Painting from Within

Developing and Evaluating a Manual-based Art therapy for Patients with Depression

Christina Blomdahl

Institute of Health and Care Sciences
Sahlgrenska Academy at University of Gothenburg

UNIVERSITY OF GOTHENBURG

Gothenburg 2017

Cover illustration: Christina Blomdahl

Painting from Within

Christina.blomdahl@gu.se

ISBN 978-91-629-0250-6 (print), ISBN: 978-91-629-0251-3 (PDF)
http://hdl.handle.net/2077/52419
Printed in Gothenburg, Sweden 2017
Ineko AB

”Var människa en halvöppen dörr

som leder till ett rum för alla”

Tomas Tranströmer

Painting from Within

Developing and Evaluating a Manual-based Art therapy for Patients with Depression

Christina Blomdahl

Institute of Health and Care Sciences
Sahlgrenska Academy at University of Gothenburg
Gothenburg, Sweden

ABSTRACT

Aim: The overall aim was to develop and evaluate a manual-based art-therapy programme for patients with depression, and hence, to clarify treatment effects and to describe participants' experiences of the treatment. The specific aims were: (I) To explore and describe how art therapy works in relation to therapeutic factors, clinical application, and circumstances in the experimental situation, for patients with depression; (II) To explore what experts in the field of art therapy consider to be the main aspects of treatment for patients with depression in clinical practice; (III) To investigate the effects of manual-based Phenomenological Art Therapy in addition to treatment as usual (PATd/TAU) compared with only treatment as usual (TAU) for patients diagnosed with moderate to severe depression; and (IV) To describe and explore the significance of manual-based Phenomenological Art Therapy as experienced by patients diagnosed with moderate to severe depression. Methods: (I) Systematic literature review according to Realist review; (II) Expert survey according to the Delphi technique (Studies I and II were used as a foundation for developing the manual-based Phenomenological Art Therapy for patients with depression (PATd)); to evaluate the effect and experience of PATd, (III) a randomized controlled trial (RCT) with intention-to-treat design was performed; and, thereafter, an interview study with (IV) a Phenomenological approach, according to Reflective Lifeworld Research. Results: (I) eight therapeutic factors were identified: self-exploration, self-expression, communication, understanding and explanation, integration, symbolic thinking, creativity, and sensory stimulation; (II) resulting in four main aspects of art therapy for patients with depression; expression through art-making and

verbal communication concerning, depressive thoughts, feelings, life experiences, and physical symptoms. (III) PATd in addition to Treatment As Usual (TAU) showed a significant reduction of depression and an improved return to work compared to participants receiving only TAU. Self-esteem significantly improved, and suicide ideation did not change for either groups. (IV) PATd facilitates meeting oneself in an inner dialogue between the evident and the unaware. The art-making and describing that experience makes oneself and the situation visible, opening up and altering understanding through the inner dialogue. Conclusions: manual-based PATd seems to work as intended, being an effective treatment, and contributes to recovery for patients with moderate to severe depression.

Keywords: Mental Health, Major Depression, Programme Development, Art Therapy

ISBN: 978-91-629-0250-6 (print), ISBN: 978-91-629-0251-3 (PDF)

