



**Evaluation of a brief art psychotherapy group for adults suffering from mild to moderate depression: Pilot pre, post & follow-up study.**

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**Title**

Evaluation of a brief art psychotherapy group for adults suffering from mild to moderate depression: Pilot pre, post & follow-up study.

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## Abstract

### Objective

Current therapies do not offer universal solutions for the 'global burden' of depression. By focusing on non-verbal communication and creativity arts therapies might present a relevant treatment option but their effectiveness remains unclear. A pilot study was undertaken to evaluate a brief art therapy group for adults suffering from depression.

### Method

Adults experiencing mild to moderate depression took part in art therapy and completed questionnaires at three points in time. The intensity of depression, levels of anxiety and general wellbeing were measured. Semi-structured interviews focused on participants' expectations and experience of therapy.

### Results

A decrease in depressive symptoms was observed immediately after the therapy and at the follow-up, and a trend for improvement of subjectively perceived wellbeing was recorded. Potential benefits of therapy recognised by participants included: acceptance of depression, readiness to express emotions, sense of self and awareness of others, readiness for meaningful relationships, sense of achievement, sense of balance and new insights, growth and meaning.

### Conclusions

The statistically significant results and participants' experience indicate that art therapy may offer a valuable treatment option for depression and further research is recommended. Future studies should explore ways of addressing both the outcomes and the process of therapy through creative methodological designs.

### Keywords

depression; arts therapies; evaluation; pilot study; art psychotherapy

## Introduction

The growing impact of depression on populations worldwide is apparent and the condition has been recognised as a 'global burden' (Scott & Dickey, 2003) or a 'global crisis' (WFMH, 2012). By 2020 it is predicted to become the second most disabling illness in the world after heart conditions (WHO, 2010) and has serious implications for individuals, their families and societies, including a rising economic burden (NICE Costing statement, 2009).

Depression, being a complex "multifactorial illness" (SIGN, 2010), affects the whole person, including the body, affect and cognitive processes, and both the aetiology and the consequences of this condition have biological, social and psychological aspects. Thus, to reflect its complex presentation, the treatment of depression requires an appropriately holistic and individual approach (O'Donohue & Graybar, 2009), often combining pharmacological, psychosocial and psychological interventions (Sudak, 2011) to reflect the varying needs of those who experience depression.

Therapies currently recommended in the UK (NICE, 2009; SIGN, 2010) either have some significant adverse effects (antidepressant medication) or do not offer universal solutions for all who suffer from depression. Talking therapies in particular, although generally successful in addressing certain symptoms of depression, may not be appropriate for those who find it difficult or impossible to engage on a verbal level. An alternative to medication and verbal therapies may be found in the form of arts therapies (art therapy, music therapy, dance movement therapy and dramatherapy), where the non-verbal communication and creative expression are in the centre of the therapeutic process. These inclusive therapies may offer a more acceptable treatment option for those who may simply not be comfortable with speaking or whose verbal communication may be impaired by

1  
2  
3 depression. Moreover, by responding to the universally human need for self-expression, arts  
4  
5 therapies could potentially address the common withdrawal within depression and  
6  
7 encourage sharing.  
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10 Although numerous case studies confirm that arts therapies are used extensively to  
11  
12 address depression (Dokter, 1996; Payne, 1996; Cattanach, 1999; Reynolds, Lim & Prior,  
13  
14 2008), the effectiveness, and to some extent the nature of these interventions remain  
15  
16 unclear and significant differences in available evidence may be observed within individual  
17  
18 arts therapies disciplines. It is apparent when considering arts therapies for depression that  
19  
20 there are more studies of music therapy than any other type of arts therapies, and in  
21  
22 particular the research on dramatherapy and depression is very limited. Relevant good  
23  
24 quality studies include: Erkkilä et al., 2011 on music therapy, Jeong et al., 2005 on dance  
25  
26 movement therapy, and Thyme et al. 2007 on art therapy. In general, quantitative research  
27  
28 on primary depression in adults is sparse, but there are significant studies which consider  
29  
30 depression outcomes in people suffering from other conditions: art therapy has been  
31  
32 examined in cancer patients (Ando et al., 2013; Thyme et al., 2009), while music therapy has  
33  
34 been studied in older adults with dementia (Chu et al., 2013; Guetin et al., 2011; Myskja &  
35  
36 Nord 2008), as well as in the cases of substance abuse (Albornoz, 2011; Silverman, 2011).  
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43 Despite relatively low numbers of research studies and mostly small samples, the  
44  
45 mentioned projects undertaken worldwide offer promising results and suggest that arts  
46  
47 therapies interventions result in a significant positive change in mood, a decrease of  
48  
49 depressive symptoms and an improvement of general wellbeing. However, arts therapies  
50  
51 and depression still remain an underresearched area with not enough high-level evidence to  
52  
53 support their effectiveness (Evans, 2003). Although research activity among arts therapists  
54  
55 may be increasing, and the need for high quality projects seems to be recognised, many of  
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1  
2  
3 the studies to date lack scientific integrity and the two available Cochrane reviews (Maratos  
4  
5 et al., 2008, Meekums et al., 2012) have confirmed the methodological inadequacy of the  
6  
7 majority of the research studies evaluating the effectiveness of arts therapies for  
8  
9 depression.  
10

11  
12 The gap in knowledge remains and more effectiveness studies of high quality are  
13  
14 required, if arts therapies are to take their place amongst more conventional treatments.  
15  
16 However, the authors believe that evaluations in the field pose specific challenges as they  
17  
18 should reflect the creative nature of the disciplines (Meekums, 1996) and focus equally on  
19  
20 the outcomes and the process (Gilroy, 2006). While outcomes are commonly associated  
21  
22 with a quantitative approach and it may be argued that process is best explored through  
23  
24 qualitative methodologies, the two paradigms are rarely combined in individual research  
25  
26 studies. The current state of research in arts therapies and depression indicates a growing  
27  
28 need for quality pilot studies (Thabane et al., 2010; Lancaster et al., 2004) to enrich our  
29  
30 understanding of the mechanisms of therapy and to enable further assessment of  
31  
32 effectiveness. Researching outcomes alongside the process of therapy seems vital in  
33  
34 exploratory studies and this is the approach taken in the current report.  
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### 42 **Aims of this research**

