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Development of an art-therapy intervention for patients with personality disorders: an intervention mapping study

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ABSTRACT
Art therapy for people diagnosed with personality disorders (PD) 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 PD 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 PD problems.

Background
Patients diagnosed with personality disorders (PDs) cluster B/C usually receive a cognitive-oriented psychotherapy or verbal therapy as a first choice. In addition to verbal therapies, multidisciplinary treatment for PD patients often consists of art therapy. Art therapy focuses 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 PDs cluster B/C mention that art therapy is valuable because of its perceived effects of art therapy, namely improved sensory perception, personal integration, improved emotion regulation, behaviour change, and insight/comprehension (Haeyen, Van Hooren, & Hutschemaekers, 2015). It seems a suitable intervention because PD consists strongly of dysregulation of emotions and instability of the self, and art therapy could be helpful for insight, positive development, stabilisation, or acceptance of these aspects. Social functioning is often a problem area for PD 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 PD 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 PD patients cluster B/C, using the Intervention Mapping (IM) protocol (Bartholomew et al., 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 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 PD 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 PD. The CINAHL, ERIC, PUBMED, SCIENCE DIRECT, 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 PDs 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 PD patients were addressed. In Step 4, the theoretical art-therapy methods and strategies resulted in a practical and organised 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

PD is not always recognised right away because it concerns deeper lying patterns of feelings, actions, and thoughts. A PD 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 PD 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 PD varies considerably. Some are able to sustain some relationships and occupational activities. People with more severe forms of PD 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 PD 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, for example nature comes to expression by the influence of nurture. We know by now that in the development of PDs, multiple genes, but also multiple environmental influences are involved (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008).

The DSM-5 lists 10 PDs, grouped into three clusters, namely cluster A (Paranoid, Schizoid, and Schizotypal PD), cluster B (Antisocial, Borderline, Histrionic, and Narcissistic PD) and cluster C (Avoidant, Dependent, and Obsessive-compulsive PD). Many people with PD 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 PD meet the diagnostic criteria for more than one disorder, for
example depression, addiction or post traumatic stress disorder (PTSD). 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 PD 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 PD can be diagnosed (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling in de GGZ, 2008). This makes PDs the most frequently diagnosed disorder of all psychiatric diagnoses. In the PD 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 A disorders are clearly the least prevalent (7.7%). This is without the people classified with an unspecified PD. We focus on people with PD cluster B and/or C, because these PD 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 PD 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 unstable 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 PD 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 PD 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 characterised 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.

### Step 2: matrix of change objectives

Next, important and changeable objectives of behaviour were chosen. For PD patients of both cluster B and C, determinants taken from Table 1 are summarised 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 – that is, about one’s goals, values, interests, and emotions. A more stable and positive sense of self could be helpful regarding several specific determinants in PDs cluster B/C, that

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

<table>
<thead>
<tr>
<th>Diagnostic group</th>
<th>Specific determinant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster B</strong></td>
<td></td>
</tr>
<tr>
<td>Antisocial personality disorder (0.2–3.3%)</td>
<td>Pervasive pattern of disregard for and violation of the rights of others, lack of empathy, bloated self-image, self-aggrandising, manipulative and impulsive behaviour</td>
</tr>
<tr>
<td>Borderline personality disorder (1.6–5.9%)</td>
<td>Pervasive pattern of instability in relationships, self-image, identity, behaviour, and affects often leading to self-harm and impulsivity</td>
</tr>
<tr>
<td>Histrionic personality disorder (1.84%)</td>
<td>Pervasive pattern of attention-seeking behaviour and excessive emotions</td>
</tr>
<tr>
<td>Narcissistic personality disorder (0–6.2%)</td>
<td>Pervasive pattern of grandiosity, need for admiration, and a lack of empathy</td>
</tr>
<tr>
<td><strong>Cluster C</strong></td>
<td></td>
</tr>
<tr>
<td>Avoidant personality disorder (2.4%)</td>
<td>Pervasive feelings of social inhibition and inadequacy, extreme sensitivity to negative evaluation</td>
</tr>
<tr>
<td>Dependent personality disorder (0.49%/0.6%)</td>
<td>Pervasive psychological need to be cared for by other people</td>
</tr>
<tr>
<td>Obsessive-compulsive personality disorder (2.1–7.9%)</td>
<td>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)</td>
</tr>
</tbody>
</table>

*In rehabilitation clinics, jail, and forensic institutes >70%.
*In mental health institutions up to 20%.
is, 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, for example, 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.

**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, van Hooren, Dokter, Smeejsters, & Hutschemaekers, 2014), expressive therapies continuum (Lusebrink, 2010), gestalt art therapy (Rhyne, 2001), and schema therapy (Young, Klosko, &
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 et al., 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 practice (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 et al., 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 & Whittaker, 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 PDs (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 PD 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 programme is directed on patients with PDs 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 PD 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-judgemental 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. For example:

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 personalised 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 focused 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, focused 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.

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 towards each other' (autonomy vs. 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 colours, experimentally drawing lines, wiping with fingers/hands, and choosing one spontaneous word based on this experience. Observe, describe, participate non-judgementally, one-mindedly, and effectively to get into the present moment.
Assignment: Make a drawing on the theme 'What is above and below surface' with coloured ink using a horizontal line. This assignment focuses 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.