http://hdl.handle.net/2077/52419

SAMMANFATTNING PÅ SVENSKA

Denna avhandling handlar om att utveckla och utvärdera en manualbaserad behandling med bildterapi för personer med depression. Depression är av World Health Organisation (WHO) klassad som folksjukdom. Det innebär att depression är mycket vanligt och leder till omfattande psykisk belastning och funktionsnedsättning. Det finns behandling som är bevisat effektiv men studier visar att nästan hälften av patienterna inte blir återställda och många inte slutför sin behandling. Bildterapi har en lång tradition inom sjukvården, främst inom psykiatriskvård. Bildterapi har inte testats tillräckligt vetenskapligt för att kunna rekommenderas som behandling vid depression, utifrån de kriterier som används för evidensbaserad behandling i Sverige. Den kliniska erfarenheten är dock god där både terapeuter och patienter bekräftar att bildterapi påverkar personens liv i en positiv riktning. Adrian Hill, en brittisk konstnär, var den första som på 1940-talet benämnde bildterapi som ett sätt att behandla sjukdom. Bildterapi har utvecklats genom att sammanfoga konstnärligt utövande och psykoterapi. I denna avhandling definieras bildterapi som bestående av två delar först bildskapandet följt av samtal mellan patienten och terapeuten om innebörden av den skapande bilden. Vid bildterapi sker bildskapandet med terapeuten närvarande. Närvarande innebär att vara tillgänglig för vad som händer under bildskapandet. Då bildterapi hittills i hög grad har bedrivits utifrån den enskilda terapeutens egen uppfattning och erfarenhet var det i denna avhandling, viktigt att försäkra sig om hur behandlingen genomfördes. Att behandling bedrivs på samma sätt är viktigt för att kunna dra slutsatser om vad som är verksamt. Detta ledde fram till behovet att utveckla ett behandlingsprogram som satte ramarna för behandlingen och därmed möjliggjorde att vetenskaplig undersöka effekten och dess betydelse. Fenomenologisk bildterapi valdes som teoretisk referensram för att skapa en grund för behandlingen. Fenomenologisk bildterapi handlar om öppenhet och att söka mening.

Syfte: Övergripande syfte var att utveckla och utvärdera en manualbaserad bildterapi för patienter med depression. Delsyfte I, var att undersöka och beskriva hur bildterapi fungerar utifrån vad som är verksamt, den kliniska tillämpningen och under vilka omständigheter bildterapi genomförs. Delsyfte II, var att undersöka vad bildterapiexperter anser vara viktiga behandlingsaspekter vid bildterapi med patienter med depression. Delsyfte III, var att undersöka effekten av manualbaserad bildterapi vid behandling av medelsvår till svår depression. Delsyfte IV, var att undersöka och beskriva erfarenheterna av manualbaserad bildterapi så som de erfars av patienter med medelsvår till svår depression.

Metod: Studie I, var en litteraturstudie där olika övningar inom bildterapi undersöktes utifrån vad som ansågs vara läkande och den kliniska tillämpningen. I studie II, svarade 18 experter på ett frågeformulär med 74 påståenden. Experterna skattade i vilken grad de instämde med påståendet. Experterna svarade på frågeformuläret totalt tre gånger. De två första studierna var utformade till att vara ett beslutstöd för utvecklandet av behandlingen och de två sista studierna utvärderade behandlingen. Behandlingen förkortas PATd, manual-based Phenomenological Art Therapy for patients with depression, manualbaserad fenomenologisk bildterapi vid depression. PATd består av olika bildterapiövningar som genomförs vid 10 behandlingstillfällen. I studie III, undersöktes om PATd påverkade depressionen och självkänslan i en studie med slumpmässig kontrollerad design. 79 patienter med medelsvår till svår depression delades in i två grupper där PATd undersöktes i tillägg till sedvanlig behandling och jämfördes med enbart sedvanlig behandling. I studie IV, intervjuades tio av patienterna om deras erfarenhet av PATd om vad som var av betydelse för dem. Intervjuerna analyserades efter metodprinciper enligt Livsvärldsfenomenologi.
Resultat: Studie I, resulterade i åtta faktorer som bidrar till återhämtning dessa var: självutforskning, uttrycka sig, kommunikation, förståelse och förklaring, integration, symboliskt tänkande, kreativitet och sinnesstimulering. Klinisk tillämpning beskrevs. Studie II, visade att: viktiga aspekter vid bildterapi är att patienten får möjlighet att uttrycka och berätta om sina depressiva tankar, känslor, livserfarenheter men även de fysiska symptom som är kopplade till depression var viktiga aspekter. Studie III, visade att PATd hade positiv effekt på depression. Självkänslan förbättrades men orsaken är oklar. Deltagarna i PATd återgick i högre grad i arbete än personer som behandlades med sedvanlig behandling. PATd ökade inte risken för självmord. Studie IV bidrog med kunskap om hur PATd fungerar ur patients perspektiv. PATd främjar att möta sig själv via en inre dialog mellan det som är uppenbart och det som är dolt. Bildskapandet och berättandet synliggör, öppnar och förändrar.
Slutsatser: PATd verkar fungera så som det var avsett och bidrar till återhämtning från depression. Avhandlingen bidrar till att visa hur man kan utveckla en manualbaserad behandling och att det är möjligt att utvärdera behandling för personer diagnostiserade med medelsvår till svår depression.

LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

I. Blomdahl C, Gunnarsson AB, Guregård S, Björklund A. A realist review of art therapy for clients with depression. The Arts in Psychotherapy 2013; 40(3):322-30.[1]

II. Blomdahl C, Gunnarsson BA, Guregård S, Rusner M, Wijk H, Björklund A. Art therapy for patients with depression: expert opinions on its main aspects for clinical practice. Journal of Mental Health 2016; 25(6); 527-35.[2]

III. Blomdahl C, Guregård S, Rusner M, Wijk H. A manual-based phenomenological art therapy for patients diagnosed with moderate to severe depression (PATd) – a randomized controlled study (submitted).[3]

IV. Blomdahl C, Wijk H, Guregård S, Rusner M. Meeting oneself in inner dialogue: a manual-based phenomenological art therapy as experienced by patients with moderate to severe depression. The Arts in Psychotherapy (In press).[4]

CONTENT

ABBREVIATIONS IV
DEFINITIONS IN SHORT VI
1 INTRODUCTION 1
2 BACKGROUND 2
2.1 Creativity and Art therapy 2
2.1.1 Creativity 2
2.1.2 Art-making becomes art therapy 3
2.1.3 Art therapy today 3
2.1.4 Art therapy in Sweden 5
2.1.5 The therapeutics in Art therapy 5
2.2 Psychiatric care in Sweden 6
2.2.1 Depression 6
2.2.2 Recovery from depression 8
2.3 Manual-based therapy 8
3 RATIONALE FOR THIS THESIS 9
4 AIM 11
4.1 Specific aims 11
5 THEORETICAL FRAMEWORK 12
5.1 Health 12
5.2 Phenomenological worldview 12
5.3 Phenomenological-based Art Therapy 13
6 METHODS 15
6.1 Study designs 16
6.2 Selection and procedure 17
6.2.1 The foundations for the development of PATd 17
6.2.2 Development of PATd 20
6.2.3 Evaluating PATd 22
6.3 Analysis methods 25

6.3.1 Literature review 25
6.3.2 Expert survey 25
6.3.3 Statistics 26
6.3.4 Qualitative analysis 26
6.4 Methodological considerations 26
6.5 Ethical considerations 28
7 RESULTS 30
7.1 Therapeutic factors in art therapy 30
7.2 Clinical applications of main factors in art therapy for patients with depression 31
7.3 The effects of PATd 32
7.4 The experiences of PATd 32
7.5 Manual-based Phenomenological Art Therapy for patients with depression 34
8 DISCUSSION 36
8.1 General discussion of major findings 36
8.2 Methodological discussion 38
8.2.1 Strengths and limitations 41
8.3 Clinical implications 42
9 CONCLUSION 43
10 FUTURE PERSPECTIVES 44
11 ACKNOWLEDGEMENTS 45
REFERENCES 47
APPENDIX 56