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45 The current pilot study was conducted with an aim to evaluate arts therapies for  
46  
47 depression and assess the feasibility of a potential randomised controlled trial. The core  
48  
49 research questions were:  
50

- 51  
52 1. What is the value of an art therapy group in the treatment of adult depression?
- 53  
54 2. Is a larger RCT feasible with available resources? What adjustments would a  
55  
56 larger study require?  
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1  
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3 The current paper focuses on question 1., while a detailed assessment of feasibility is  
4  
5 available from the first author's PhD thesis (Zubala, 2013). The first research question  
6  
7 demanded addressing more specific objectives, which were:  
8  
9

- 10 • to identify any changes in depression levels (primary outcome)
- 11
- 12 • to identify any changes in anxiety levels and general wellbeing (secondary outcomes)
- 13
- 14 • to collect participants' evaluation of the experience of an art therapy group.
- 15
- 16

17 Other objectives included an exploration of significant moments in the therapeutic  
18  
19 process. These objectives were met through observation and an arts-based inquiry; the  
20  
21 findings will be presented in a separate publication.  
22  
23

24 The complexity of objectives of this research study required flexible and creative  
25  
26 approaches to the research design, data collection and analysis methods. The use of mixed  
27  
28 methods allowed for different perspectives to form a coherent in-depth evaluation.  
29  
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31

### 32 **Ethical approval**

33  
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35  
36 Specific measures have been put in place to ensure participants' safety and  
37  
38 wellbeing. Suitability of those measures was thoroughly assessed by the Research Ethics  
39  
40 Committee at Queen Margaret University as well as the local NHS Research Ethics  
41  
42 Committee and the NHS Research and Development Office, from which suitable ethical  
43  
44 approvals were obtained in September 2012. An Honorary Research Contract, enabling the  
45  
46 researcher to access NHS premises for the purpose of the project, was obtained in February  
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48 2013.  
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## Methodology

### Procedure: pilot single group pretest, posttest, follow-up study

A pilot single group study of a pretest, posttest and follow-up design was conducted in which an art therapy group treatment for adults suffering from depression was facilitated. The participants' response to therapy was evaluated using a battery of questionnaires as well as interviews and observation.

### Intervention

An art therapy group was facilitated in 2013. The group met twice weekly over the period of five weeks; nine one-hour long sessions were offered. The intervention was manualised in line with the current guidelines for depression (e.g. Jongsma et al., 2006) and good arts therapies practice. The treatment manual was also guided by research on depression and psychotherapy and reflected the findings from earlier stages of the a larger research on arts therapies and depression including the nationwide survey of arts therapists (Zubala et al., 2013; Zubala et al., 2014a,b).

The manual was intended to give guidance to both the therapist and the researcher, while preparing, facilitating and reflecting on the intervention. By no means did it aim to provide an exhaustive list of tools or activities to be used. Rather, it highlighted the main theoretical underpinnings of the planned intervention, discussed the aims of the therapy in the specific context of adult depression, provided an overview of the expected life of the group, pictured the general structure of each session and suggested exemplary activities. (For more details and for the treatment manual itself please refer to Appendix 11 in Zubala, 2013.)



1  
2  
3 Several approaches underpinned the intervention, which was: a) brief, b) group  
4  
5 based, c) person-centred, and d) incorporating psychodynamic principles. The unavoidably  
6  
7 brief character of the therapy demanded establishing of a positive therapeutic alliance early  
8  
9 in the process and a more active approach on the therapist's side. Discouraging dependence  
10  
11 while providing appropriate holding (Mander, 2006) was considered crucial. The many  
12  
13 unique therapeutic factors of group therapy (Yalom & Leszcz, 2005) were considered in the  
14  
15 manual, as were the potential challenges of group work in the context of depression. The  
16  
17 need to relate and engage versus the tendency to isolate were expected in the group.  
18  
19  
20  
21 Psychodynamic principles, generally highly valued among arts therapists and art therapists  
22  
23 in particular (Karkou & Sanderson, 2006; Zubala et al., 2013), in this project concerned the  
24  
25 role of unconsciousness, insight and relationships within the group reflecting connections  
26  
27 with self and others. The person-centred character of the intervention followed the qualities  
28  
29 listed by Rogers (1951): acceptance, genuineness and empathy, and other humanistic  
30  
31 principles including belief in the natural human potential to grow and the central role of  
32  
33 self-expression and creativity.  
34  
35  
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39 The ultimate aims of therapy highlighted, among others: instillation of hope,  
40  
41 confidence building, encouraging creativity and self-expression, development of social  
42  
43 support and increasing self-awareness and appreciation of others. Aims more specific to the  
44  
45 particular group were developed following individual clinical assessments. Examples of main  
46  
47 underlying problems of the group included: difficulties with forming relationships and  
48  
49 trusting people, lack of self-confidence, tiredness, lack of motivation, social isolation and  
50  
51 loss or bereavement. Psychological mechanisms responsible for the most common problems  
52  
53 identified were then named and counterbalanced by a corresponding therapeutic aim (e.g.  
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2  
3 relaxation in response to constant fighting, expression in response to blockage, awareness  
4  
5 of others in response to self-consciousness – see Appendix 12 in Zubala, 2013).  
6  
7

8  
9 The sessions offered general structure and flexibility at the same time and included:

