. This scale showed good internal reliability and good test-retest reliability. The scale was also sensitive to change. However, we did not have the correct research design to attribute this change uniquely to art therapy; patients in the sample of this psychometric study also received other forms of treatment. Next, the validity of the SERATS was evaluated by examining the association between de SERATS on the one hand and a measure on psychological flexibility (i.e. the Acceptance and Action Questionnaire-II; AAQ-II; Jacobs, Kleen, de Groot, & A-Tjak, 2008) and a measure on general mental functioning (i.e. Outcome Questionnaire 45; OQ45; Lambert et al., 1996). The SERATS did not correlate with both outcomes. This result indicated that the SERATS in that patient sample showed discriminant validity but lacked convergent validity. This lack is evidently problematic for the use of the SERATS.

These reported findings (Haeyen, van Hooren, van der Veld, & Hutschemaekers, 2017a) on the validity and the sensitivity to change ask for a second investigation. In this second investigation we want to examine (1) whether the validity of the SERATS is supported, and (2) whether the change in the SERATS can be uniquely attributed to art therapy.

The randomised clinical trial (RCT) that we have performed (Haeyen, van Hooren, van der Veld, & Hutschemaekers, 2017b) enables us to address these two questions. Sensitivity to change can be correctly evaluated because in the RCT patients only received art therapy. The RCT allows for a broader test of validity because it contains a variety of outcomes. However, it should be noted that the RCT was not designed to validate the SERATS. Therefore, we do not have ante hoc hypothesis about the relation between the SERATS and the outcome measures.

Table 1. *The nine items of the Self-Expression and Emotion Regulation Scale (SERATS).*

1	I get in touch with my feelings through the process of making art
2	I am able to depict my feelings in art therapy
3	Through the process of making art, I am able to discover what is at play within me
4	I am able to express my feelings through the process of making art
5	I am able to make things fall into place in the art
6	Making art is a kind of outlet for me
7	A piece of art I have created can help me hold on to a particular feeling
8	I apply the new behaviour that I have been experimenting with in art therapy outside of the therapy setting
9	I gain greater insight into my psyche through art therapy

METHOD

Data and design of the study

Validity and sensitivity to change was evaluated using data from the RCT, which was discussed in Chapter 5. In the RCT, we followed patients with cluster B/C personality disorders and took measures at three moments. The control group consisted of patients on a waiting list, and the treatment group consisted of patients receiving no other treatment than art therapy. Therefore, only patients receiving art therapy treatment (n = 32) could complete the SERATS and were included in this study.

Measures

Self-expression and Emotion Regulation in Art Therapy Scale (SERATS; Haeyen, van Hooren, van der Veld, & Hutschemaekers, 2017a). The SERATS measures self-expression and emotion regulation in art therapy among personality disorder cluster B/C patients. The instrument consists of nine items (e.g. *"I am able to depict my feelings in art therapy."* and *"Making art is kind of an outlet for me."*), that are scored on a 5-point Likert scale running from never true (1) to almost always true (5). The reliability is good, but the validity is not yet established (Haeyen, van Hooren, van der Veld, & Hutschemaekers, 2017a).

Acceptance and Action Questionnaire - II (AAQ-II; Jacobs, Kleen, de Groot, & A-Tjak, 2008). The AAQ-II measures psychological flexibility in terms of the acceptance and avoidance of emotions. The instrument consists of 10 items (e.g. *"I'm afraid of my feelings."* and *"I am in control of my life.")* that are scored on a 7-point Likert scale running from never true (1) to always true (7). The psychometric properties are good (Jacobs, Kleen, Groot, and A-Tjak, 2008).

Mindfulness Attention Awareness Scale (MAAS; Schroevers, Nyklícek, & Topman, 2008*).* The MAAS measures awareness of and attention to what is taking place in the present. The instrument consists of 15 items (e.g. *"I notice that I do things without paying attention." and "I find it difficult to stay focussed on what's happening in the present.")* that are scored on a 6-point Likert scale ranging from almost always (1) to almost never (6). The reliability and validity are good (Brown & Ryan, 2003; Carlson & Brown, 2005).

Mental Health Continuum – short form (MHC-SF; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011). The MHC-SF measures social-, emotional-, and psychological well-being. The instrument consists of 14 items (e.g. *"During the past month, how often did you feel happy?"* and *"During the past month, how often did you feel that your life has a sense of direction or meaning to it?"*) that are scored on a 6-point Likert scale ranging from never (0) to every day (5). Psychometric characteristics are good (Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011).

Outcome Questionnaire 45 (OQ45; Lambert, 1996; De Jong, et al., 2007). The OQ45 measures psychological functioning in terms of symptom distress, interpersonal relations, and social role. The instrument consists of 45 items (e.g. *"I get along well with others."* and *"I blame myself for things.")* scored on a 5-point Likert scale ranging from never (0) to almost always (4). The psychometric properties of the Dutch version are good (De Jong, & Nugter, 2004).

Schema Mode Inventory 1.1 (SMI; Young et al., 2007). The SMI measures 14 different states of mind, the modes, which an individual may experience for shorter or longer periods. Examples of modes are the vulnerable child, the raging child, the compliant surrender, the punitive parent, or the healthy adult. The instrument consists of 124 items (e.g. *"I often feel alone in the world."* or *"I feel listened to, understood, and validated.")* scored on a 6-point Likert scale ranging from never or almost never (1) to all of the time (6). The psychometry is good (Lobbestael, 2008).

Analysis

All analyses were performed with SPSS 22 (IBM Corp., 2013). Convergent and discriminant validity was evaluated by inspection of the Pearson correlations between the SERATS and the AAQ-II, the MAAS, the MHC-SF, the OQ45, and the SMI. We estimated correlations between the post-test scores. These scores were observed immediately after the last art therapy session (10 weeks after the start of the art therapy treatment). We did not use the 'pre-test' scores, because those were not observed at the same moment, this is because the SERATS was administered immediately after the first art therapy session, while the other measures were administered in the week before the first session.

Sensitivity to change was evaluated by comparing the SERATS scores on the first measurement occasion with the scores on the second measurement occasion (post-test).

Patients only received art therapy treatment, therefore, the observed change could be attributed to art therapy. Changes in outcomes were evaluated using GLM repeated measures. In addition to the GLM analysis, we also estimated the effect size of the change using Cohen's *d*.

RESULTS

Convergent and discriminant validity

We do not have ante hoc hypotheses about how strongly the SERATS should correlate with the outcomes, because the outcomes were not specifically collected to test the validity of the SERATS. The SERATS was developed to capture art therapy specific effects, related to emotion regulation and self-expression, such as resolving inner conflicts (AATA, 2017), awareness of the here and now (Gussak & Rosal, 2016), and achieving personal insight (Malchiodi, 2015). In this context, we can formulate two post hoc – in the sense that they were developed after the data collection – hypotheses. Namely, the AAQ-II and the MAAS should correlate higher with the SERATS than the other outcomes. The AAQ-II measures acceptance and avoidance of emotions, which is addressed in self-expression and corresponds to emotion regulation. The MAAS measures awareness of and attention to what is taking place in the present, which is addressed in emotion regulation. Furthermore, it is hypothesized that the relationship between the SERATS and the other outcomes is much lower. If this pattern of high and low correlations is found, then the SERATS shows convergent and discriminant validity.

Table 2 shows the correlations of the SERATS with the AAQ-II, the MAAS, the MHC-SF, the OQ45, and the SMI. Against our expectations, both the AAQ-II (r =.11, p > 0.05) and the MAAS (r = .29, p > 0.05) were not significantly correlated with the SERATS. In line with our expectations, the SERATS did not significantly correlate with the OQ45, the MHC-SF, and the 14 modes of the SMI. In the absence of any significant correlation, we concluded that our data did not provide evidence to support the validity of the SERATS.

Table 2. *Pearson Correlations with the SERATS at the post-test (n=32).*

Outcome measures[a]	Correlation
AAQ_II	0.11
MAAS	0.29
MHC-SF	0.09
OQ45	-0.30
SMI Vulnerable Child	-0.24
SMI Angry Child	-0.15
SMI Enraged Child	-0.02
SMI Impulsive Child	-0.16
SMI Undisciplined Child	-0.15
SMI Happy Child	0.27
SMI Compliant Surrender	-0.27
SMI Detached Protector	-0.17
SMI Detached Self-Soother	-0.19
SMI Self-Aggrandizer	0.01
SMI Bully and Attack	-0.07
SMI Punitive Parent	-0.07
SMI Demanding Parent	-0.04
SMI Healthy Adult	0.22

* p<.05, ** p<.01

[a] SERATS = Self-expression and Emotion Regulation in Art Therapy Scale; AAQ-II = Acceptance and Action Questionnaire II; MAAS = Mindfulness Attention Awareness Scale; MHC-SF = Mental Health Continuum – short form; OQ45 = Outcome Questionnaire 45; SMI = Schema Mode Inventory

Sensitivity to change

Sensitivity to change was evaluated by comparing the SERATS scores on the first measurement occasion with the scores on the second measurement occasion (post-test). The effect of time was significant for SERATS, F (1, 31) = 111.55, p = .00. In addition, the effect size was very large, d = 2.03. Therefore, we concluded that the SERATS was sensitive to change, which was in line with the results presented in Chapter 3. In addition, the other outcome measures also showed significant changes, indicating mental health improvements.

Table 3. *GLM repeated measures analyses and Cohen's d (n = 32).*

Outcome measures[a]	T1[b] Mean (SD)	T2 Mean (SD)	F	df	Sig.	Cohen's *d*
SERATS	3.29 (0.52)	4.16 (0.31)	111.55	1	0.00	2.03
AAQ-II	30.44 (9.07)	40.03 (7.04)	60.00	1	0.00	1.18
MAAS	3.20 (0.80)	4.14 (0.69)	190.74	1	0.00	1.26
MHC-SF	1.76 (0.88)	2.51 (0.75)	99.97	1	0.00	0.92
OQ45	91.47 (22.44)	68.31 (17.24)	68.70	1	0.00	-1.16
SMI Vulnerable Child	3.76 (0.94)	2.80 (0.76)	84.82	1	0.00	-1.12
SMI Angry Child	3.20 (0.81)	2.65 (0.62)	36.40	1	0.00	-0.76
SMI Enraged Child	1.86 (0.63)	1.50 (0.49)	37.30	1	0.00	-0.64
SMI Impulsive Child	3.10 (0.84)	2.21 (0.68)	60.20	1	0.00	-1.17
SMI Undisciplined Child	3.17 (0.87)	2.93 (0.84)	6.01	1	0.02	-0.28
SMI Happy Child	2.76 (0.80)	3.63 (0.63)	110.92	1	0.00	1.21
SMI Compliant Surrender	3.53 (0.83)	2.91 (0.70)	43.60	1	0.00	-0.81
SMI Detached Protector	2.98 (0.88)	2.16 (0.61)	63.29	1	0.00	-1.08
SMI Detached Self-Soother	3.62 (0.89)	2.95 (0.66)	32.22	1	0.00	-0.86
SMI Self-Aggrandizer	2.93 (0.81)	2.48 (0.77)	45.30	1	0.00	-0.57
SMI Bully and Attack	2.03 (0.63)	1.81 (0.44)	16.85	1	0.00	-0.34
SMI Punitive Parent	2.75 (0.85)	2.03 (0.60)	58.51	1	0.00	-0.98
SMI Demanding Parent	4.11 (0.89)	3.58 (0.77)	49.37	1	0.00	-0.64
SMI Healthy Adult	3.59 (0.64)	4.29 (0.55)	76.51	1	0.00	1.17

[a] SERATS = Self-expression and Emotion Regulation in Art Therapy Scale; AAQ-II = Acceptance and Action Questionnaire II; MAAS = Mindfulness Attention Awareness Scale; MHC-SF = Mental Health Continuum – short form; OQ45 = Outcome questionnaire 45; SMI = Schema Mode Inventory.

[b] At T1, the SERATS was observed immediately after the first art therapy session, and the other outcomes were observed in the week before the first session. At T2, all outcomes were observed immediately after the last session.

DISCUSSION

Given all the effort put into the development of the SERATS, these results were disappointing. We developed the SERATS as art therapy lacked outcome measures that could be used to monitor the specific effects of art therapy. Based on open interviews with patients, we constructed five domains that were assumed to be affected: sensory perception; personal integration; emotion regulation; behaviour change; and insight/comprehension. Factor analysis of the original item set did not reproduce these separate domains, even though they were supposed to be in the items. Instead, a single factor was found, which contained nine items from all five different domains. Although the SERATS showed good psychometric properties, it lacked construct

validity. Therefore, the focus for this discussion is, how could this happen? We will first discuss statistical issues that might have contributed to this result. Then we will focus again on convergent validity, but from a slightly different angle of the choice of validating measures.