ABBREVIATIONS

ABI	Art-Based Intervention questionnaire
C-Sy	Cognitive-Symbolic level in ETC
Cr	Creative level level in ETC
ETC	Expressive Therapies Continuum
ICF	International Classification of Functioning, Disability and Health
K-S	Kinaesthetic-Sensory level in ETC
MADRS-S	Montgomery Åsberg Depression Rating Scale – Self-rating
MRC	Medical Research Council
P-A	Perceptual-Affective level in ETC
PATd	Manual-based Phenomenological Art Therapy for patients with depression
PATd/TAU	Manual-based Phenomenological Art Therapy in addition to treatment as usual
RCT	Randomized Controlled Trial
RSES	Rosenberg Self-Esteem Scale
RLR	Reflective Lifeworld Research
SAD	Seasonal Affective Disorder
SOC	Sense Of Coherence
SRBt	Svenska Riksförbundet för Bildterapeuter [Swedish National Association for Art therapists]

SSI	Scale for Suicide Ideation
TAU	Treatment As Usual
WHO	World Health Organization

DEFINITIONS IN SHORT

This thesis is about art therapy. It exists alongside several nearby therapies and practices in the area; therefore, these are described below to define the scope of this thesis.

Art Therapy In Swedish: Bildterapi	Art therapy is a form of psychotherapy that uses art material as its primary mode of expression and communication. Within this context, art is not used as a diagnostic tool, but instead, as a medium to address emotional issues, which may be confusing and distressing.[5]
Art task or art theme In Swedish: Bilduppgift	Various topics designed to act as a starting point for reflection and art-making.[6]

Other nearby therapies and practices not included in this thesis:

Arts therapies In Swedish: Konstnärliga terapier	An umbrella term that includes art therapy, dance-movement therapy, drama therapy, and music therapy.[7]
Arts practice in health care In Swedish: Bildskapande med konstnär	Artists who make art projects together with patients. The focus is on artistic expression. The artist is not included in regular health care practice.[8]
Expressive Arts therapy In Swedish: Uttryckande konstterapi	Combines the visual arts, movement, drama, music, writing, and other creative processes. Encourages an evolving multimodal approach by integrating the arts processes and allowing one to flow into another.[9]

1 INTRODUCTION

My interest in art therapy was aroused during my training as an Occupational Therapist in the early ’90s. Every term included a course involving creative activities with a therapeutic purpose. During my years as an Occupational Therapist, when suitable, I always tried to engage patients in creative activities to cope with distress and anxiety. After I graduated with an MSc in Art Therapy in 2009, I used art therapy frequently in my encounters with patients. Often the patients I met had long experiences of prior psychiatric care, but did not respond to the regular treatment as expected. It was therefore very reassuring to me to experience that many of the patients who participated in art therapy found a new zest for life and that they could move on with their lives towards health. My curiosity was aroused, and I wanted to explore whether my practice-based experience of patient recovery was valid and could pass scientific evaluation. That was the reason and my starting-point for immersing myself in the area of art therapy.

When I started to investigate the area, I soon discovered that the evidence-based knowledge of art therapy for patients with depression was scarce. In addition, the area also showed a lack of theoretical foundation. It became evident that there was a need to create a base for art therapy in order to be able to evaluate art therapy scientifically.

In Sweden, as well as internationally, there is a growing interest in the arts and their importance for health. The area is complex and incorporates a wide range of arts disciplines, such as music, dance, and visual arts, and their connection to health.[10] This thesis is about art therapy and has the aim of developing a manual-based art therapy programme and evaluating the original treatment developed here for patients with depression.

My hope is that this thesis will contribute by providing enhanced knowledge about art therapy and its possibility to support the recovery of patients with depression.