10  
11 a) introduction (mostly verbal, invitation to participants to reflect on last session and/or  
12  
13 time in-between sessions, 10-20 minutes), b) art making (usually individual work at shared  
14  
15 table, 20-40 minutes), c) conclusion (sharing art work – visually and verbally, final  
16  
17 reflections, 10-20 minutes). In most sessions a theme emerged in the introductory stage  
18  
19 which was then explored by participants through art making. Structure was considered  
20  
21 particularly important in the context of depression, when the sense of self and confidence  
22  
23 are often low and making choices may be difficult (Brok, 2011). It was intended to relieve  
24  
25 anxiety, leading to a more meaningful engagement with the process of therapy. Providing a  
26  
27 safe space that did not affect the creative and therapeutic process was the key intention  
28  
29 and participants were invited to change the structure and make choices at all times.  
30  
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32  
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34

### 35 36 **Setting**

37  
38 A local mental health hospital was identified as a safe and most appropriate place for  
39  
40 both purposes: the interviews and the facilitation of treatment. Office spaces for conducting  
41  
42 interviews were available within an outpatient service while an art room within an  
43  
44 occupational therapy department provided a suitable space for art therapy.  
45  
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47

### 48 49 **Therapist**

50  
51 A qualified art therapist with a special interest in depression volunteered to deliver  
52  
53 group therapy in this project. The therapist offered her time to meet with the researcher on  
54  
55 two occasions before the start of the treatment and was invited to comment on the  
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1  
2  
3 emerging treatment manual. Time was allocated before and after each session for the  
4  
5 therapist and the researcher to consult the progress and share insights and suggestions for  
6  
7 further intervention. Thus, it needs to be acknowledged that the actual intervention was  
8  
9 shaped by both the treatment manual and the therapist's experience. During the sessions,  
10  
11 the researcher was present but inactive and the clinical decisions were made by the  
12  
13 therapist alone.  
14  
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18

### 19 **Participants**

20  
21 This pilot study looked to recruit participants who: a) were adults (age between 16  
22  
23 and 65), b) suffered from mild to moderate depression (based on self-disclosure and  
24  
25 assessed through completion of PHQ-9), c) were willing not to engage in any other, new to  
26  
27 them, psychotherapeutic treatments during the course of the study (unless they have  
28  
29 already been in a long term therapy). Exclusion criteria applied to those a) who were not  
30  
31 able to give an informed consent, b) whose English was not fluent enough to communicate  
32  
33 meaningfully, c) who suffered from any mental health condition with a psychotic  
34  
35 component (based on self-disclosure and observation), d) whose severity of depression  
36  
37 might have affected their ability to complete the required questionnaires and might have  
38  
39 significantly lowered the likelihood of regular attendance. It was accepted that the  
40  
41 participants were treated as they would normally be in the NHS health care system while  
42  
43 attending the arts therapies group. It was therefore understood that some or all of them  
44  
45 might have been receiving pharmacotherapy and/or counselling sessions while in the art  
46  
47 therapy group.  
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55 Participants were recruited during a two-week period from the community, through  
56  
57 voluntary organisations and self-referred in response to online and paper advertising. A  
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3 total number of around 60 mental health services and community support groups were  
4  
5 contacted via e-mail and post, of which some expressed a specific interest in advertising and  
6  
7 promoting the project in their newsletters and bulletins. Information about the research  
8  
9 was also distributed (in the form of leaflets and posters) in 28 different places in the city  
10  
11 centre: nine GP practices, three Community Mental Health Teams, four community centres,  
12  
13 student counselling services at three universities and a selection of several private services  
14  
15 focusing on wellbeing and health. A dedicated website was additionally created, with  
16  
17 downloadable pdf versions of both the information sheet and the consent form. This  
18  
19 ensured that the potential participants could be given enough time to reflect on the project  
20  
21 and its possible implications before making an informed decision to take part.  
22  
23  
24  
25

26  
27 Twelve potential participants (or their relatives) contacted the researcher during the  
28  
29 two weeks of recruitment, of whom seven signed the consent form. Two of them resigned  
30  
31 from taking part due to the inconvenient days/times of therapy and the final group  
32  
33 consisted of five participants, female and male, whose age ranged from 32 to 65. In order to  
34  
35 protect participants' identities, either aggregated data or individual data with no age or  
36  
37 gender labels attached will be presented in the following sections (the anonymous form of  
38  
39 "she/he" will be used).  
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#### 46 **Quantitative methods: Questionnaires**

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48  
49 In this study the severity of depression was a primary outcome measure, while the  
50  
51 levels of anxiety and general wellbeing constituted secondary outcome measures.  
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53  
54 Participants were asked to complete three questionnaires (PHQ-9, GAD-7 and WHO-5) on  
55  
56 three occasions: before the treatment (week 0), after the treatment (week 5) and during a  
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2  
3 follow-up (week 16-17). The PHQ-9 was additionally filled in by each participant in the  
4  
5 middle of the treatment (week 3). The researcher arranged to meet with the participants for  
6  
7 collection of these data. The initial interview was offered immediately after a potential  
8  
9 participant stated that she/he was willing to take part in this project and the earliest  
10  
11 convenient date was agreed. The final interviews were arranged for the day after the last  
12  
13 therapy session. The follow-up interviews were arranged individually in weeks 16 and 17  
14  
15 from the start of the project (11-12 weeks after the therapy has ended).  
16  
17  
18

19  
20 The severity of depression, a primary outcome measure, was assessed through the  
21  
22 **PHQ-9** questionnaire (Kroenke et al., 2001), a short scale widely used within the NHS. It has  
23  
24 proved to be a valid and reliable tool, which correlates highly with other commonly used  
25  
26 measures like BDI-II or HAD-D (University of Aberdeen, 2011). In addition to being sensitive  
27  
28 to change and therefore suitable to assess changes in depression levels over time, the scale  
29  
30 is used as a screening and monitoring tool and served all of these purposes in this project.  
31  
32

33  
34 The levels of general anxiety were measured using **GAD-7** (Spitzer et al., 2006),  
35  
36 which has been frequently applied as a secondary outcome measure in depression trials  
37  
38 alongside PHQ-9 (Instruction Manual for PHQ and GAD-7, 2012).  
39