Statistically there are two issues, the sample size and the assumption of normality. The sample size was small, with only 32 patients, therefore, quite large effects were needed to indicate significant results. The correlations with the validating measures were not only non-significant, they were also low. For the correct calculation of the correlation coefficient, it is assumed that the variables have a normal distribution. We visually inspected the histograms for all measures and did not found any problematic distributions. In addition, to find influential outliers, we have printed Q-Q plots for the 'pre-test' SERATS and the post-test SERATS. We have not observed any deviations from normality, indicating the absence of influential outliers. Overall, we have to conclude that the lack of construct validity is not the result of statistical issues.

In the design for the development of the SERATS, we have not explicitly included measures to test for convergent and discriminant validity. The measures we used were, above all, chosen for testing the effects of art therapy. This implies that it is theoretically possible that the lack of convergent validity is related to a wrong choice of measures. In favour of this argument are the many SERATS items containing the verb 'able'. This provides us with the impression that the SERATS might measure skills, which implicitly measure if and how patients learn to apply art therapy techniques to their 'unique' set of problems. Learning skills to deal with the problems that patients with personality disorders of clusters B or C face is relevant and makes sense. Therefore, we think the SERATS catches relevant aspects of personality disorder cluster B problems (impulse control and emotion regulation) and cluster C problems (anxiety). However, if these are really the skills measured by the SERATS, we would expect that better skills are related to higher scores on well-being. But Table 2 does not provide an indication for that.

Another interpretation is also possible: the SERATS could be a reflection of something else other than the effects, for example, development in the experienced quality of the therapeutic relationship, or the growing familiarity of the patient with art making during therapy. Although these hypotheses need further exploration, we are not sure if they will bring us much further, given the original purpose of constructing an instrument for measuring the effect of art therapy.

Based on the conclusions from this study, we do not recommend the use of the SERATS at this very moment. More research is needed. Further research on convergent validity of the SERATS should focus on the relation between the SERATS and scales focussed on emotion regulation or self-expression.

CONCLUSION

In Chapter 3, we introduced the SERATS and concluded that the scale had good psychometric properties, except that it lacked convergent validity. In addition, the SERATS was sensitive to change, but by design, this change could not be uniquely attributed to art therapy. These conclusions asked for a study on the validity and sensitivity to change in more detail, using the data of the RCT. The analyses of the RCT data revealed that the SERATS was indeed sensitive to change, supported discriminant validity, but lacked convergent validity, meaning that it measured something empirically unique. However, the SERATS was so unique that it was unrelated to the other outcome measures (lack of convergent validity). Therefore, it is hard to say what the SERATS is measuring exactly. In the absence of convergent validity, we are obliged to advice against use of the SERATS as an outcome measure for art therapy, at the moment. More research is needed.

CHAPTER 8.

Summary and General Discussion

INTRODUCTION

In this final chapter, a summary of this dissertation is first presented. Thereafter, the results are connected and interpreted. And finally, the broader implications of our study are discussed: What could the role of art therapy be in mental health care? How could the quality of art therapy be improved? And what further research should be recommended?

SUMMARY

Chapter 1

Art therapy, a treatment based on the experience and the use of art materials, aims to target emotional functioning, self-expression and well-being for patients. It is quite frequently used in mental health care. Although clinical experiences suggest art therapy is an effective intervention, art therapy is poorly researched and a sound scientific base for this intervention is needed (Reynolds, Nabors, & Quinlan 2000; Slayton, D'Archer & Kaplan, 2010; Van Lith, Schofield, & Fenner, 2013).

One of the areas, in which art therapy has been commonly offered for many years is the treatment of people with personality disorders of clusters B or C. Art therapy is often part of the treatment programme for this target group, because both therapists and patients believe that it makes an important contribution to the successful outcome of treatment. Scientific evidence of this is, however, weak at best. The few available studies are mostly limited in sample size and quality and they seem at best promising. Moreover, the art therapy interventions for personality disorders have not been described systematically, clearly and explicitly enough, especially not according to the steps that are necessary to develop the interventions to a proven effective status (Spring, 2007; Veerman & van Yperen, 2007). In brief, there is an evidence gap and a theoretical need to study art therapy. Art therapy needs further development and its quality could benefit from a better substantiation.

The aim of this dissertation was, therefore, to examine the effects of art therapy in the context of treatment for patients diagnosed with personality disorders of clusters B or C. The main research questions were: How effective is art therapy? And what can be said about the nature of these effects?

Chapter 2

In Chapter 2, we explored the patients' perspective on effects of art therapy in the treatment of personality disorders of clusters B or C. It was aimed at providing insight into the perceived effects of art therapy to reveal relevant outcome categories for further research.

Twenty-nine adult patients were interviewed in individual and focus-group in-depth interviews, starting with a topic list that was derived from literature. Data were collected and

analysed using the Grounded Theory Approach. The combined results of the analyses lead to theoretical model about the effects of art therapy. This model consisted of five effect categories: (1) perception; (2) personal integration; (3) emotion and impulse regulation; (4) behaviour change; and (5) insight and comprehension. Improved perception is about experiencing the present moment, and is assumed to provide the basis upon which other therapeutic effect categories can grow. The effects concern a more complete experience of the self and greater balance to handle emotions or impulses, accept, develop and adopt different behaviours towards the self and others and to better understand oneself and others.

The analyses also showed that, compared to verbal therapy, patients experienced art therapy as an experiential treatment with a complementary quality next to verbal therapy and a more direct way to access emotions, which they attributed to the appeal of art materials and art making to bodily sensations and emotional responses. Patients stated that art therapy confronted them with themselves and their own patterns of feelings, thoughts and behaviours, going further than a conscious, rational level and leading to greater emotional awareness. Art therapy was found to address the core problems of patients with PD, to offer a specific pathway to greater emotional awareness, and to promote a constructive regulation of emotions.

Chapter 3

To evaluate art therapy, a specific scale for measuring the contribution of art therapy in multidisciplinary programs is needed. Such scale will stimulate the quality of art therapy and stimulate insight in the contribution to the treatment process as such. Our aim was to develop an instrument to measure perceived effects of art therapy among personality disorder patients with emotional and self-regulation problems. As no instruments were available to measure the specific effects of art therapy, we used the effect categories described above as input for the development of an assessment tool for examining the contribution of art therapy in multidisciplinary treatment of personality disorders.

The 'Self-expression and Emotion Regulation in Art Therapy Scale' (SERATS) was constructed in a series of analyses, in which the psychometric properties of the SERATS were tested, using two independent patient samples, respectively. Patients who participated had been diagnosed with personality disorders of clusters B or C.

The analyses resulted in a unidimensional 9-item scale. The scale is context specific, meaning that all items describe what happens to a patient in the context of art therapy. The scale can therefore only be used together with art therapy. The scale showed a high internal reliability and high test-retest reliability. Furthermore, the scale showed sensitivity to change. However, this change could not be attributed to art therapy, because patients received other forms of therapy simultaneous with art therapy. Finally, we were not able to confirm the validity of the scale. For this reason it is advised not to use the scale until further research is performed on the validity of the SERATS.

Chapter 4

A sound and evidence-based intervention aimed at management of ineffective behaviours among personality disorder patients was required to be able to investigate the effects of art therapy. In Chapter 4 the aim was to develop a protocolled art therapy intervention for patients with personality disorders of clusters B or C. The principles of Intervention Mapping were applied to guide the development, implementation, and planned evaluation of the art therapy intervention. Empirical findings, theoretical models, and clinical practice experiences were combined to construct a programme tailored to the needs of the target group aimed at change objectives that are central for personality disorder patients. This resulted in a structured 10-session, art therapy intervention programme to increase effective behaviour in personality disorder patients. The intervention aimed at: experiencing a (more) stable and positive sense of self, ability to express and regulate emotions, understanding of emotions, thoughts and behaviours, and using improved social and problem-solving skills. In addition, the recommended attitude of the therapist was described, as well as boundary conditions and guidelines for use. A manual or workbook was written for the intervention to be implemented. To our knowledge, it was the first time that a number of potentially effective art therapy methods were combined into a protocol led programme for this patient population.

Chapter 5

We performed a randomised controlled trial (RCT) based on the systematically developed art therapy intervention protocol. The aim of this RCT was to evaluate the effects of the developed art therapy intervention for patients with a personality disorder. A total of 74 adult patients diagnosed with a personality disorders of clusters B or C (SCID-II) were randomly assigned to (1) weekly group art therapy (1.5 hours, 10 weeks) or (2) a waiting list group. The Outcome Questionnaire 45 (OQ45), Acceptance and Action Questionnaire-II (AAQ-II), and Schema Mode Inventory version 1 (SMI) were assessed at baseline, at post-test (10 weeks after baseline), and in a follow-up (5 weeks after post-test). Fifty-seven patients completed the research.

Compared to patients in the waiting list group, patients who received the protocolled art therapy intervention showed a decrease in personality disorder pathology, including maladaptive schema modes (less impulsivity, detachment, vulnerability and punitive behaviour) and experiential avoidance (more acceptance of unpleasant inner experiences, such as thoughts, feelings and physical sensations). Patients of the experimental group also showed an increase in mental health functioning at a symptom-level and adaptive schema modes (pleasant feelings, spontaneity and self-regulation). The effect sizes were large to very large. The effect sizes of the change in the outcomes indicate that there is a substantial improvement of mental health after the intervention.

Our results were equal, but sometimes even more pronounced compared with efficacy studies with the same target group, i.e. the same specific population of patients with personality disorders of clusters B or C or a Borderline personality disorder only. The

interventions consisted of outpatient psychological treatment programmes of the same duration (three months) and the same intensity of weekly sessions. However, our design (RCT) was stronger and the number of patients was higher.

In conclusion, the results of our RCT emphasized the potential of art therapy as an effective treatment option and showed its efficacy. Art therapy not only reduced personality disorder pathology and maladaptive modes, but also helped patients to develop adaptive, positive modes, indicating better positive mental health and self-regulation.

Chapter 6

Art therapy is often linked with general and positive mental health by art therapists and literature. This suggests a focus on positive mental health: resilience, well-being and, flexibility. This might also suggest that art therapy is less effective on specific symptom reduction. To test this hypothesis, we analysed the data from the RCT (see Chapter 5) with scales grouped in two domains: mental health scales versus mental illness scales, to compare the results on these different domains of effect.

The domain of mental health was covered with the AAQ-II, the Dutch Mental Health Continuum-Short Form (MHC-SF), the Mindful Attention Awareness Scale (MAAS) and the SMI adaptive scale. The domain of mental illness was covered with the SMI maladaptive scale and two subscales of the OQ45. We examined measurements at baseline and post-intervention after 10 weeks. Effect sizes for mental health and mental illness were calculated.

The change in results showed *very large effect sizes* for measures of mental illness *as wells as* for measures on mental health. This was a surprising result, given the recent dominant view of art therapy as mainly oriented toward positive mental health. We conclude that art therapy was not only a general intervention for improving well-being and quality of life but art therapy also emerged as a specific therapy that reduces specific symptoms.

In addition, a principal component analysis was performed for each group of indicators and factor score regression was also used to examine the distinctiveness of the concepts. We found that mental health was strongly correlated to mental illness, which indicates that the distinction between both concepts is problematic or even non-existent. Based on this study, positive mental health and mental illness could be considered two sides of the same coin.

Chapter 7

In this chapter we explored the validity of the SERATS with a broader range of measures. Secondly, we investigated if the change in the SERATS can be attributed uniquely to art therapy. We used data from the RCT of the experimental group (who completed the SERATS) on the first two measurement occasions. To evaluate the validity we examined first the correlations between the SERATS and the AAQ-II, MAAS, the OQ45, the SMI, and the MHC-SF. Based on post-hoc reasoning, we anticipated that the correlation between the SERATS on the one hand and the AAQ-II and the MAAS on the other would be more higher compared to the

other outcome measures. Secondly, we examined if the SERATS-scores also changed in an isolated art therapy intervention. This means that patients only receive art therapy and no other interventions. Then, changes in outcome are only due to art therapy.

The results revealed that the SERATS was sensitive to change due to art therapy. Against our expectations, however, no outcome measure correlated with the SERATS. So, discriminant validity was supported, but the SERATS lacked convergent validity. Based on these results, we advised against the use of the SERATS. Further research on the construct validity is necessary to reveal what the SERATS exactly is measuring. Until then, we cannot decide on the usefulness of the SERATS.