2 BACKGROUND

2.1 Creativity and Art therapy

2.1.1 Creativity

Creativity is a cognitive ability, just like remembering and thinking. These abilities make the world understandable and manageable. Cognitive abilities affect how we process, value and act on information about ourselves and the world around us.[11]

According to Seligman and Csikszentmihalyi,[12] creativity is one of the ingredients that can contribute to meaning in life. Creativity is commonly defined as the generating of ideas or products that are both novel, that is to say, original and unusual, and useful, that is to say, valuable, or helpful.[13,14] Symbolic thinking is a mental process that is connected to creativity through the formation of inner images and the loading of these inner images with symbolic meaning.[15]

Another way to describe creativity is that being creative is a means of self-expression. The connection between art and life is complex, and art-making experiences can give a sense of empowerment and have the potential to influence life.[16]

Creativity has been associated with openness in experiences and our ability to regulate emotions.[17] Openness involves emotional and motivational characteristics, such as seeking new experiences and the feeling of a wide range of emotions. Further, cognitive characteristics consist of imaginative thinking, and social expression through nonconformity. Characteristics related to self-regulation include those such as the absorption and tolerance of ambiguity.[18] Self-expression involves the formulation of matters relevant to the person. Any aspect of the person can be expressed in a number of ways.[19]

There have been several attempts to connect creativity with mental illness, but there seems not to have been any such connection when examining people who do not excel at being creative.[20] Instead, it has been reported that high levels of depressive symptoms appear to have a restraining effect on creativity.[21] However, creativity has also been shown to be a factor in improving depressive symptoms in several studies.[22] Hence, creativity seems to be affected by depression and both seem to be situated on opposite poles. Depression leads to

introversion and withdrawal, in contrast to the openness characterized by being creative.

2.1.2 Art-making becomes art therapy

Throughout our history, people have shown creativity when painting pictures. Discoveries of rock paintings tell us something about the concepts and the surroundings that people understood and lived in.[23] There seems to be an inner need to express ourselves through images.[24] According to Malchiodi,[25] art-making, when used to promote healing, has been practised since our earliest documented history. Art has been recognized for being more than decorative; for its ability to communicate and clarify inner experience, conveying a deep range of emotions without words. People have been using art spontaneously to support their own recovery throughout humankind.[25]

Art therapy (in Swedish; Bildterapi) is about visual art, such as drawing, painting, doodling or sculpting.[26,27] In the 1940s, a British artist, Adian Hill, was the first to use the term 'art therapy' when describing the benefits of visual art-making in his recovery from tuberculosis.[28] At the same time, Margret Naumberg began to use art therapy to describe her work with spontaneous art expression with disabled children.[29] Art therapy was and still is a fusion between artistic expression and psychology, and became a new discipline in several countries. Art therapy has also been described as painting from within.[25]

2.1.3 Art therapy today

To date, no consensus exists about how to define art therapy, which carries different meanings to different individuals, depending on the background and theoretical frame of reference of the therapist.[27] The application of art therapy in practice also differs between therapists. Commonly, different art material is used to express experiences, feelings, and thoughts. The art materials usually consist of poster paint, watercolours, charcoal, pencils, or clay, when creating two- or three-dimensional images.[25]

An art task is used as a starting point from which to help participants start reflection and art-making. Art tasks also provide clarity on what art therapy is, and act as the guidance and structure on which the participants can build. Art tasks can be interpreted on many levels, and therefore are flexible for meeting participants' different needs.[30] The clinical application of art tasks differ in relation to whether any art tasks are given to reflect on, or if free painting is preferred. Practice also differs in relation to whether the patient can choose art material freely or that specific art materials are recommended.[15,25]

A way to understand these different orientations in art therapy is to see art therapy as a continuum. At one end of the continuum is art as therapy, which places an emphasis on the therapeutics of the art-making.[31] At the other end of the continuum is art psychotherapy, which stresses the importance of the relationship between the therapist and the patient and this assemblage is seen as an arena for the transference and countertransference of earlier relationships.[32]

Van Lith and Fenner[31] have developed a practice continuum that describes the complexity of the application of art therapy in practice. The continuum goes from *individual art-making*; where art-making is carried out without therapeutic intention. *Studio art-making* consist of the intention to make art with little support from the therapist. *Art-making with emphasis on skill development and mastery*; places the emphasis on the therapist teaching art skills. *Programme facilitated and structured art groups* places emphasis on personal expression about issues. *Individual art-making with healing purpose* places emphasis on personal growth with therapeutic intentions, while *Art psychotherapy* places emphasis on the relationship between the patient, the therapist and the image in order to gain insight and bring about therapeutic change[31] (Figure 1). Art therapy in this thesis is situated mainly on the level of individual art-making, but with therapeutic purpose and with intention to promote internal changes.