40  
41 The measurement of general wellbeing was based on the **WHO-5** Well-being Index  
42  
43 (WHO-5, online) - a 5-item non-invasive scale consisting of positively constructed  
44  
45 statements, developed to assess subjective quality of life as a dimension of psychological  
46  
47 wellbeing and successfully used as a screening tool for depression (Primack, 2003). The  
48  
49 items in this scale relate to the positive mood, vitality and interest in things as opposed to  
50  
51 the symptoms of ill-health or disability.  
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53

54  
55 The validity and reliability of the aforementioned self-reporting scales used in this  
56  
57 research were carefully checked, as was their applicability to the population in question. It  
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1  
2  
3 was believed that the combination of the questionnaires would provide a relatively  
4  
5 comprehensive picture of various aspects of depression in response to the intervention,  
6  
7 while not being too overwhelming for the participants. Achieving a balance between  
8  
9 potentially available new knowledge (research value) and the participants' comfort was  
10  
11 particularly important for the researcher.  
12  
13

### 14 15 16 17 18 **Qualitative method: semi-structured interviews** 19

20  
21 Not only did this research aim to evaluate arts therapies for their ability to alleviate  
22  
23 symptoms of depression, but importantly to understand participants' experience of the art  
24  
25 therapy group. Therefore, collection of qualitative data was embedded in the study design,  
26  
27 following a general quantitative frame.  
28  
29

30  
31 The interviews with the participants were conducted by the researcher prior to and  
32  
33 after the treatment, as well as in the follow-up. Their main purpose was to collect direct  
34  
35 accounts from the participants of their expectations and experiences of an art therapy  
36  
37 group. The interviews were conducted in a semi-structured format to allow for a person-  
38  
39 centred approach as well as for scientific reliability and the reduction of researcher's bias. It  
40  
41 needs to be noted that the interviews had a dual role and intended to enable the collection  
42  
43 of data (research purpose) as well as the psychological assessment (clinical purpose) and  
44  
45 were thus facilitated by the researcher who is a qualified psychologist. In addition, the  
46  
47 qualitative data collected needed to reflect the two aims: the assessment of outcomes and  
48  
49 process of therapy and the assessment of feasibility of a larger study. Themes relating to the  
50  
51 assessment of feasibility will not be presented in this report due to limitation in the length  
52  
53  
54  
55  
56  
57 of this paper (please refer to Zubala, 2013).  
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1  
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3 The initial and final interviews were audio recorded, while in the follow-up  
4  
5 interviews notes were taken as needed. The findings resulted in a series of themes, which  
6  
7 will be presented briefly in this report and in more detail in a separate publication.  
8  
9

### 10 11 12 13 **Quantitative analysis**

14  
15 Due to a small sample and the assumed lack of normal distribution, the data  
16  
17 collected through the questionnaires were analysed using a non-parametric statistical test  
18  
19 (a related samples Wilcoxon test) to allow for comparison of the results before and after the  
20  
21 treatment. Scores for each questionnaire completed by the participants were compared in  
22  
23 combinations as follows: 1) the pre therapy (initial) with post therapy (final) result, 2) the  
24  
25 pre therapy (initial) with follow up (follow-up) result. Additional comparisons were  
26  
27 performed on the initial and interim scores as well as the interim and final scores of PHQ-9,  
28  
29 for which such data were available.  
30  
31  
32  
33  
34

35 A series of null hypotheses assuming the equality in the median of differences  
36  
37 between mentioned scores were tested; the statistical significance of any observed changes  
38  
39 was assessed and areas of highest significance were highlighted.  
40  
41  
42  
43  
44

### 45 46 **Qualitative analysis**

47  
48 Thematic analysis (Vaismoradi et al., 2013, Braun & Clarke, 2006) served as a general  
49  
50 framework for approaching qualitative data. Template analysis (King, 2011) was then  
51  
52 employed to allow for themes to emerge from both the interview schedule and the free-  
53  
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1  
2  
3 flowing participants' responses. Qualitative data analysis software (NVivo, 2010) was used  
4  
5 throughout the process to assist with the data storage, coding and classification.  
6

7  
8 The content of the initial, final and follow-up interviews was initially coded according  
9  
10 to the categories derived from the questions. While specific themes were looked at within  
11  
12 the participants' responses, the method of template analysis allowed for unpredicted topics  
13  
14 to emerge. Both the expected and emerging themes were then grouped into categories to  
15  
16 provide a meaningful structure to the analyzed data.  
17

18  
19 Specific parts of the same datasets additionally enabled both the evaluation of the  
20  
21 intervention and the assessment of feasibility of a larger study. The process of analysis was  
22  
23 carried with both aims in mind and simultaneously. In practice, a separate category for the  
24  
25 assessment of feasibility was created where any suitable pieces of information could have  
26  
27 been placed.  
28  
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33

## 34 **Results**

35  
36  
37 All five participants completed the full course of treatment, with an overall  
38  
39 attendance rate of 87%. Also, all attended the initial, final and follow-up interviews in  
40  
41 person and completed the set of questionnaires, with an exemption of one case when a  
42  
43 participant missed her/his follow-up interview but agreed to communicate via email.  
44  
45  
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### 51 **Assessment of changes in depressive symptoms: Outcomes from questionnaires**

52  
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54 Scores for each questionnaire completed by the participants were compared to  
55  
56 identify any changes. Table 1 lists the hypotheses and the results of testing. Figures 1, 2 and  
57  
58  
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60



1  
2  
3 further present individual participants' scores on the three questionnaires measured at  
4  
5 four (PHQ-9) or three points in time (GAD-7 and WHO-5). Graphs offer an immediate visual  
6  
7 assessment of the trends in the scores. [Table 1 around here]  
8  
9