DISCUSSION

In this dissertation, two important results emerged. Firstly, we found a strong effect of art therapy on various popular outcome measures. This is new and beyond expectations. Secondly, these effects could hardly be differentiated: on all measures art therapy is showing more or less the same positive results. In this discussion, we will further explore these two main outcomes.

1. Strong effects of art therapy

The main conclusion of this dissertation is that art therapy in patients with personality disorders of clusters B or C is effective. Art therapy has beneficial effects on patients with personality disorders (Chapters 2, 5 and 6): it reduces general disfunctioning, as well as specific symptoms of personality disorders of clusters B or C. Due to art therapy, the presence of early maladaptive behaviours or states typical for personality disorders decrease (less impulsivity, detachment, vulnerability and punitive behaviours) and adaptive modes become stronger (pleasant feeling, spontaneity and self-regulation). Unpleasant inner thoughts, feelings and physical sensations appear to be more easily accepted.

What can we say about the effects and what does it say about art therapy? The effect is robust, especially when compared to other studies on other interventions, based on low cost, especially in relation to the negative image that the treatment of personality disorders has as being expensive and not often very effective. Based on the results here we can conclude that patients are helped very well within a short time and therefore at low cost.

The effects of art therapy seem certainly more than spontaneous recovery. The effects are related to the intervention; in the waiting list control group no positive effects have been found. At the same time we are not able to formulate causal statements about the underlying mechanisms, because non-specific factors e.g. attention and hope, are not ruled out. This is a major limitation of our design (RCT with waiting list as control group). Differentiating between general (non-specific) and specific effects of art therapy requires additional research. However, this limitation does not imply that nothing can be said about the specificity of the effects. On the

base of available literature on assumed working mechanisms of art therapy, we can elaborate on their probability. This could help us to go in more detail on the specific characteristics for art therapy.

Elements of art therapy and personality disorder problems

In the general introduction, we distinguished on the base of literature three specific elements of art therapy: (1) the art process - the active working phase in which there is something made; (2) the art product - the concrete result of the art process; and (3) the interaction - concerning all direct and indirect interventions and communication about the way one relates to the art process and the art product in contact with each other. These specific elements offer therapeutic possibilities to target problems of patients with personality disorders of clusters B or C, i.e. emotion regulation, self-regulation, enduring and inflexible patterns (of cognitions, emotions and behaviours) and interpersonal functioning. What can be said, on the base of our data, about the potential of these elements, as well as their plausibility to target these problems?

Emotion regulation. We assumed in the general introduction that art therapy is helpful in reducing emotion regulation problems. First, because the art process makes it possible to experience and explore emotions e.g. (inner) conflicts. Second, the art product mirrors these experiences and emotions in a concrete way and offers a more distant perspective from these emotions, which promotes (self-) reflection. The qualitative interviews in Chapter 2 support these ideas, as well as quantitative outcomes of the Schema Mode Inventory (SMI) reported in Chapter 5. Both chapters provide strong evidence that experiential and emotional processes are indeed addressed in art therapy. The large effects in change on scales concerning difficult emotional states such as feeling lonely, detached, being impulsive or punitive towards oneself and others (Chapter 5) could reveal a specific quality of art therapy: patients learn to express and deal with difficult emotions, to move, make choices, and to self-regulate. Art therapy facilitates restoration of emotional contact with experiences, as was reported by patients in Chapter 2. These mechanisms may contribute to emotion integration which is highly relevant for personality disorder patients (Huckvale & Learmonth, 2009; Rubin, 2001). An expectation that has partly been falsified is the view of experts that art therapy is a 'safe haven' for exploring emotions. Patients experience art therapy sometimes as threatening, because they fear emotion dysregulation, loss of control in case of strong emotions and confrontation with painful emotions (Chapter 2).

Self-regulation. Literature and art therapists in the field suggest that art therapy provides the opportunity to work on self-regulation problems. This, because in the art process the patient is responsible for creation of the art product, which requires self-direction and self-management and the resultant art product expresses aspects of his/her identity. In the RCT, art therapy has shown to improve self-regulation: patients report more psychological overview and control/mastery which is linked to the Healthy Adult mode in the SMI ($\Delta d = 1.60$).

In addition, psychological well-being has improved, meaning a better personal performance including aspects, such as autonomy and self-acceptance which are crucial for self-regulation (MHC-SF, Psychological well-being Δd = .99 or factor Mental Health Δd = 1.06). In Chapter 2, we have shown that patients report explicitly that art therapy results in integration of conflictive intra-psychic emotions. According to the patients themselves art therapy helps a lot in developing their internal dialogue, in their own tempo, developing personal expression and self-reflection, based on the process and the art product. They stated that art therapy has a different dynamic than verbal therapy i.e. more gradual, with relatively more concentration on the self and more 'undisturbed' inner dialogue. Mindful attention improved (MAAS Δd = 1.26).

Enduring and inflexible patterns (of cognitions, emotions and behaviours) are targeted in art therapy. These patterns can concern negative or detached thoughts, vulnerable or intense feelings or impulsive actions. The patterns become present and possibly to be influenced because art therapy concerns experiential situations which stimulate spontaneity and play, but also include challenges and confrontations. The results on the SMI in Chapters 5 and 6 show a decrease in many problematic patterns in the presence of early maladaptive schema modes, i.e. less impulsivity, detachment, vulnerability and punitive behaviours. Our results also show that art therapy indeed offers stimulation of spontaneity and play (Happy Child mode: Δd = 1.55) and also helps to develop more healthy patterns (Healthy Adult: Δd = 1.60). In addition, patients in Chapter 2 report that art therapy improves personal insight and comprehension about personal patterns and that it provides input to behavioural change. Compared to the more cognitive verbal therapies, they sometimes experience art therapy as a better therapeutic entrance to explore their dysfunctional patterns. Changing problematic patterns in cognition, emotions and behaviours requires 'affect tolerance' and experiential acceptance. The results in Chapters 2, 4, 5 and 6 show that art therapy offers the opportunity to practise with this. The effects in the RCT show that the emotional state of feeling flat or indifferent about most things decreases, as measured with the Detached Protector mode (Δd = -1.31). The assumption that art therapy improves experiential acceptance, however, does not come forward in the RCT. The results on the AAQ-II, a measure on experiential acceptance, show a much smaller effect (Δd = .11) than expected.

Interpersonal functioning. Art therapy could improve interpersonal (empathy or intimacy) functioning, because the interactive playfield and the communication bridge for difficult personal themes, which could be explored in art without being directly verbally 'addressed'. Interpersonal functioning has indeed strongly improved in the RCT, measured with the OQ45 Interpersonal Relations subscale. Also, feelings of loneliness decrease, as can be seen with the Vulnerable Child mode of the SMI (Δd = -1.24). This emotional state is specifically related to childhood abandonment and abuse and is known to have a destructive effect on interpersonal functioning. As a result of art therapy patients feel more connected to other people and are more open to get more involved with people, as is shown by the decrease of the Detached Protector mode (Δd = -1.31). Patients confirm that by giving meaning (to mentalize)

through objects in the form of pieces of artwork mentalization is indeed stimulated (Bateman & Fonagy, 2004; Springham, Findlay, Woods, & Harris, 2012; Verfaille, 2016).

In brief, many assumptions can be linked to our data. However, the various effect sizes do not differentiate very much and do not seem very specific. That is the reason we cannot fully exclude that art therapy is just an extraordinarily strong non-specific factor. This lack of differentiation between the outcome measures is the second important finding in this dissertation.

2. Lack of differentiation

The lack of differentiation in the outcomes is remarkable and requires explanation. Are the effects of art therapy not as differentiated as we (experts, researchers and patients) generally assume, or are we just dealing with an ordinary error or limitation in the study design?

Regarding the RCT, one explanation that could be put forward is the use of a waiting list condition as a control group without any substantial activity. If the control condition had been another treatment or prevention activity, it would have been possible to control for non-specific factors, which maybe would have provided a more differentiated effect for art therapy. A second explanation could be the use of rather general effect measures. By also using instruments that were expected *not* to show effects of art therapy, we should have had a possibility to test the hypothesis of just the non-specific effect. A third explanation could be the choice of the intervention in the RCT, because it was aimed at different goals, it could have been too wide and a-specific. Fourthly, it could be that there were too few participants to find significant differences between the different outcome measures. The sample size was based on one overall difference, not on finding subtle differences (i.e. small differences in effect sizes) between those measures.

The lack of differentiation was also found in the results of the SERATS. In the interviews, patients reported effects on five different dimensions. In Chapter 3, only one dimension was found, not five. How can these findings be interpreted? It could be that our operationalization of the dimensions failed. Another possibility could be that the subdivision is not as relevant and independent as experts and patients think it is. For the SERATS development, we had a fair amount of cases. If art therapy effects were distinguishable, we would have found them in this study. Therefore, we do not think the lack of differential effects is solely due to methodological issues.

The lack of differentiation was also found in Chapter 6. We tried to find an empirical distinction between illness and health measures by using different strong instruments, but we did not find strong differences. We should suspect the operationalizations of the two concepts of mental illness and positive mental health as main explanation. However, even if the operationalizations have been weak, the results (high correlations) remain unexpected and against our hypotheses.

Exploration of the meaning of two powerful results

The results show a quite massive effect of art therapy without much differentiation. But instead of attributing the lack of differentiation to methodological issues, we can also assume that we found something real and meaningful.

In Chapter 5, we compared our results with results of other studies evaluating mainly psychotherapeutic interventions to see if we found real and meaningful results. The results on symptom reduction were similar and also not very differentiated. In these studies, the measures on general functioning and symptoms (e.g. SCL-90, Q45, QOL) showed similar results, with the same medium to large effect sizes of 0.66 (Van Vreeswijk, Spinhoven, Eurelings-Bontekoe & Broersen, 2014) to 0.81 (Renner et al., 2013). Also, personality disorder-specific measures showed similar results; decrease of BPD severity in global terms with large effect sizes (-1.02 Gratz & Gundersen, 2006; -1.01, Soler et al., 2009), as well as very large effects on affective instability (-1.65), impulsivity (-1.30), and depression (-1.20) (Gratz & Gundersen, 2006). With regard to the schema modes, a very large result we found was on impulsivity (-1.66 Impulsive Child) and a similar result was found in the study of Gratz and Gundersen (2006) on an emotion regulation group training (-1.30; DERS-impulse control).

However, with regard to other schema modes, some striking differences appear. In other studies, early maladaptive schemas decreased with an effect size of 0.88, whereas adaptive modes showed medium effect sizes of 0.40 and 0.58 (Renner et al., 2013; Van Vreeswijk, Spinhoven, Eurelings-Bontekoe & Broersen, 2014). Our results showed very large effect sizes ranging from -1.24 to -1.31 concerning a decrease of early maladaptive schemas e.g. vulnerability, punitive behaviour and detachment (Vulnerable Child -1.24, Punitive Parent -1.29, Detached Protector -1.31), as well as an increase of adaptive schema modes (Happy Child 1.55, Healthy Adult 1.60). Thus, within the overall non-differentiating effects, we see these peaks in the results which could be significant for art therapy.

We also found the lack of differentiation between positive mental health and mental illness in clinical populations. Why not assume that this lack of differentiation is due to the characteristics of the patient population itself, i.e. the severity of their psychic problems? If so, the more severe the problems, the less the patient is able to differentiate between their complaints and their reactions towards those problems. This hypothesis is brought forward by Van Erp Taalman Kip and Hutschemaekers (2017). In a healthy population, a distinction can be found between well-being and psychic complaints, whereas in a clinical sample, this distinction appears to be absent. If this hypothesis is correct, we could assume that the lack of distinction between different outcome measures is directly related to the severity of the mental health problems of the patients under study; the more severe the problems, the less distinction between outcome measures.

Our interpretation has practical, as well as theoretical consequences. Practical, because the concepts we use to differentiate between therapy effects, do not refer to 'real' and 'profound' differences in outcome in the mental health care. The value of these concepts

is depending on their usability in clinical practice such as their metaphorical power to help patients to overcome their problems. Possible theoretical consequences have already been mentioned in Chapter 6: the popular distinction between mental health and mental illness may be valuable in a healthy population (Lamers et al., 2014; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011), but not in our population of patients with severe mental disorders. The hypothesis of one major outcome effect for patients with severe mental health problems could also explain the results of Chapter 3. Why not assume that the different effects, as reported by (former) patients, emerge with recovery: healthy persons can make distinctions which ill patients cannot. All that is of course a hypothesis that needs to be proven. It asks for further investigation, actually in healthy subjects, preferably in the laboratory.