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

<table>
<thead>
<tr>
<th>Number</th>
<th>Art assignments</th>
<th>Change objectives</th>
<th>Performance objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Warming up: verbal exploration of emotions</td>
<td>1, 2, 3, 4</td>
<td>1, 2, 3, 7, 8, 9</td>
</tr>
<tr>
<td></td>
<td>Assignment 1: exploring basic emotions (fear, angry, happy, sad) in abstract</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>using sensory/motoric vs. symbolic art using pastels</td>
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<td></td>
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<tr>
<td></td>
<td>Assignment 2: 'Three sheets of paper working towards each other' (autonomy</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>vs. collaboration, with paint; interpersonal effectiveness)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Evaluation: reflection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Warming up: exploring present emotions with pastels ('What &amp; How skills';</td>
<td>1, 2, 3, 4</td>
<td>1, 2, 3, 4, 5, 7</td>
</tr>
<tr>
<td></td>
<td>observe, describe, participate &amp; non-judgementally, one-mindedly, effectively)</td>
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<tr>
<td></td>
<td>Assignment: 'Above and below surface' with coloured ink (emotion regulation,</td>
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<tr>
<td></td>
<td>dialectic theme)</td>
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<td></td>
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<tr>
<td></td>
<td>Evaluation: reflection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Warming up: relaxation and 'Personal weather message' with drawing materials</td>
<td>1, 2, 3</td>
<td>1, 2, 3, 4, 5, 7</td>
</tr>
<tr>
<td></td>
<td>Assignment: 'Life line', displayed in line, form, and colour (emotion regulation)</td>
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<td></td>
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<td></td>
<td>Evaluation: reflection</td>
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<tr>
<td>4</td>
<td>Warming up: exploring clay; sensory, motoric and affective (mindfulness skills)</td>
<td>1, 2, 3, 5</td>
<td>1, 2, 3, 4, 5, 6, 7, 9, 10</td>
</tr>
<tr>
<td></td>
<td>Assignment: two clay figures; 'Big self &amp; little self', what does the child need?</td>
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<tr>
<td></td>
<td>(exploring own schema modes)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Evaluation: dialogue between clay figures; exploring internal dialogue, reflection</td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td>Warming up: material experiment ('What &amp; How skills')</td>
<td>1, 2, 3, 4</td>
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<td>Assignment: 'Emerging painting' (improving the moment)</td>
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<td>Evaluation: titles for each other's work, reflection</td>
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<td>6</td>
<td>Assignment: 'The tormentor' (exploring negative feelings and thoughts/ helping</td>
<td>1, 2, 3, 5</td>
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<td>symbol; opposite action)</td>
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<td>Evaluation: reflection</td>
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<td>7</td>
<td>Warming up: imagination (improve the moment)</td>
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<td>Assignment: 'Clay monsters' (exploring anger and fear; emotion regulation)</td>
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<td>Evaluation: putting the monsters together, making up sounds and texts, reflection</td>
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<td>8</td>
<td>Assignment: 'Group painting' and role-play (interpersonal effectiveness, active</td>
<td>1, 2, 3, 4</td>
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<td>Evaluation: reflection</td>
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<td>9</td>
<td>Warming up: mindfulness exercise</td>
<td>2, 3, 5</td>
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<td>Assignment: 'Image of emotional pain' and soothing reaction; distress tolerance,</td>
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<td>opposite action to painful emotions, self-soothing</td>
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<td>Evaluation: reflection</td>
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<td>10</td>
<td>Assignment: 'Emotion in clay and other material' (emotion and experience</td>
<td>1, 2, 3</td>
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<td>Evaluation: reflection</td>
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Extra assignment 2: ‘Choose your most important art work’, for a leaving group member.
Assignment: Draw a personal ‘Life line’ to express your personal experiences in your history of life from birth until now using line, form, and colour. This assignment focuses on emotional organising and structuring of life experiences by transforming these into a creative expression, using a line, shapes, and colours 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 focused on the exploring of different self-images, schema modes, and polarities in the person, for example, 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 focused 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 focuses 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 focused 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, colour, 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 focused 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 PD 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 re-parenting’ 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 PD 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 PD symptomatology and other questionnaires that measure relevant concepts, for example, 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 PDs 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 PD 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 $\Delta d = -1.66$, detached emotional state $\Delta d = -1.31$, ‘happy child’ state $\Delta d = 1.55$, ‘healthy adult’ state $\Delta d = 1.60$; symptom distress $\Delta d = -1.94$).

Discussion
In this paper, we have described the systematic development of an art-therapy intervention programme aimed at people with PDs 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 PD and art-therapy literature were used to build a solid framework aimed at change objectives that are central for PD 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 PD 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 PD pathology and to organise collegial support or intervention.

In conclusion, the art-therapy intervention programme seems to be promising for patients with PDs 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 PDs 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.

Disclosure statement
No potential conflict of interest was reported by the authors.

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Susan van Hooren is professor at Zuyd University of applied sciences and Open University of the Netherlands. She is head of the research centre of arts therapies in the Netherlands, known as KenVaK and is head of the master of arts therapies. She has – as (neuro) psychologist and sexologist – clinical experience with a broad range of psychopathological disorders. Her research, supervising, and teaching focus on evaluating arts therapeutic interventions and its working factors, aging, sexology, and clinical psychology.

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References