### 10 11 **Assessment of changes in depression levels (PHQ-9)**

12  
13  
14 Statistically significant differences between the initial and the final, as well as the  
15  
16 initial and the interim scores (both  $p=.042$ ) in PHQ-9 suggest that the level of severity of  
17  
18 participants' depression decreased after the course of art therapy. The decrease in  
19  
20 depression levels remained equally significant ( $p=.043$ ) in the follow-up assessment (as  
21  
22 compared to the initial scores). For all participants the final and follow-up PHQ-9 scores  
23  
24 were lower than the initial measurement. In addition, two of the participants, whose  
25  
26 depression was initially relatively mild, did not present symptoms of depression in their final  
27  
28 and follow-up assessments (score lower than 5).  
29  
30  
31

32  
33 A general trend towards a decrease in depression levels may be observed in  
34  
35 participants' individual scores. The effect seems to be more linear for those participants  
36  
37 whose depression was initially mild (P4 and P5), more complex for the participants with  
38  
39 initially moderate depression (P2 and P3) and less obvious for the participant, whose  
40  
41 depression was initially more severe. [Figure 1 around here]  
42  
43  
44

### 45 46 **Assessment of changes in anxiety levels (GAD-7)**

47  
48  
49 No statistically significant difference was found between the initial, final and follow-  
50  
51 up scores in GAD-7. The results were mixed for different participants, with three members  
52  
53 of the group showing a decrease and two members an increase in anxiety levels at the end  
54  
55 of the therapy. Both participants, whose anxiety increased during the project, showed a  
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1  
2  
3 slight decrease of depression levels. In the follow-up assessment, four participants revealed  
4  
5 lower levels of anxiety in comparison with measurements pre-therapy, while one participant  
6  
7 scored higher than in the initial assessment. *[Figure 2 around here]*  
8  
9

### 10 ***Assessment of changes in general well-being (WHO-5)***

11  
12  
13  
14 No statistically significant difference was found between the initial, final and follow-  
15  
16 up scores in WHO-5. However, four out of five participants reported improved well-being  
17  
18 and an increased satisfaction with life immediately after their therapy, while those factors  
19  
20 lowered for one participant. In the follow-up assessment four participants revealed an  
21  
22 improved well-being in comparison to the pre-therapy state, while no change was observed  
23  
24 for one participant. These results were additionally complemented by the interviews.  
25  
26 Although the observed changes were not statistically significant, a possible trend towards  
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28 improvement in wellbeing, especially in longer term (in the follow-up, 10-11 weeks after  
29  
30 therapy) is worth noting. *[Figure 3 around here]*  
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### 36 ***Summary of results***

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39 A statistically significant decrease in depression levels, assessed using a relevant  
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41 questionnaire, was noted immediately after the treatment and in the 11 weeks follow-up in  
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43 all five participants attending a brief group art therapy. Improvement in perceived wellbeing  
44  
45 was noted by four participants immediately after the therapy and in the 11 weeks follow-up,  
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47 although the effect was not statistically significant. No significant effect of therapy on the  
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49 levels of anxiety was noted, while it increased for some participants and decreased for  
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51 others.  
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### Themes from initial, final and follow-up interviews: Brief summary

The interviews with participants at three points in time were crucial for the understanding of their experience of art therapy and involvement in the project. Participants' evaluation of the research process, invaluable in assessing the feasibility of a larger study, has been presented in the author's doctoral thesis (Zubala, 2013). Findings from the participants' comments on the therapy process will be presented elsewhere in more detail and summarised here for a more condensed essence of the participants' experience to complement the quantitative results.

#### *Initial interviews*

The initial interviews enabled understanding of the characteristics of participants as individuals and as a group of adults sharing similar mental health difficulties. Participants described the nature of their depression as characterised by: low mood, poor concentration, lack of motivation, withdrawal from social contacts, tiredness, problems with sleep, increased anger, suicidal or self-harm thoughts and feelings of guilt, emptiness, weight, effort and feeling old. It is important to note that not all of the symptoms were mentioned by every participant, but some were present in most responses. All participants located the beginning of their depression in their teenage or early adult years. However, some mentioned that the awareness of their condition came in later life. Two participants highlighted that striving to stay in balance is an important aspect of their condition.

The perception of self and the images of ideal self helped further understand the nature of participants' problems and establish treatment aims. While they described themselves as quiet, reserved, not confident, anxious, impulsive and interested in people, they wished they were more confident, more adventurous, less angry, feel more meaning

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3 and lightness in their lives and have meaningful and satisfying relationships with other  
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5 people.  
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8 The interviews offered a further understanding of the usual coping strategies and  
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10 resources available to participants. Most realised that involvement in satisfying activities  
11  
12 throughout the day helped relieve their depression but they often found it difficult to  
13  
14 engage due to low motivation. Social and family support was limited for most participants  
15  
16 and they often mentioned family disputes or a lack of understanding from relatives as the  
17  
18 factors contributing to their depression. At least three participants recognised altered  
19  
20 thinking patterns when depressed, involving persistent negative thoughts and focusing on  
21  
22 themselves. Simple coping mechanisms like repression were used and it was noted that  
23  
24 directing the thought process on other people was helpful.  
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29 All participants had received some sort of professional mental health support at  
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31 certain points in the past (support from GPs and psychiatrists, often antidepressants), and  
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33 all had some experience of talking therapies, including CBT, CAT and counselling – all with  
34  
35 varying effects. None of the participants had had experience of arts therapies before the  
36  
37 project.  
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41 The participants expected their art therapy sessions to be challenging and a hard  
42  
43 work, as well as a learning experience and an opportunity to relax, while “not talking but  
44  
45 doing”. They hoped that it would offer an outlet for emotions as well as new insights and  
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47 rediscoveries. Although specific expectations seemed to have been present, some  
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49 participants spoke about their uncertainty mostly and avoided admitting expectations.  
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### 52 ***Final interviews***