IMPLICATIONS: WHERE DOES THIS LEAD?

Consequences for the use of art therapy in personality disorder treatment

Based on the findings presented in this dissertation, we advocate appropriate use of art therapy in personality disorder treatment and adjustment of the present Dutch multidisciplinary guideline for treatment of personality disorders (Landelijke Stuurgroep Multidisciplinaire Richtlijn Ontwikkeling in de GGZ, 2008) and the Care standard personality disorders (Trimbos Instituut, 2017). In the current edition of these documents, art therapy is described as a supportive treatment and as a possible helpful add-on therapy for use alongside evidence-based psychotherapeutic treatment, for example, to get in touch with patients who are difficult to reach emotionally. The findings in this dissertation show that art therapy is not only a *supportive* treatment, next to other interventions for personality disorders. It has proven to be an effective treatment in itself. Therefore, an update about the use of art therapy is required. Certainly because art therapy is also is expected a cost-effective intervention: in a short time non-expensive professionals reach major effects.

Experiential techniques receive more attention nowadays by verbal therapists because these techniques are increasingly incorporated in cognitive behavioural therapies (e.g. Schema Focused Therapy, Acceptance and Commitment Therapy and Compassion Focussed Therapy), mostly as a supplementary way to form a central base of verbal interventions. Arntz (2011, 2012), for example, states that these experiential techniques (used as a part of Schema Focussed Therapy) hold a promise for therapeutic use, although he emphasizes the need for systematic empirical evaluation of these techniques and to unravel underlying mechanisms of change. We give credence to the work of Arntz and colleagues, but our results go further: they show that experiential techniques are powerful in themselves, and not only as a supplement to verbal therapy.

Quality improvement of art therapy

The process of articulating and standardizing (art therapy) interventions in mental health care practice has started several years ago, with the growing substantiation of interventions by implementing evidence-based practice and practice-based evidence. Art therapy is better and more explicitly described, has become more explicit and more transparent, for example, by explicating modules as elements of a treatment programme. For art therapy, this process involves a change in method; less intuitive, less solely process-oriented and more explicit by using predetermined goals often translated in modules with a fixed duration, and methodology. Art therapy opens itself to a measurable and methodically communicable way of working (ZiN, 2015). This process does not necessarily change art therapy itself, as suggested in the quote from Pablo Picasso: *"learn the rules like a pro, so you can break them like an artist"* (RVS, 2017). Many art therapists feel comfortable with an artist's perspective. They prefer the creative, revealing an open space in therapy, in which creativity can flourish and new ideas and creations arise. However, art therapists have a responsibility in working towards therapeutic goals of people who seek aid for their mental problems. This requires strategies and plans, as well as tuning-in. Although personality disorder problems are frequently complex, a standardized treatment offers a helpful therapeutic structure, in which tuning-in is still as important as ever. Art therapy will profit from inclining more towards planning, standardizing, using protocols and directives, although some art therapists might perceive this as restrictive or static. For art therapy in general, standardizing is necessary in the steps needed for research and to counter the diverse and diffuse image of this profession. This also means leaving the idea that this profession does not fit research. Based on combined empirical findings, theoretical models, and clinical practice experience, programmes can be constructed, fitting the needs of specific target groups. These art therapy programmes could (and should) be developed, described and tested in a clear and systematic way.

Art therapists improve the quality of their interventions by paying systematic attention to the aim of symptom reduction next to enhancing positive mental health. This is a consequence of the perspective on art therapy as also a specific therapy to reduce specific symptoms as described in the findings in Chapter 6. With this pointed out, one should be critical about the traditional theoretical assumptions of art therapy.

Further research

There is a considerable theoretical, as well as practical need for more investigation into art therapy and its effects. To improve 'the state of the science and practice' of art therapy we need to further clarify the impact of art therapy on mental health. This knowledge should be based on an integration of research knowledge, clinical expertise and preferences of patients, i.e. the principles of Evidence Based Practice (RVS, 2017). For example, it would be important to further substantiate the use of art therapy in treatment programmes, not only for patients with personality disorders but also for patients with anxiety, mood en cognitive disorders like

schizophrenia and dementia. It also would be interesting to know how art therapy stimulates non-specific effects but, based on our results, we esteem it more urgent to look specific factors and effects of art therapy. What exactly are the specific working mechanisms of art therapy?

Effects on other mental disorders. Our study has been on the efficacy of art therapy on personality disorders. The choice for this patient group has been rather practical (my own expertise and interest, availability of patients). It would certainly be of high interest to investigate in research on efficacy of art therapy in other mental disorders. Art therapy is often part of treatment programs for patients with anxiety and mood disorders. Art therapy is also used in the treatment of patients with psychotic symptoms as well as in treatment programs for older patients suffering from dementia. We do not see any reason why art therapy would be less effective in the treatment for those patient groups. We strongly recommend starting research on the efficacy of art therapy for other mental disorders. If comparable designs are used, we could compare the results and use them as a first indicator of the specificity of art therapy.

Differentiation of specific and non-specific factors. This could also be a focus of further art therapy research. Of course, art therapy makes use of non-specific factors, like focussed attention, hope, working methodically with treatment goals, as any other therapy does. This helps patients to get moving forward and provides hope. We think that the treatment effects of art therapy as shown in this dissertation cannot be reduced to non-specific factors alone. Also specific factors are at stake, i.e. factors directly related to a specific therapy. We strongly recommend investigating these effects due to art therapy by comparing art therapy directly with another therapy, for example with Dialectical Behaviour Therapy or Acceptance and Commitment Therapy. This research question first needs an appropriate theoretical framework concerning the specific effects of both treatments. Next, it also needs a specific RCT design, in which both treatment groups function at the same time, as experimental group and as control group of each other. Although this design would require a large sample, we would not expect any larger overall differences between both groups. However, we think it would be relatively easy to realize in a specific outpatient clinical setting.

Another design to be considered is an 'add-on' design, in which treatment as usual (TAU) is compared to TAU combined with additional art therapy. With this design, the added value of art therapy could be explored, as well as the unique and specific effects of art therapy, compared to the treatment as usual. This type of research could also directly provide an insight into the effects of recent trends in mental health care of ruling out art therapy from evidence based treatment programmes. Although this design has high ecological value and provides figures to contribute to the actual political discussion about the usefulness of art therapy in multidisciplinary treatment programmes, we do not think this type of research will easily lead to unambiguous outcomes. First of all, it requires a very large number of participants in order to gain enough power to provide significant differences in outcome. Moreover, it will be difficult to realize such a study in mental health care practice, because daily practice is often

inconsistent and shows important transformations over time. Moreover, in these treatment programmes patients quite often discontinue therapy. Also, ethical aspects can be at stake, because this design could imply limitations in other treatment possibilities for patients in need of psychological support.

Specific art therapy factors and effects. Further research could also be performed on specific art therapy-factors, like working with different materials and techniques. One question that has been unanswered yet is what role the art medium played in achieving positive outcome. It would be interesting to interview the patients who participated in the RCT to find out what specific art therapy factors were at stake and to what extent e.g. art assignments, material interaction, preferred approach of the art process by evaluating experiences with the art medium from patient and expert perspectives with a focus on emotion regulation. The aim of this would be to determine a *causal explanation* (Lub, 2014) for why art therapy led to the effects achieved by the RCT intervention to add to the *causal relation* found in the RCT. It would certainly be interesting to explore if different materials have different physiological effects e.g. on arousal, measured with physiological outcome measures.

CONCLUSION

This dissertation has been one of the first serious attempts to explore effects of art therapy. Its main conclusion is that art therapy in patients with personality disorders of clusters B or C is effective. We have found that art therapy has several beneficial effects for personality disorder patients (Chapters 2, 5 and 6). First, it is effective in reducing mental illness: in reducing general mental disfunctioning, and in reducing specific symptoms of personality disorders of clusters B or C like early maladaptive behaviours or states (impulsivity, detachment, vulnerability and punitive behaviours). Second, it enhances adaptive modes (pleasant feeling and self-regulation) and ameliorates positive mental health; it increases well being and other positive measures. Finally, unpleasant inner thoughts, feelings, and physical sensations appear to be more easily accepted. Because negative and positive health outcomes are highly correlated this asks for a reappraisal of the relation between negative and positive health outcomes. Some of the effects are the result of non-specific factors, while others appear related to art therapy itself. We think that the strengths of art therapy are: the direct, experiential therapeutic entry, the possibility for the art therapist to approach the patient and his problems in an indirect way and the qualities involved in working with art materials, the art process and art product. Further research is needed to explore the effects of art therapy and to relate them to the underlying working mechanisms of art therapy. Meanwhile we strongly advise mental health care to invest in more art therapy for their patients with personality disorders. It offers good outcomes in a short time.

CHAPTER 9.

Samenvatting en algemene discussie

INLEIDING

In dit laatste hoofdstuk zal eerst een samenvatting van deze dissertatie worden gepresenteerd. Daarna zullen de resultaten worden verbonden en geïnterpreteerd. Als laatste worden de implicaties van onze studie bediscussieerd: wat kan de rol van beeldende therapie in de geestelijke gezondheidszorg zijn; hoe kan de kwaliteit van beeldende therapie verbeterd worden en welk verder onderzoek is aan te bevelen?

SAMENVATTING

Hoofdstuk 1

Beeldende therapie, een behandelvorm waarin beeldende materialen op een methodische manier worden ingezet, is gericht op doelen die te maken hebben met emotioneel functioneren, zelfexpressie en welzijn voor patiënten. Deze vorm van therapie wordt vrij frequent ingezet in de geestelijke gezondheidszorg. Hoewel praktijkervaringen suggereren dat beeldende therapie een effectieve interventie is, is beeldende therapie weinig onderzocht en is er een degelijke wetenschappelijke basis nodig voor deze interventie (Reynolds, Nabors, & Quinlan 2000; Slayton, D'Archer & Kaplan, 2010; Van Lith, Schofield, & Fenner, 2013).

Een van de terreinen waar beeldende therapie al vele jaren aangeboden wordt is de behandeling van mensen met persoonlijkheidsstoornissen cluster B/C. Beeldende therapie is vaak deel van het behandelingsprogramma voor deze doelgroep omdat zowel therapeuten als patiënten geloven dat beeldende therapie een belangrijke bijdrage in het behandelingsresultaat levert. Het beschikbare wetenschappelijke bewijs is echter zwak. De weinige beschikbare studies zijn grotendeels gelimiteerd in steekproefgrootte en kwaliteit en zien er in het beste geval veelbelovend uit. Verder valt op dat de beeldende therapeutische interventies voor persoonlijkheidsstoornissen niet systematisch, duidelijk en expliciet genoeg zijn beschreven, vooral niet volgens de stappen die nodig zijn om de interventies tot een bewezen effectieve status te ontwikkelen (Spring, 2007; Veerman & van Yperen, 2007). In het kort kan gesteld worden dat er een duidelijke behoefte is aan nader onderzoek naar beeldende therapie. Door meer onderzoek zou beeldende therapie verder onderbouwd kunnen worden en kwalitatief verbeterd kunnen worden.

Het doel van deze dissertatie was daarom om de effecten van beeldende therapie te onderzoeken in de context van de behandeling van patiënten gediagnosticeerd met persoonlijkheidsstoornissen cluster B/C. De belangrijkste onderzoeksvragen waren: Hoe effectief is beeldende therapie? En wat kan er gezegd worden over de aard van deze effecten?

Hoofdstuk 2

In hoofdstuk 2 hebben we het patiëntenperspectief op de effecten van beeldende therapie in de behandeling van persoonlijkheidsstoornissen cluster B/C geëxploreerd. Het doel hiervan was om inzicht te krijgen in de waargenomen effecten van beeldende therapie om relevante resultaat-categorieën voor verder onderzoek vast te stellen.

Negenentwintig volwassen patiënten zijn geïnterviewd in individuele en focusgroep diepte-interviews, beginnend met een onderwerpenlijst afgeleid uit de literatuur. Data werden verzameld en geanalyseerd met behulp van de Grounded Theory Approach. In de laatste stap van de analyse integreerden we de resultaten in een theoretisch model. Dit model bestond uit vijf effectcategorieën: (1) perceptie; (2) persoonlijke integratie; (3) emotie- en impulsregulatie; (4) gedragsverandering; en (5) inzicht en begrip. Verbeterde perceptie betreft het ervaren van het actuele moment en werd gezien als de basis waarop de andere therapeutische effecten zich kunnen ontwikkelen. De effecten betreffen een meer complete ervaring van zichzelf, meer balans in het hanteren van emoties en impulsen, acceptatie, ontwikkeling en het zich eigen maken van ander gedrag ten opzichte van zichzelf en anderen en een beter begrip van zichzelf en anderen.