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3 In their final interviews, most participants felt that the reality of therapy was  
4  
5 different to what they had expected. However, the analysis of comments in the final  
6  
7 interviews showed that some or most of the initial expectations were met. The participants  
8  
9 described their experience of art therapy as valuable, interesting and challenging and shared  
10  
11 what they liked and disliked in the process. Feelings of achievement and relief were also  
12  
13 mentioned. Some aspects of the therapy (like being in a group and self expression) had both  
14  
15 pejorative and positive connotations.  
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20 Certain moments in therapy were identified by the participants as carrying more  
21  
22 meaning than others. These significant, best remembered moments in therapy concerned  
23  
24 either times when a particular personal insight was gained (e.g. rediscovered aspects of self,  
25  
26 increased knowledge of self) or a connection or meaningful exchange between the group  
27  
28 members occurred (typically triggered by engagement in discussion after art making). Often  
29  
30 the most memorable moments indicated times when progress in therapy was made.  
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34 The outcomes of the therapy in most cases were not immediately obvious to the  
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36 participants and they reported uncertainty of the treatment effects and doubts whether the  
37  
38 therapy had been helpful. However, further responses revealed diverse areas in which  
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40 changes were acknowledged by the participants. Among these were: increased awareness  
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42 and appreciation of others; increased self awareness / knowledge of self / realisation of own  
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44 needs; a sense of achievement; willingness and readiness to further explore own creativity  
45  
46 outside of therapy sessions; friendship born within the group; increase of anxiety; and  
47  
48 improvement in physical symptoms (better sleep, less headaches).  
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53 Certain themes were common and seemed most significant in participants'  
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55 evaluation of the process of their therapy and these were named by the researcher as:  
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3 “being in a group”, “challenges of therapy”, “depression as elephant” and “meaning of  
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5 therapy”.

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8         Participation in the therapy was considered challenging by the participants. Being  
9  
10 and working in a group seemed to have been the most remembered and valued and  
11  
12 simultaneously the most distressing and unwanted experience in the therapy. For most  
13  
14 participants it was difficult to make art in front of others and to share feelings in the  
15  
16 discussion at the end of sessions. Therefore being in a group was identified as one of the  
17  
18 biggest challenges the participants experienced alongside the difficulties with self-  
19  
20 expression and spontaneous creativity (i.e. difficulties with being spontaneous in using art  
21  
22 materials and deciding on the content of an artwork).  
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27         One participant recognised that the subject of depression often remained “an  
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29 elephant in the room” and others admitted that they were often anxious or not comfortable  
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31 with bringing it up for discussion in fear that this would cause distress in the group, although  
32  
33 they shared the willingness to explore the nature of depression further. The paradox of the  
34  
35 need for deeper exploration of the subject combined with anxiety and the  
36  
37 apprehensiveness of sharing painful experiences with others was apparent.  
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41         Finally, most participants were inclined to reflect on the process of therapy and  
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43 recognised that the therapy was meaningful to them although were often unable to  
44  
45 precisely locate the meaning in context. Potential ability of the art therapy to enhance  
46  
47 creativity and motivation was considered especially relevant to depression. The areas which  
48  
49 triggered new insights concerned openness towards others and their problems, new ideas  
50  
51 about the essence of creativity and spontaneity and reflections on the expression and  
52  
53 awareness of emotions.  
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### ***Follow-up interviews***

The time between the final and follow-up interviews (approximately 11 weeks) seemed to have allowed for the experiences to consolidate and enabled a deeper understanding of the therapy process. New insights emerged and the participants shared their reflections on the process. It is apparent that for most participants the meaning of the therapy became clearer with time while the immediate outcomes of treatment were less obvious. The subtlety of these newly realised implications was acknowledged and they included:

- a) enhancement of creativity, spontaneity and motivation
- b) acceptance of own feelings, which need to be experienced in therapy
- c) expression of emotions, “getting things out”
- d) increase of openness towards others, willingness to share and realisation how others may be helpful
- e) acceptance of depression.

### **Discussion**

The presented project was essentially a pilot study aiming to assess the feasibility of a larger and more rigorous investigation and to assist in the development of a coherent intervention. The relatively small number of participants is actually considered optimal for a psychotherapy group (Bateman et al., 2010). It is often highlighted that for a deeper therapeutic process to take place, a sufficiently long treatment is required and many research studies that evaluated arts therapies through RCTs worldwide adopted a 12 week intervention (Jeong et al., 2005; Hamamci, 2006). However, recent trends in arts therapies

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3 RCT-based research seem to support the tendency to shorten the total time of treatment,  
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5 while intensifying it by providing therapeutic sessions more often than once a week  
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8 (Castillo-Perez et al., 2010; Erkkilä et al., 2011). A similar approach was adopted in this  
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10 study, but the findings seem to indicate that a longer treatment might be preferred by  
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12 participants and potentially lead to more consistent outcomes.  
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15 All five participants completed the full course of treatment and attended interviews  
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17 at three points in time. Willingness to accept the offered therapy and compliance with  
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19 treatment may be explained by autonomous motivation, which is among the factors  
20  
21 contributing to the success of psychotherapeutic interventions (Zuroff et al., 2007). The fact  
22  
23 that the participants needed to take initiative to sign up for their therapy seemed to have  
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25 explained their heightened motivation to complete the treatment and the willingness to  
26  
27 engage in the challenging aspects of the process, as reported by the participants and  
28  
29 observed by the researcher. Although a detailed feasibility assessment is not a subject of the  
30  
31 current report, it is worth mentioning that the brief recruitment of just over two weeks and  
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33 in a local area only resulted in interest exceeding expectation and the researcher was in fact  
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35 contacted by volunteers willing to participate beyond the timeframe of this project. This  
36  
37 indicates the attractiveness of art therapy for adults who experience depression and has  
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39 clear implications for a potential larger trial. With sufficient time given for reflection and  
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41 making a decision to consider this form of therapy, participants are likely to complete the  
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43 full course of treatment.  
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50 Although the sample was too small to allow for generalisation, a statistically  
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52 significant tendency of depression scores to lower following the therapy was observed.  
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55 Similar results were obtained from a number of arts therapies studies (Erkkilä et al., 2011;  
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57 Jeong et al., 2005; Thyme et al., 2007). While the current study did not include a control  
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3 group, it may not be concluded with certainty whether this effect occurred as an implication  
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5 to the therapy or whether it was due to other reasons, including a possible spontaneous  
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7 recovery from depression (Ankarberg & Falkenström, 2008).  
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11 The results concerning anxiety and wellbeing were inconclusive, while no statistically  
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13 significant differences were found between the pre and post therapy scores. The lack of  
14  
15 confirmation of an impact of the therapy on these factors does not, however, equal an  
16  
17 absence of such influence. In the follow-up an improvement of subjective wellbeing levels  
18  
19 was noted in the scores of four out of five participants. The positive impact of arts therapies  
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21 on general wellbeing has been widely recognised (Karkou & Sanderson, 2006) but, to the  
22  
23 authors' knowledge, has not yet been documented in the treatment of depression.  
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28 In the current study a decrease of anxiety levels was noted in the scores of three out  
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30 of five participants while two participants experienced an increase of anxiety. This may  
31  
32 potentially be a temporary effect of the therapy, which might have been too brief to  
33  
34 adequately support participants who may need longer time for benefiting from the  
35  
36 treatment. Supposing that the course of the therapy was too short to offer substantial  
37  
38 improvement, it is possible that the therapy ended when some of the participants were  
39  
40 experiencing increased anxiety, a "spike" (Hayes et al., 2007) often expected in the middle  
41  
42 of the treatment. A longer therapy would potentially allow to address those anxieties.  
43  
44 Alternatively, the effect may be an example of a common in psychotherapy phenomenon  
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46 that an approaching end of the treatment itself, regardless its duration, causes an increase  
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48 of anxiety, when facing the reality outside of the therapy room becomes inevitable.  
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53 Interviews with the participants indicate that in the current study the increase of  
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55 anxiety should perhaps be considered alongside the need for meaningful connections and  
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3 relationships. While 'being in a group' was valued by the participants, it presented  
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5 challenges and was met with growing anxieties. More in-depth analysis of this and other  
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7 themes emerging from this project will be presented elsewhere.  
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## 10 11 12 13 **Limitations**

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17 The main limitation of this study was the lack of a control group potentially enabling  
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19 comparison and conclusions regarding efficacy. A short timeframe, additionally limited by  
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21 the lengthy process of obtaining necessary ethical approvals meant that a pilot trial could  
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23 not be attempted. However, the assessment of effectiveness or results of a statistical  
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25 significance were not among the aims, as were not achievable within the set boundaries of  
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27 time, budget and expertise. Instead, all efforts were made to ensure that a sound basis for  
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29 further research was created and trends rather than effects were observed. Assessment of  
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31 feasibility of a larger study was considered very seriously and the project followed the  
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33 procedure of a pretest, posttest and follow-up study as rigorously as was possible, given the  
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35 limitations of resources.  
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41 If the study was to be conducted with the participation of patients using NHS  
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43 services for their mental health condition, participants with co-morbid mental health  
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45 diagnoses could be easily excluded to ensure better control of variables. In this study the  
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47 participants' formal diagnoses could not be confirmed, as they were recruited directly from  
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49 the community. This 'real life' research, however, accepted that the participants were  
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51 recruited based on what they disclosed and a simple clinical assessment during the initial  
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53 interview with the researcher.  
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3 Other limitations to this study included: a lack of formal recruitment of a therapist  
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5 and a lack of opportunities for potential participants to enrol in the project using  
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7 communication channels other than e-mail.  
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## 10 11 12 13 **Conclusions**