De analyses lieten zien dat, vergeleken met verbale therapie, patiënten beeldende therapie ervoeren als een ervaringsgerichte behandeling met een complementaire kwaliteit naast verbale therapie en als een meer directe manier om toegang tot emoties te krijgen. Dit schreven ze toe aan het appèl van beeldende materialen en het maken van beeldend werk op lichamelijke sensaties en emotionele responsen. Patiënten verklaarden dat beeldende therapie hen confronteerde met henzelf en hun eigen patronen in gevoelens, gedachten en gedrag, verdergaand dan een bewust, rationeel niveau en leidend tot een sterker emotioneel bewustzijn. Beeldende therapie kwam naar voren als goed passend bij en aansluitend op de kernproblemen van patiënten met persoonlijkheidsstoornissen, het bood een specifieke weg naar meer bewust zijn van emoties en draagt bij aan constructieve emotieregulatie.

Hoofdstuk 3

Om beeldende therapie te evalueren is een specifiek instrument nodig dat de bijdrage van beeldende therapie in multidisciplinaire programma's kan meten. Een dergelijke schaal zal de kwaliteit van beeldende therapie stimuleren en inzicht stimuleren in de bijdrage aan het behandelproces. Ons doel was om een instrument te ontwikkelen om waargenomen effecten te meten van beeldende therapie bij patiënten met persoonlijkheidsstoornissen met emotie- en zelfregulatieproblemen. Er waren geen beschikbare instrumenten beschikbaar om de specifieke effecten van beeldende therapie te meten. Daarom hebben we de effectcategorieën, zoals in hoofdstuk 2 beschreven, gebruikt als input voor de ontwikkeling van een vragenlijst voor het vaststellen van de bijdrage van beeldende therapie in multidisciplinaire behandeling van persoonlijkheidsstoornissen in de klinische praktijk.

De 'Self-expression and Emotion Regulation in Arts Therapy Scale' (SERATS) werd geconstrueerd in een serie van analyses waarin de psychometrische eigenschappen van de SERATS ontwikkeld en getest zijn. Er werd gebruik gemaakt van twee onafhankelijke patiëntsteekproeven. Patiënten die deelnamen hadden elk een diagnose persoonlijkheidsstoornis PS cluster B/C.

De analyse resulteerde in een eendimensionele 9-item schaal. De schaal is context-specifiek, hetgeen betekent dat alle items beschrijven wat een patient kan ervaren in de context van beeldende therapie. De schaal kan daarom alleen gebruikt worden bij beeldende therapie. De schaal toonde een hoge interne betrouwbaarheid en hoge test - hertest betrouwbaarheid. Verder liet de schaal gevoeligheid voor verandering zien. De verandering kon in deze studie niet worden toegeschreven aan beeldende therapie omdat patiënten andere therapieën hadden, naast beeldende therapie. De validiteit van de schaal hebben we niet kunnen vaststellen. Om deze reden adviseren we om de schaal niet te gebruiken voordat verder onderzoek naar de validiteit van de SERATS is uitgevoerd.

Hoofdstuk 4

Een degelijke en evidence-based interventie gericht op het hanteren van ineffectieve gedragingen van patiënten met persoonlijkheidsstoornissen was vereist om de effecten van beeldende therapie te kunnen onderzoeken. Het doel in dit hoofdstuk was om een geprotocolleerde beeldende therapie-interventie te ontwikkelen voor patiënten met een persoonlijkheidsstoornis cluster B/C. De principes van Intervention Mapping werden toegepast om de ontwikkeling, implementatie en geplande evaluatie van beeldende therapie-interventie te leiden. Empirische bevindingen, theoretische modellen en klinische ervaringen werden gecombineerd om een programma te ontwikkelen, toegesneden op de behoeften van de doelgroep, gericht op de centrale behandeldoelen van patiënten met persoonlijkheidsstoornissen. Dit resulteerde in een gestructureerd 10-sessie beeldend therapeutisch interventieprogramma ter verbetering van het functioneren van patiënten met persoonlijkheidsstoornissen. De interventie richt zich op: het ervaren van een (meer) stabiel en positief zelfgevoel, in staat zijn emoties te uiten en te reguleren, emoties, gedachten en gedragingen te begrijpen, en gebruik te maken van verbeterde sociale en probleemoplossende vaardigheden. Verder zijn ook aanbevelingen beschreven ten aanzien van de houding van de therapeut, evenals randvoorwaarden en gebruiksadviezen. Een handleiding is geschreven voor de implementatie van de interventie. Voor zover ons bekend, was dit de eerste keer dat een aantal potentieel effectieve beeldende therapiemethoden is gecombineerd in een protocol gestuurd programma voor deze patiëntenpopulatie.

Hoofdstuk 5

We hebben een randomised controlled trial (RCT) uitgevoerd, gebaseerd op het systematisch ontwikkelde beeldende therapeutische interventieprotocol. Het doel van dit RCT was om de effecten te evalueren van de ontwikkelde beeldende therapie-interventie voor patiënten met

een persoonlijkheidsstoornis. In totaal 74 volwassen participanten gediagnosticeerd met een persoonlijkheidsstoornis cluster B/C (SCID-II) zijn gerandomiseerd ingedeeld in (1) een wekelijkse beeldende therapiegroep (1.5 uur, 10 weken) of (2) een wachtlijstgroep. De Outcome Questionnaire 45 (OQ45), Acceptance and Action Questionnaire-II (AAQ-II), en Schema Mode Inventory (SMI-II) zijn afgenomen bij baseline, post-test (10 weken na baseline), en follow-up (5 weken na post-test). Zevenenvijftig patiënten completeerden het onderzoeksprotocol.

Vergeleken met de patiënten in de wachtlijstgroep, lieten patiënten die de geprotocolleerde beeldendetherapie-interventie ontvingen een afname zien van persoonlijkheidsstoornis pathologie zoals maladaptieve schemamodi (minder impulsiviteit, onthechting, kwetsbaarheid en bestraffend gedrag) en ervaringsvermijding (meer acceptatie van onaangename innerlijke ervaringen, zoals gedachten, gevoelens en fysieke sensaties). Deze patiënten van de experimentele groep lieten tevens een verbetering zien in hun geestelijke gezondheid op symptoomniveau en adaptieve schemamodi (aangename gevoelens, spontaniteit en zelfregulatie). De effectgroottes waren groot tot erg groot. Deze effectgroottes van de verandering in de uitkomsten indiceren dat er een substantiële verbetering was van mentale gezondheid na de interventie.

Onze resultaten waren gelijk of meer uitgesproken in vergelijking met andere studies met dezelfde doelgroep, dat wil zeggen dezelfde specifieke populatie met patiënten met een persoonlijkheidsstoornis cluster B of C of met een Borderline persoonlijkheidsstoornis alleen. De interventies bestonden uit poliklinische behandelprogramma's met dezelfde duur (3 maanden) en dezelfde intensiteit van wekelijke sessies. Echter, ons onderzoeksdesign (RCT) was sterker en het aantal patiënten hoger.

Samenvattend, de resultaten van onze RCT laten het potentieel van beeldende therapie zien als effectieve behandeloptie en toonden de effectiviteit van beeldendetherapie aan. Beeldende therapie verminderde niet alleen persoonlijkheidsstoornis pathologie en maladaptieve modi maar hielp patiënten ook om adaptieve positieve modi te ontwikkelen die betere positieve geestelijke gezondheid en zelfregulatie indiceren.

Hoofdstuk 6

Beeldende therapie wordt vaak in verband gebracht met algemene positieve geestelijke gezondheid door beeldend therapeuten en in de literatuur. Dit suggereert een nadruk op veerkracht, welzijn en flexibiliteit. Dit zou kunnen suggereren dat beeldende therapie minder effectief is op specifieke symptoomreductie. Om deze hypothese te toetsen hebben we de data van het RCT geanalyseerd (zie hoofdstuk 5) met uitkomstmaten in twee domeinen geclusterd: positieve geestelijke gezondheid-schalen tegenover psychische stoornis-schalen, om de resultaten op deze twee domeinen van effect te vergelijken.

Het domein van positieve geestelijke gezondheid werd gemeten met de AAQ-II, de Dutch Mental Health Continuum-Short Form (MHC-SF), de Mindful Attention Awareness Scale (MAAS) en de SMI-II adaptieve schaal. Het domein van psychische stoornissen werden gemeten

met de SMI maladaptieve schaal en twee subschalen van de OQ45. We onderzochten metingen bij baseline en post-interventie na 10 weken. Effectgroottes voor geestelijke gezondheid en psychische stoornissen zijn gecalculeerd.

De resultaten lieten erg grote effectgroottes zien voor uitkomstmaten voor psychische stoornissen evenals voor uitkomstmaten voor geestelijke gezondheid. Dit was een verrassend resultaat, gezien de dominante opvatting dat beeldende therapie meer georiënteerd lijkt op positieve geestelijke gezondheid. We concluderen dat beeldende therapie niet alleen een generieke interventie is ter verbetering van welzijn en kwaliteit van leven maar dat het ook een specifieke therapie is ter reductie van specifieke symptomen.

In aanvulling werd een principale component analyse uitgevoerd voor elke groep van indicatoren en factor score regressie werd gebruikt om de onderscheidbaarheid van de concepten te onderzoeken. We vonden dat geestelijke gezondheid sterk gerelateerd was aan psychische stoornis, wat indiceert dat het onderscheid tussen beide concepten problematisch of zelfs niet-bestaand is. Gebaseerd op deze studie zouden positieve geestelijke gezondheid en psychische stoornissen als twee kanten van dezelfde munt kunnen worden gezien.

Hoofdstuk 7

In dit hoofdstuk exploreerden we de validiteit van de SERATS met een bredere range aan uitkomstmaten. Ten tweede wilden we onderzoeken of de verandering in de SERATS aan beeldende therapie alleen kan worden toegeschreven. We hebben data gebruikt van het RCT van de experimentele groep (welke de SERATS had ingevuld) op de eerste twee meetmomenten. Om de validiteit te evalueren bekeken we eerst de correlaties tussen de SERATS en de AAQ-II, MAAS, de OQ45, de SMI-1.1, en de MHC-SF. Gebaseerd op post-hoc redeneringen verwachtten we dat de correlatiecoëfficiënten tussen de SERATS aan de ene kant en de AAQ-II en de MAAS aan de andere kant meer geprononceerd zouden zijn dan ten opzichte van de andere uitkomstmaten. Ten tweede onderzochten we of de SERATS-scores ook veranderden als gevolg van een geïsoleerde beeldende therapie-interventie. Dit betekent dat patiënten alleen beeldende therapie ontvingen en geen andere interventies. Zo zouden uitkomsten alleen aan beeldende therapie kunnen worden toegeschreven.

De resultaten lieten zien dat de SERATS gevoelig was voor verandering door beeldende therapie. Tegen onze verwachtingen in, correleerde de SERATS niet met een van de andere uitkomstmaten. Dus discriminante validiteit werd bevestigd, maar het ontbrak de SERATS aan convergente validiteit. Gebaseerd op deze resultaten adviseren we de SERATS niet te gebruiken. Verder onderzoek naar de construct validiteit is nodig zodat duidelijk wordt wat de SERATS precies meet. Tot dan kunnen we geen verdere uitspraken doen over de bruikbaarheid van de SERATS.

DISCUSSIE

In deze dissertatie kwamen twee belangrijke resultaten naar voren. Ten eerste vonden we een sterk effect van beeldende therapie op een verscheidenheid aan uitkomstmaten. Dit is nieuw en buiten verwachting. Ten tweede kon de variantie in effecten/resultaten nauwelijks gedifferentieerd worden: op alle instrumenten laat beeldende therapie min of meer dezelfde positieve resultaten zien. In deze discussie zullen we deze twee hoofduitkomsten verder verkennen.