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17 In this study a brief art therapy group for adults suffering from mild to moderate  
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19 depression was evaluated based on treatment outcomes and participant experience. It may  
20  
21 be concluded that a brief group art therapy may be a safe, acceptable and valuable  
22  
23 intervention for adults suffering from depression. While it remains unclear whether the  
24  
25 particular intervention was effective, it was received well by the participants and may  
26  
27 potentially allow for a number of benefits, including a decrease in the symptoms of  
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29 depression and an improvement in the subjectively perceived wellbeing. Although no  
30  
31 certain conclusions may be drawn as to whether the art therapy or other factors were  
32  
33 responsible for the changes observed in this study, a trend was recorded for the depression  
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35 scores to lower immediately after the therapy and remain on similar or even lower levels  
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37 during the follow-up assessment. The statistically significant results as well as participants'  
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39 feedback regarding their therapy are promising and open an area for further research  
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41 exploration.  
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48 Areas of psychological wellbeing which may potentially be enhanced through arts  
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50 therapies include an increase of: acceptance of depression and its challenges, creativity and  
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52 readiness to express emotions, sense of self and awareness of others, readiness for  
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54 meaningful communication and relationships. Additionally, arts therapies may potentially  
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56 bring a sense of achievement, a sense of balance and new insights and may facilitate growth  
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3 and finding meaning for adults suffering from depression. However, arts therapies practice  
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5 with depression is demanding and brings challenges to both the therapists and the clients. It  
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7 is thus important that the therapists understand the concepts core to depression and likely  
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9 to play a vital role in the therapy process, e.g. time, layers of symptoms covering the main  
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11 problem, the feeling of being trapped, the need for hope and relaxation to relieve initial  
12  
13 tension (Zubala et al., 2014b).  
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16  
17 It needs to be noted that these conclusions should be placed within the context of  
18  
19 this particular brief group art therapy intervention only and do not claim to offer an  
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21 evaluation of arts therapies practice in general. However, by proposing and successfully  
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23 implementing a creative research design while providing promising findings, this pilot study  
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25 has offered a background for further larger scale research, extended in size and scope in the  
26  
27 future.  
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31 It is recommended that controlled studies are undertaken to evaluate arts therapies  
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33 for depression. These should adopt suitable creative research designs and focus on the  
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35 process as well as the outcomes to offer findings meaningful to academic and clinical  
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37 populations, and to the depression sufferers themselves. Evaluating treatment outcomes as  
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39 well as participant experience of the therapy is crucial for a comprehensive assessment of  
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41 arts therapies' potential to address depression. Therefore, further similar pilot studies are  
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43 much needed in other arts therapies disciplines. Well conducted and creative projects could  
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45 eventually lead to comprehensive large scale evaluations, establishing the unique role that  
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47 arts therapies might play in a global challenge to tackle depression.  
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3 **Table**  
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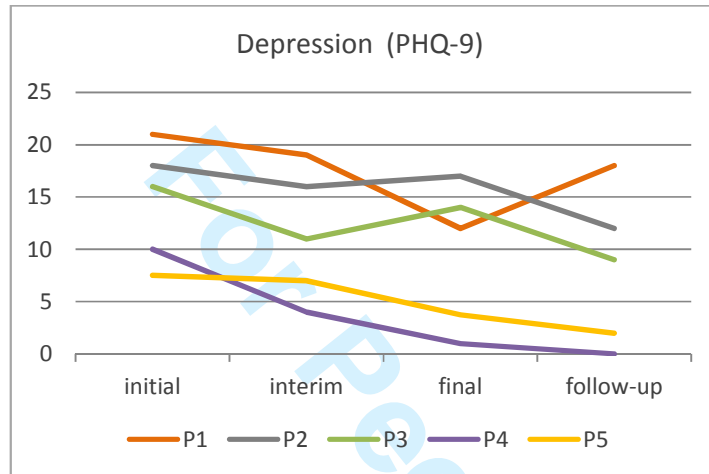
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Null Hypothesis	Sig.	Decision
The median of differences between <b>PHQ9initial</b> and <b>PHQ9final</b> equals 0.	.042*	Reject the NH
The median of differences between <b>PHQ9initial</b> and <b>PHQ9interim</b> equals 0.	.042*	Reject the NH
The median of differences between <b>PHQ9interim</b> and <b>PHQ9final</b> equals 0.	.279	Retain the NH
The median of differences between <b>PHQ9initial</b> and <b>PHQ9follow-up</b> equals 0.	.043*	Reject the NH
The median of differences between <b>GAD7initial</b> and <b>GAD7final</b> equals 0.	.492	Retain the NH
The median of differences between <b>GAD7initial</b> and <b>GAD7follow-up</b> equals 0.	.197	Retain the NH
The median of differences between <b>WHO5initial</b> and <b>WHO5final</b> equals 0.	.223	Retain the NH
The median of differences between <b>WHO5initial</b> and <b>WHO5follow-up</b> equals 0.	.068	Retain the NH

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29 Table 1: Null hypotheses tested with Related-Samples Wilcoxon Signed Rank Test (significance level  
30 of <.05 highlighted).  
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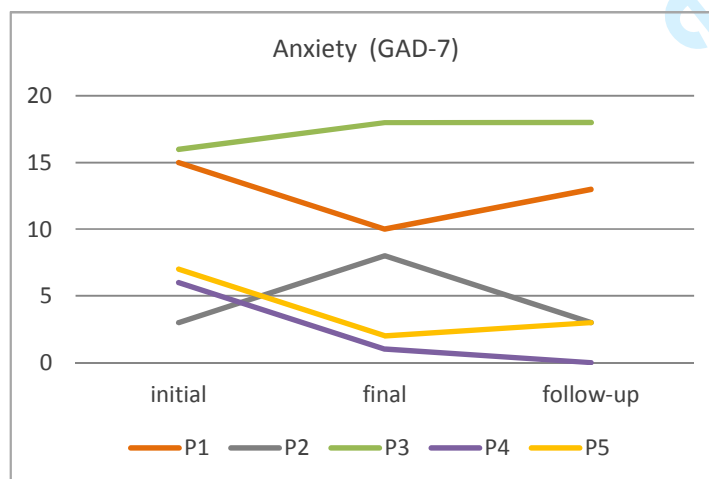
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## Figures



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Figure 1: Individual scores on PHQ-9 measured in four points in time: pre therapy ('initial'), during therapy ('interim'), post therapy ('final') and in follow-up (follow-up). ('P' indicates individual participants.)



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Figure 2: Individual scores on GAD-7 measured in three points in time: pre therapy ('initial'), post therapy ('final') and in follow-up ('follow-up'). ('P' indicate individual participants.)

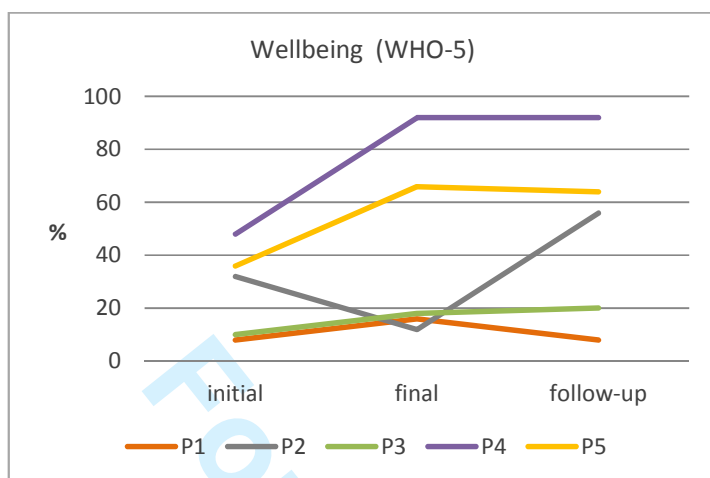


Figure 3: Individual scores on WHO-5 measured in three points in time: pre therapy ('initial'), post therapy ('final') and in follow-up ('follow-up'). ('P' indicate individual participants.)