1. Sterk effect van beeldende therapie

De hoofdconclusie van deze dissertatie is dat beeldende therapie effectief is voor patiënten met een persoonlijkheidsstoornis, cluster B/C. Beeldende therapie heeft gunstige effecten op patiënten met persoonlijkheidsstoornissen (hoofdstukken 2, 5 en 6): het vermindert zowel algemene disfunctie als ook specifieke symptomen van persoonlijkheidsstoornissen cluster B/C. Door beeldende therapie vermindert de aanwezigheid van vroege maladaptieve gedragingen of toestanden die typisch zijn voor persoonlijkheidsstoornissen (minder impulsiviteit, onthechting, kwetsbaarheid en bestraffend gedrag) en adaptieve toestanden worden sterker (aangenaam gevoel, spontaniteit en zelfregulatie). Onaangename innerlijke/interne gedachten, gevoelens en fysieke sensaties worden makkelijker geaccepteerd.

Wat kunnen we zeggen over de effecten en wat zegt het over beeldende therapie? Het effect is robuust, zeker vergeleken met andere studies, gebaseerd op de lage kosten, zeker in verband met het negatieve beeld dat de behandeling van persoonlijkheidsstoornissen heeft als zijnde duur en vaak niet erg effectief. Gebaseerd op de resultaten in dit onderzoek, worden patiënten in een korte tijd en daarom tegen lage kosten geholpen.

De effecten van beeldende therapie lijken zeker erder te gaan dan alleen spontaan herstel. De effecten zijn gerelateerd aan de interventie; in de wachtlijst-controlegroep werd geen positief effect gevonden. Tegelijkertijd kunnen we geen causale beweringen doen over de onderliggende mechanismen omdat non-specifieke factoren zoals aandacht en hoop niet uitgesloten zijn. Dit is een belangrijke beperking van ons onderzoeksontwerp (RCT met wachtlijst als controlegroep). Het differentiëren tussen algemene (non-specifieke) en specifieke effecten van beeldende therapie behoeft aanvullend onderzoek. Echter, deze beperking impliceert niet dat niets gezegd kan worden over de specificiteit van de effecten. Op basis van de beschikbare literatuur over de veronderstelde werkingsmechanismen van beeldende therapie kunnen we de waarschijnlijkheid ervan uitwerken. Dit zou ons kunnen helpen om beter te kunnen beschrijven wat karakteristiek is voor beeldende therapie.

Elementen van beeldende therapie en persoonlijkheidsstoornissen

In de algemene introductie hebben we op basis van de literatuur drie specifieke elementen van beeldende therapie onderscheiden: (1) het beeldend proces, de actieve werkfase waarin iets

gemaakt wordt; (2) het beeldend product, het concrete resultaat van het beeldend proces; en (3) de interactie, betreffende alle directe en indirecte interventies en communicaties over de manier waarop men zich verhoudt tot het beeldend proces en het beeldend product, in contact met elkaar. Deze specifieke elementen bieden therapeutische mogelijkheden om problemen van patiënten met persoonlijkheidsstoornissen cluster B/C aan te pakken. Het gaat daarbij om: emotieregulatie, zelfregulatie, voortdurende en inflexibele patronen (van cognities, emoties en gedragingen) en interpersoonlijke functioneren. Wat kan worden gezegd, op basis van onze gegevens, over het potentieel van deze elementen, evenals over hun plausibiliteit dat zij deze problemen kunnen aanpakken?

Emotieregulatie. We stelden in de algemene introductie dat beeldende therapie behulpzaam is bij het reduceren van emotieregulatieproblemen. Ten eerste omdat het beeldend proces het mogelijk maakt om emoties en (innerlijke) conflicten te ervaren en te verkennen. Ten tweede omdat het beeldend product deze ervaringen en emoties op een concrete wijze spiegelt en de mogelijkheid biedt tot een ander perspectief, met meer afstand, ten opzichte van deze emoties, hetgeen (zelf)-)reflectie bevordert. De kwalitatieve interviews in hoofdstuk 2 bevestigen deze processen evenals de resultaten van de SMI beschreven in hoofdstuk 5. Beide hoofdstukken bieden sterk bewijs dat ervarings- en emotionele processen inderdaad aangepakt worden in beeldende therapie. De grote effecten in verandering op schalen met betrekking tot moeilijke emotionele toestanden/modi zijn zoals gevoelens van eenzaamheid, onthechting, impulsiviteit of bestraffend gedrag ten opzichte van zichzelf of anderen (hoofdstuk 5) zouden een specifieke kwaliteit van beeldende therapie kunnen onthullen: patiënten leren moeilijke emoties uit te drukken en ermee om te gaan, in beweging te komen, keuzes te maken en zichzelf te reguleren. Beeldende therapie faciliteert het herstellen van emotioneel contact met ervaringen, zoals gerapporteerd door patiënten in hoofdstuk 2. Deze mechanismen dragen mogelijk bij aan emotieregulatie wat in hoge mate relevant is voor patiënten met persoonlijkheidsstoornissen (Huckvale & Learmonth, 2009; Rubin, 2001). Een andere verwachting die deels gefalsifieerd is, is het beeld van therapeuten dat beeldende therapie een 'veilige have' is om emoties te exploreren. Patiënten ervaarden beeldende therapie soms als bedreigend omdat ze emotionele disregulatie, verlies van controle bij sterke emoties en confrontatie met pijnlijke emoties vrezen (hoofdstuk 2).

Zelfregulatie. Literatuur en beeldend therapeuten suggereren dat beeldende therapie de kans biedt om te werken aan zelfregulatieproblemen. Dit omdat de patiënt in het beeldend proces zelf verantwoordelijk is voor de creatie van beeldend werk, hetgeen zelfsturing en zelfmanagement vraagt. Het resulterende beeldend werk drukt aspecten uit van de eigen identiteit. In het RCT verbeterde beeldende therapie zelfregulatie, aangezien patiënten meer psychologisch overzicht en controle ervoeren dat gelinkt is aan de Gezonde Volwassene modus in de SMI (Δ *d* = 1.60). Verder verbeterde het psychologisch welzijn, hetgeen een betere persoonlijke prestatie betekent, inclusief aspecten als autonomie en zelfacceptatie die cruciaal zijn voor zelfregulatie (MHC-SF, Psychological well-being Δ *d* = .99 of factor Mental

Health Δ *d* = 1.06). In hoofdstuk 2 hebben we laten zien dat patiënten expliciet rapporteerden dat beeldende therapie resulteerde in integratie van conflicterende intrapsychisch emoties. Volgens de patiënten zelf hielp beeldende therapie hen sterk in het ontwikkelen van hun interne dialoog, in hun eigen tempo, hun persoonlijke expressie en zelfreflectie ontwikkelend, gebaseerd op het proces en het beeldend product. Ze verklaarden dat beeldende therapie een andere dynamiek heeft dan verbale therapie, namelijk meer gradueel, met relatief meer concentratie op zichzelf en meer 'onverstoorde' innerlijke dialoog. Bewuste aandacht (mindful attention) verbeterde (MAAS Δ *d* = 1.26).

Voortdurende en inflexibele patronen (in cognities, emoties en gedrag) worden doelgericht aangepakt in beeldende therapie. In deze patronen kan het gaan om negatieve of onthechte gedachten, kwetsbare of zeer intense gevoelens of impulsieve acties/gedragingen. Deze patronen worden aanwezig en mogelijk beïnvloedbaar omdat beeldende therapie een ervaringsgerichte situatie betreft, die spontaniteit en spel kan stimuleren, maar die ook uitdagingen en confrontaties bevat. De resultaten op de SMI in hoofdstuk 5 en 6 tonen een afname in veel problematische patronen wat betreft de aanwezigheid van vroege maladaptieve schemamodi, namelijk minder impulsiviteit, onthechtheid, kwetsbaarheid en bestraffend gedrag. Onze resultaten laten zien dat beeldende therapie inderdaad spontaniteit en spel stimuleert (Blije Kind modus: Δ *d* = 1.55) en ook helpt om meer gezonde patronen te ontwikkelen (Gezonde Volwassene modus: Δ *d* = 1.60). Daarnaast meldden patiënten in hoofdstuk 2 dat beeldende therapie persoonlijk inzicht en begrip verbeterde met betrekking tot hun patronen en dat dit input gaf tot gedragsverandering. Vergeleken met de meer cognitieve verbale therapieën, ervoeren zij beeldende therapie soms als een betere therapeutische ingang om hun disfunctionele patronen te verkennen. Het veranderen van problematische patronen in cognities, emoties en gedragingen vraagt om 'affecttolerantie' en ervaringsacceptatie. De resultaten in hoofdstuk 2, 4, 5 en 6 laten zien dat beeldende therapie de kans biedt hiermee te oefenen. De effecten in het RCT tonen dat de emotionele staat van zich vlak of onverschillig voelen over de meeste dingen afnam, zoals gemeten met de Onthechte Beschermer modus (Δ *d* = -1.31). De aanname met betrekking tot ervaringsacceptatie, echter, kwam niet naar voren in het RCT. De resultaten op de AAQ-II, een uitkomstmaat voor experiëntiële acceptatie, laten een veel kleiner effect (Δ *d* = .11) zien dan verwacht.

Interpersoonlijk functioneren. Beeldende therapie zou interpersoonlijk (empathisch of intiem) functioneren kunnen verbeteren omdat het interactieve speelveld en de communicatie een brug leggen voor moeilijke persoonlijke thema's, wat zou kunnen worden verkend in het beeldend werken zonder direct verbaal 'geadresseerd' te worden. Het interpersoonlijk functioneren verbeterde inderdaad sterk in het RCT, zoals gemeten met de OQ45 Interpersonal Relations subschaal. Verder namen gevoelens van eenzaamheid af, zoals gezien kan worden in de score op de Kwetsbare Kind modus in de SMI (Δ *d* = -1.24). Deze emotionele toestand is specifiek gerelateerd aan verlatenheid/achterlating in de kindertijd en misbruik en staaat erom bekend een destructief effect te hebben op het interpersoonlijk functioneren. Als resultaat van

beeldende therapie voelden patiënten zich meer verbonden met andere mensen en waren ze meer open om sterker betrokken te raken bij mensen, zoals de afname van de Onthechte Beschermer modus (Δ *d* = -1.31) laat zien. Patiënten bevestigden dat door betekenis te geven (te mentaliseren) via objecten in de vorm van beeldende werkstukken waardoor mentalisering inderdaad werd gestimuleerd (Bateman & Fonagy, 2004; Springham, Findlay, Woods, & Harris, 2012; Verfaille, 2016).

In het kort: vele aannames kunnen met onze data verbonden worden. Echter, de verschillende effectgroottes differentiëren niet erg en lijken niet erg specifiek. Daarom kunnen we niet volledig uitsluiten dat beeldende therapie gewoon een buitengewoon sterke non-specifieke factor is. Dit gebrek aan differentiatie tussen de uitkomstmaten is het tweede belangrijke resultaat in deze dissertatie.

2. Gebrek aan differentiatie

Het gebrek aan differentiatie in de uitkomsten is onverwacht en vereist uitleg. Zijn de resultaten van beeldende therapie niet zo gedifferentieerd als men (experts, researchers en patiënten) in het algemeen aanneemt of betreft het hier een fout of beperking in het onderzoeksontwerp?

Wat het RCT betreft, zou een verklaring kunnen zijn dat er een wachtlijstconditie als controlegroep werd gebruikt zonder enige supplementaire activiteit. Als de controleconditie een andere behandel- of preventieactiviteit was geweest dan zou het mogelijk zijn geweest om te controleren op non-specifieke factoren, hetgeen mogelijk een meer gedifferentieerd effect van beeldende therapie zou hebben getoond. Een tweede verklaring zou het gebruik van redelijk algemene uitkomstmaten kunnen zijn. Door ook gebruik te maken van instrumenten waarop geen effecten van beeldende therapie verwacht worden, hadden we de mogelijkheid om de hypothese van alleen non-specifiek effect kunnen testen. Een derde verklaring zou de keuze van de interventie in het RCT kunnen zijn. Omdat de interventie gericht was op verschillende doelen zou deze te breed en te aspecifiek kunnen zijn geweest. Ten vierde, het zou kunnen dat er te weinig participanten waren om significante verschillen tussen de diverse uitkomstmaten te vinden. De steekproefgrootte was gebaseerd op een globaal verschil, niet op het vinden van subtiele verschillen (namelijk kleine verschillen in effectgroottes) tussen die uitkomstmaten.

Het gebrek aan differentiatie werd ook aangetroffen in de resultaten van de SERATS. In de interviews rapporteerden patiënten effecten op vijf verschillende dimensies. In hoofdstuk 3 werden er niet vijf maar werd er slechts één dimensie gevonden. Hoe kunnen deze bevindingen geïnterpreteerd worden? Het zou kunnen zijn dat onze operationalisatie van de dimensies niet goed was. Een andere mogelijkheid zou kunnen zijn dat de onderverdeling niet zo relevant en onafhankelijk is als experts en patiënten denken. Voor de ontwikkeling van de SERATS hadden we een flink aantal cases. Als de beeldende therapie-effecten onderscheidbaar waren, dan zouden we ze gevonden hebben. Hierom denken wij niet dat het gebrek aan differentieerbare effecten louter door methodologische problemen komt.

Het gebrek aan differentiatie werd ook gevonden in hoofdstuk 6. We probeerden een empirisch onderscheid te vinden tussen psychische stoornis en positive mentale gezondheid door gebruik te maken van verschillende sterke instrumenten, maar we vonden geen grote verschillen. We kunnen vermoeden dat de operationalisaties van de twee concepten een verklaring hiervoor zijn. Echter, zelfs als de operationalisaties zwak waren blijven de resultaten (hoge correlaties) onverwacht en tegen onze hypotheses in.

Verkenning van de betekenis van deze twee krachtige resultaten

De resultaten laten een vrij massief effect van beeldende therapie zien zonder veel differentiatie. In plaats van het gebrek aan differentiatie toe te schrijven aan methodologische kwesties kunnen we ook veronderstellen dat we iets hebben gevonden dat echt en betekenisvol is.

In hoofdstuk 5 vergeleken we onze resultaten met die van andere studies die hoofdzakelijk psychotherapeutische interventies evalueren om te zien of we echte en betekenisvolle resultaten vonden. De resultaten op symptoomreductie waren vergelijkbaar en ook niet erg gedifferentieerd. In deze studies toonden de meetinstrumenten met betrekking tot algemeen functioneren en symptomen (bijv. SCL-90, OQ45, QOL) dezelfde resultaten, met dezelfde medium tot grote effectgroottes van .66 (Van Vreeswijk, Spinhoven, Eurelings-Bontekoe & Broersen, 2014) tot .81 (Renner et al., 2013). Ook persoonlijkheidsstoornis-specifieke uitkomstmaten lieten vergelijkbare resultaten zien; afname van ernst van Borderline persoonlijkheidsstoornis in globale termen met grote effectgroottes (-1.02 Gratz & Gundersen, 2006; -1.01, Soler et al., 2009) evenals grote effecten op affectieve instabiliteit (-1.65), impulsiviteit (–1.30) en depressie (-1.20) (Gratz & Gundersen, 2006). Met betrekking tot de schemamodi vonden wij een groot resultaat op impulsiviteit (-1.66 Impulsieve Kind modus). Een vergelijkbaar resultaat werd gevonden in het onderzoek van Gratz en Gundersen (2006) bij een emotieregulatie-groepstraining (-1.30; DERS-impulse control).

Echter, met betrekking tot de andere schemamodi, verschijnen enkele opvallende verschillen. In andere onderzoeken was een afname te zien van vroege maladaptieve schema's met een effectgrootte van -.88 en een toename van adaptieve modes met een *medium* effectgrootte van .40 en .58 (Renner et al., 2013; Van Vreeswijk, Spinhoven, Eurelings-Bontekoe & Broersen, 2014). Onze resultaten lieten *erg grote* effecten zien, variërend van -1.24 tot -1.31, betreffende een afname van vroege maladaptieve schema's zoals bijvoorbeeld kwetsbaarheid, bestraffend gedrag en onthechtheid (Kwetsbare Kind modus -1.24, Bestraffende Ouder modus -1.29, Onthechte Beschermer modus -1.31) als ook een toename in adaptieve schemamodi (Blije Kind modus1.55, Gezonde Volwassene 1.60). Dus binnen de, over het algemeen weinig gedifferentieerde, effecten zien we pieken in de resultaten die van betekenis zouden kunnen zijn voor beeldende therapie.

We hebben ook gebrek aan differentiatie gevonden tussen positieve mentale gezondheid en psychisch stoornis in klinische populaties. Waarom nemen we niet aan dat het gebrek in differentiatie verklaard wordt door de patiëntpopulatie zelf en de ernst van hun

psychische problemen? Zo ja, hoe ernstiger de problemen, hoe minder de patiënt in staat is om te differentiëren tussen zijn klachten en zijn reacties op de problemen. Deze hypothese werd naar voren gebracht door Van Erp Taalman Kip en Hutschemaekers (2017). In een gezonde populatie werd onderscheid gevonden tussen welzijn en psychische klachten terwijl in een klinische populatie dit onderscheid afwezig lijkt. Als deze hypothese correct is, kunnen we veronderstellen dat het gebrek aan onderscheidbaarheid tussen verschillende uitkomstmaten direct gerelateerd is aan de ernst van de geestelijke problemen van de mensen die bestudeerd worden; hoe ernstiger de problemen, hoe minder onderscheid tussen uitkomstmaten.

Onze interpretatie heeft zowel praktische als theoretische consequenties. Praktisch omdat de concepten die we gebruiken om te differentiëren tussen verschillende therapie-effecten, niet refereren naar echte en diepgaande verschillen in uitkomst in de geestelijke gezondheidszorg. De waarde van deze concepten hangt af van hun bruikbaarheid in de klinische praktijk zoals de metaforische kracht ervan die patiënten helpt hun problemen te overwinnen. Mogelijke theoretische consequenties zijn al vermeld in hoofdstuk 6: het populaire onderscheid tussen positieve geestelijke gezondheid en psychische stoornis kan bruikbaar zijn in een gezonde populatie (Lamers et al., 2014; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011), maar niet in onze populatie van patiënten met ernstige persoonlijkheidsstoornissen. De hypothese van een hoofd-effect zou ook de resultaten van hoofdstuk 3 kunnen verklaren. Waarom nemen we niet aan dat de verschillende effecten, zoals gerapporteerd door patiënten, sterker ontstaan naar mate het herstel vordert: gezonde mensen zijn beter in staat de distincties te maken vergeleken met patiënten met een ernstige psychische stoornis. Dit is natuurlijk een hypothese die nog bewezen moet worden. Het vraagt om verder onderzoek, in dit geval bij gezonde proefpersonen, bij voorkeur in een laboratoriumsituatie.

IMPLICATIES: WAAR LEIDT DIT TOE?

Consequenties voor het gebruik van beeldende therapie in de behandeling van persoonlijkheidsstoornissen

Gebaseerd op de bevindingen gepresenteerd in deze dissertatie pleiten we voor gepast gebruik van beeldende therapie in de behandeling van persoonlijkheidsstoornissen en aanpassing van de huidige Nederlandse multidisciplinaire richtlijn voor behandeling van persoonlijkheidsstoornissen (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008) en de Zorgstandaard PS (Trimbos Instituut, 2017). In de huidige editie van deze documenten wordt beeldende therapie beschreven als een ondersteunende behandeling en als een mogelijke behulpzame toegevoegde therapie in te zetten naast evidence based psychotherapeutische behandeling, bijvoorbeeld om in contact te komen met patiënten die moeilijk te bereiken zijn op emotioneel vlak. De bevindingen van deze dissertatie laten zien dat beeldende therapie niet uitsluitend een *ondersteunende* behandeling is naast andere

interventies voor persoonlijkheidsstoornissen. Het is bewezen een effectieve behandeling te zijn op zichzelf. Daarom is een bijstelling over het inzetten van beeldende therapie vereist. Zeker omdat beeldende therapie naar verwachting een kosteneffectieve interventie is: in een korte tijd bereiken niet-dure professionals belangrijke effecten.

Ervaringsgerichte technieken staan de laatste tijd meer in de aandacht van gesprekstherapeuten omdat deze technieken in toegenomen mate opgenomen zijn in cognitieve gedragstherapieën (bijv. Schema Focused Therapy (SFT), Acceptance and Commitment Therapy en Compassion Focused Therapy), grotendeels op een supplementaire manier toegevoegd aan een centrale basis van verbale interventies. Arntz (2011, 2012) bijvoorbeeld heeft gesteld dat deze ervaringsgerichte technieken (gebruikt als onderdeel in SFT) veelbelovend lijken voor therapeutisch gebruik hoewel hij benadrukt dat deze technieken systematische empirische evaluatie moeten ondergaan om hun effectiviteit te testen en de onderliggende mechanismen van verandering te ontrafelen. We bieden met onze studies steun aan Arntz en collega's maar onze resultaten gaan verder: ze laten zien dat ervaringsgerichte technieken op zichzelf krachtig zijn en niet enkel werken als supplement in verbale therapieën.

Kwaliteitsverbetering van beeldende therapie

Het proces van articuleren en standaardiseren van (beeldende therapie) interventies in de praktijk van de geestelijke gezondheidszorg begon verscheidene jaren geleden toen meer gewicht werd gegeven aan de onderbouwing van interventies door de implementatie van evidence-based practice en practice-based evidence. Beeldende therapie is beter en meer expliciet beschreven bijvoorbeeld in modules als onderdelen van een behandelprogramma. Voor beeldende therapie hield dit proces een verandering in voor de manier van werken; minder intuïtief, minder uitsluitend proces-georiënteerd en meer expliciet door gebruik te maken van vooraf bepaalde doelen vaak vertaald tot modules met een vaste duur en methodologie. Beeldende therapie opent zichzelf voor een meetbare en methodisch communiceerbare manier van werken (ZiN, 2015). Dit proces verandert niet noodzakelijk beeldende therapie zelf, zoals geïllustreerd door een citaat van Pablo Picasso: 'Leer de regels als een pro, zodat je ze kunt breken als een kunstenaar' (RVS, 2017). Vele beeldend therapeuten voelen zich comfortabel in een kunstenaarsperspectief, de voorkeur gevend aan de creatieve, onthullende en open ruimte in therapie waarin creativiteit kan floreren en nieuwe ideeën en creaties ontstaan. Echter, beeldend therapeuten hebben een verantwoordelijkheid in het werken aan therapeutische doelen van mensen die hulp zoeken voor hun psychische problemen. Dit vraagt strategieën en plannen naast afstemming. Hoewel persoonlijkheidstoornis-problemen veelal complex zijn, biedt een gestandaardiseerde behandeling een helpende therapeutische structuur waarin afstemming even belangrijk is als altijd. Beeldende therapie zal er baat bij hebben om meer richting planning, standaardisatie, protocol- en richtlijngebruik te gaan, ook al zouden sommige beeldend therapeuten dit mogelijk als te restrictief of statisch beleven. Voor beeldende therapie in het algemeen is standaardisatie nodig voor de stappen die nodig zijn in

onderzoek en om het diverse en diffuse imago van dit vak tegen te gaan. Dit betekent ook het loslaten van het idee dat dit vak niet geschikt is voor onderzoek. Gebaseerd op gecombineerde empirische bevindingen, theoretische modellen en klinische praktijkervaring, kunnen programma's geconstrueerd worden, passend bij de behoeften van specifieke doelgroepen. En deze beeldende therapieprogramma's kunnen (en moeten) worden ontwikkeld, beschreven en getest op een duidelijke en systematische wijze.

Beeldend therapeuten kunnen de kwaliteit van hun interventies verbeteren door meer systematische aandacht te besteden aan symptoomreductie als doel. Dit is een gevolg van het perspectief op beeldende therapie als ook een specifieke therapie met interventies om specifieke symptomen te reduceren zoals beschreven in de resultaten in hoofdstuk 6. In dit licht zou men kritisch moeten zijn over de theoretische aannames over beeldende therapie.

Verder onderzoek

Er is een aanzienlijke theoretische als ook praktische behoefte naar meer onderzoek naar beeldende therapie en de effecten ervan. Om de 'stand van wetenschap en praktijk' voor patiënten met persoonlijkheidsstoornissen te verbeteren is het nodig om de impact van beeldende therapie op geestelijke gezondheid nader te verhelderen. Deze kennis zou gebaseerd moeten zijn op een integratie van onderzoekskennis, klinische expertise en voorkeuren van patiënten, namelijk de principes van evidence-based practice (RVS, 2017). Zo is het van belang om het gebruik van beeldende therapie in behandelingsprogramma's verder te onderbouwen, niet alleen voor patiënten met persoonlijkheidsstoornissen maar ook voor patiënten met angst-, stemmings- en cognitieve stoornissen zoals schizofrenie en dementie. Ook zou het interessant zijn te weten hoe beeldende therapie non-specifieke effecten stimuleert, maar gebaseerd op onze resultaten verwachten dat het dringender is om te kijken naar specifieke factoren en effecten van beeldende therapie. Wat zijn precies de werkingsmechanismen van beeldende therapie?

Effecten op andere psychische stoornissen. Onze studie betrof de effecten van beeldende therapie voor persoonlijkheidsstoornissen. De keuze voor deze groep patiënten was nogal praktisch (mijn eigen deskundigheid en interesse, de beschikbaarheid van patiënten). Het is zeker van groot belang om te onderzoeken wat de effecten zijn van beeldende therapie bij andere psychische stoornissen. Beeldende therapie is vaak onderdeel van behandelingsprogramma's voor patiënten met angst- en stemmingsstoornissen. Beeldende therapie wordt ook gebruikt in de behandeling van patiënten met psychotische symptomen als ook in behandelprogramma's voor oudere patiënten die lijden aan dementie. Wij zien geen reden waarom zou beeldende therapie minder effectief zou zijn in de behandeling van deze patiëntengroepen. We raden sterk aan onderzoek te doen naar de effecten, de doeltreffendheid en de werkingsmechanismen van beeldende therapie voor andere psychische stoornissen. Als vergelijkbare onderzoeksontwerpen worden gebruikt, kunnen we de resultaten vergelijken en deze gebruiken als een eerste indicator van het specifieke van beeldende therapie.

Differentiatie van specifieke en non-specifieke factoren. Dit zou ook een focus van verder beeldende therapieonderzoek kunnen zijn. Vanzelfsprekend maakt beeldende therapie gebruik van non-specifieke factoren, zoals gefocuste aandacht, hoop, methodisch werken met behandelingsdoelen zoals bij elke andere therapie het geval is. Dit helpt patiënten om vooruit te komen en het biedt hoop. We denken dat de behandeleffecten zoals naar voren gekomen in deze dissertatie niet gereduceerd kunnen worden tot non-specifieke factoren alleen. Ook specifieke factoren zijn in het spel, direct gerelateerd aan een specifieke therapie. We bevelen sterk aan om de effecten toegeschreven aan beeldende therapie te onderzoeken door beeldende therapie direct te vergelijken met een andere therapie, bijvoorbeeld met dialectische Gedragstherapie of Acceptance and Commitment Therapy. Deze onderzoeksvraag heeft ten eerste een gepast theoretisch model nodig met betrekking tot de specifieke effecten van beide therapieën. Vervolgens heeft het ook een specifiek RCT design nodig waarin beide behandelgroepen op hetzelfde moment als experimentele en controlegroep functioneren voor elkaar. Alhoewel dit design een groot aantal deelnemers vereist - we verwachten niet zozeer grote verschillen tussen beide groepen - denken we dat het relatief goed te realiseren is in een poliklinische setting.

Een ander design om te overwegen is een 'add-on' design waarin een behandeling als gebruikelijk (Treatment As Usual - TAU) vergeleken wordt met TAU waar beeldende therapie aan is toegevoegd. In dit design zou de toegevoegde waarde van beeldende therapie verder onderzocht kunnen worden evenals unieke en specifieke effecten van beeldende therapie in vergelijking met de TAU. Dit type onderzoek zou ook direct inzicht kunnen verschaffen in wat de effecten zijn van het verwijderen van beeldende therapie uit behandelprogramma's. Hoewel dit design hoge ecologische waarde heeft en gegevens aanlevert ten behoeve van de actuele politieke discussie over de bruikbaarheid van beeldende therapie in multidisciplinaire behandelprogramma's, denken we niet dat dit type onderzoek gemakkelijk leidt tot ondubbelzinnige uitkomsten. Ten eerste vereist het een zeer groot aantal deelnemers om voldoende power te bereiken om significante verschillen in uitkomsten op te leveren. Verder zal een dergelijke studie moeilijk te realiseren zijn in de praktijk van de geestelijke gezondheidszorg omdat de dagelijkse praktijk veelal inconsistent is en grote veranderingen doormaakt door de tijd heen. Verder vallen patiënten vaak uit in deze behandelprogramma's. Ook kunnen ethische aspecten aan de orde zijn omdat een dergelijk onderzoeksontwerp beperking van andere behandelmogelijkheden kan impliceren voor patiënten die psychologische ondersteuning nodig hebben.

Specifieke beeldende therapiefactoren en effecten. Nader onderzoek zou kunnen worden uitgevoerd naar specifieke factoren zoals het werken met verschillende materialen en technieken. Een vraag die nog onbeantwoord is gebleven is de vraag welke rol het beeldend werken speelde in het verkrijgen van de positieve resultaten. Het zou interessant zijn om de patiënten van het RCT te interviewen om uit te vinden welke specifieke beeldende therapiefactoren van belang waren en in welke mate, bijvoorbeeld beeldende opdrachten,

materiaalinteractie, geprefereerde benadering van het beeldend proces door het evalueren van ervaringen met het beeldend werken vanuit patiënt- en expertperspectief met een focus op emotieregulatie. Het doel hiervan zou zijn om een *causale verklaring* (Lub, 2014) vast te stellen voor waarom beeldende therapie leidde tot de resultaten behaald door het RCT interventie, als toevoeging aan de *causale relatie* zoals gevonden in het RCT. Het zou ook zeker interessant zijn om te verkennen of verschillende materialen verschillende fysiologische effecten hebben op bijv. arousal, gemeten met fysiologische meetinstrumenten.

CONCLUSIE

Deze dissertatie was een van de eerste serieuze pogingen om de effecten van beeldende therapie te exploreren. De hoofdconclusie is dat beeldende therapie bij patiënten met persoonlijkheidsstoornissen effectief is. We hebben gevonden dat beeldende therapie meerdere gunstige effecten heeft voor deze patiëntengroep (hoofdstuk 2, 5 en 6). Ten eerste is beeldende therapie effectief in het reduceren van de psychische stoornis: in het reduceren van algemeen psychisch disfunctioneren en in het reduceren van specifieke symptomen van persoonlijkheidsstoornissen cluster B/C zoals vroege maladaptieve gedragingen of emotionele toestanden (impulsiviteit, onthechtheid, kwetsbaarheid en bestraffend gedrag). Ten tweede bevordert het adaptieve modi (aangename gevoelens, spontaniteit en zelfregulatie) en verbetert het positieve mentale gezondheid; het versterkt welbevinden en andere positieve uitkomstmaten. Ten laatste lijken onaangename innerlijke gedachten, gevoelens en fysieke sensaties makkelijker geaccepteerd te worden. Omdat de negatieve en positieve mentale gezondheidsresultaten in hoge mate gecorreleerd zijn, vraagt dit om een herwaardering van de relatie hiertussen. Sommige van de effecten zijn mogelijk gevolg van niet-specifieke factoren, terwijl andere gerelateerd lijken te zijn aan beeldende therapie zelf. De kracht van beeldende therapie zou kunnen zijn: de directe, ervaringsgerichte therapeutische ingang, de mogelijkheid van de beeldend therapeut om de patiënt en diens problemen te benaderen op een indirecte manier en de kwaliteiten die betrokken zijn bij het werken met beeldende materialen, het beeldend proces en het beeldend werkstuk. Meer onderzoek is nodig om de effecten van beeldende therapie nader te exploreren en om deze te relateren aan de onderliggende werkingsmechanismen van beeldende therapie. Ondertussen raden wij de geestelijke gezondheidszorg aan meer te investeren in beeldende therapie voor hun patiënten met persoonlijkheidsstoornissen. Het biedt goede resultaten in een korte tijd.


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APPENDICES

Self-expression and Emotion Regulation in Art Therapy Scale, English and Dutch version

SERATS

Self-expression and Emotion Regulation in Art Therapy Scale

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Name: *
Age : Sex: M / F**
Date:
Treatment setting: Clinic / Multi-day part-time program / Outpatient**
Treatment Form: Group / Individual / Both**

* Your data will be processed anonymously ** Delete if not applicable

INSTRUCTION

The following statements will to a greater or lesser extent statements apply to you. Please read the statements carefully and answer them right away by ticking the chosen answer. Do not skip questions.

	Item	1. Never true	2. Seldom true	3. Some-times true	4. Often true	5. (Almost) always true
1	I get in touch with my feelings through the process of making art					
2	I am able to depict my feelings in art therapy					
3	Through the process of making art, I am able to discover what is at play within me					
4	I am able to express my feelings through the process of making art					
5	I am able to make things fall into place in the art					
6	Making art is a kind of outlet for me					
7	A piece of art I have created can help me hold on to a particular feeling					
8	I apply the new behaviour that I have been experimenting with in art therapy outside of the therapy setting					
9	I gain greater insight into my psyche through art therapy					

SERATS

Self-expression and Emotion Regulation in Art Therapy Scale

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Naam: *
Leeftijd : Geslacht: M / V**
Datum:
Behandelsetting: Kliniek / Meerdaags deeltijdprogramma / Poliklinisch**
Behandelvorm: Groep / Individueel / Beide**

* Uw gegevens worden anoniem verwerkt ** Doorhalen wat niet van toepassing is

INSTRUCTIE

De volgende uitspraken kunnen in meer of mindere mate op u van toepassing zijn. Lees de uitspraken zorgvuldig en beantwoord ze vlot door het gekozen antwoord aan te kruisen. Sla a.u.b. geen vragen over.

	Stelling	1. Nooit waar	2. Zelden waar	3. Soms waar	4. Vaak waar	5. (Bijna) altijd waar
1	Ik kom in contact met mijn gevoel via het beeldend werken					
2	In de beeldende therapie kan ik mijn gevoelens verbeelden					
3	Door mijn beeldend werk kom ik erachter wat er bij mij speelt					
4	Via het beeldend werken kan ik gevoelens uiten					
5	In het beeldend werk kan ik zaken een plek geven					
6	Beeldend werken is voor mij een soort uitlaatklep					
7	Een werkstuk dat ik gemaakt heb kan me helpen om een bepaald gevoel vast te houden					
8	Het nieuwe gedrag, waarmee ik in de beeldende therapie heb geëxperimenteerd, kan ik buiten de therapie proberen in te zetten					
9	Ik krijg inzicht in mijzelf door beeldende therapie					

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Suzanne Haeyen was born on 26 November 1966 in Geldrop. She obtained her pre-university education diploma in 1986, after which she started studying art therapy at HAN University of Applied Sciences. After graduating in 1990, she was hired as an art therapist at the De Wellen psychiatric centre, now GGNet, centre for mental health care; first at the crisis intervention clinic and later at Scelta, a centre of expertise for treatment of people with personality disorders. In 1998 she also became the chair of the department of arts therapies and psychomotor therapy that organises training within GGNet. From 2003 to 2014 she was the chair of GNOON network for research and eduaction for arts and psychomotor therapists (GGZ Netwerk voor Onderzoek & Opleiding Nijmegen, Mental Healthcare Network for Research & Education Nijmegen) and coordinated annual regional symposia. Since 2002 she has worked as a senior lecturer and from 2008 to 2015 as a coordinator of the part-time education for Arts Therapies at HAN University of Applied Sciences (HAN CTO). She is a member of the national research centre KenVak which focuses on development of knowledge of arts therapies.

In 2011 she obtained her Master's Degree in Art Therapy from Zuyd University of Applied Sciences after which she started her PhD in 2012 at the Faculty of Social Sciences at the Behavioural Science Institute at Radboud University in Nijmegen. In 2012 she started lecturing for the Master of Art Therapies programme and in 2015 she became a key team member of the programme.

She has published several articles and books since 1994 including the books *Niet uitleven maar beleven: Beeldende therapie bij persoonlijkheidsproblematiek* (Don't act out, but live through: Art therapy for personality problems, 2007) and *De verbindende kwaliteit van beeldende therapie* (The Connecting Quality of Art Therapy. Effects of Art Therapy, 2011). She was the co-editor of the *Uit de verf. Art Therapy handbook* (Handbook of Art Therapy: Express Yourself), wrote several articles and chapters in multiple handbooks (Claassen, & Pol, 2015; Ingenhoven, van Reekum, van Luyn & Luyten, 2012; Schweizer, et al. 2009; Vreeswijk, Broersen & Nadort, 2012). She has made contributions about the field of art therapy in the he multidisciplinary guideline for treatment of personality disorders (2008) and to the standard of care for personality problems (2017), and was project leader and author of the 'Landelijk Domeinprofiel voor bacheloropleidingen voor Vaktherapeutische Beroepen' (National Domain Profile for Bachelor programmes for Arts Therapies and Psychomotor Therapy Professions, 2016). She won the Young Arntz Investigator Award 2017 for her research presentation at the 7th Schema therapy conference in Amsterdam.

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