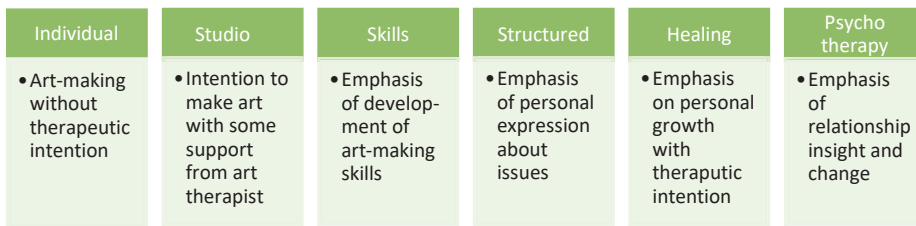

Figure 1. Description of art therapy practice continuum

During the 1970s, Kagin and Lusebrink[33] developed and described a theoretical framework for Art Therapy called the Expressive Therapies Continuum (ETC). ETC has been used as a practice model in the development of PATd (see Methods section: Development of PATd).

Consequently, art therapy, in this thesis, is defined as a two-phase treatment: art-making; followed by the verbalizing of this experience, with an emphasis on the importance of both art-making and verbalizing the art experience.

2.1.4 Art therapy in Sweden

In Sweden, art therapy is not yet recognized as being evidence-based,[34] and Art Therapist is only just beginning to be recognized as a profession. There are very few established posts as art therapist in the profession. Most of those who have passed the training to become Art Therapists continue in their usual posts with the addition of art therapy to their list of qualifications.[35]

In 2006, The Swedish National Association of Art Therapists (SRBt) was founded. The goals of the organisation are to amalgamate Art Therapists throughout Sweden, to develop Art Therapist as a profession, and to maintain a high standard of quality and ethics within the field. SRBt has approved three education establishments. Umeå University offers a Master's degree programme in Art therapy, and specialist training in Art therapy.[35] The Art therapy Institute, Niarte, provides a three-year programme of art therapy education as an independent vocational training equivalent at college level, which is an integrative art psychotherapy and includes basic psychotherapy.[36] The third course, arranged by Ateljé för Bildterapi AB, is a two-year education programme in Jungian art therapy with the possibility of completing a third tutorial year.[37]

2.1.5 The therapeutics in Art therapy

There is no consensus regarding the application of art therapy, and there are no set optimum standards, which complicates its scientific evaluation. Art therapy for patients with depression is mostly based on proven experience, but is rarely described or evaluated according to scientific practice. Further, most of the existing studies were concerned with art-making with people affected by mental health issues, and not those designed specifically for people with depression.[38]

Zubala, MacIntyre, Gleeson, and Karkou[26] investigated the occurrence of patients with depression in arts therapists' clinical practice and found that depression was the most common disorder amongst their patients. However, only a few studies investigated how art therapy affects depression. The research in the field of art therapy usually comprises participants with different diagnoses where depression is one amongst others. Additionally, several studies focus on depression as a consequence of other disorders, such as cancer,[39-41] or on depression as one of several psychiatric diagnoses.[42,43]

Egberg Thyme, Sundin, Wiberg, Öster, Åström, and Lindh[39] showed that art therapy is an effective treatment for reactive depression related to cancer disorders, and that it is just as effective as verbal short-term psychodynamic therapy. Körlin, Nybäck, and Goldberg[44] stated that art therapies gave better results than pharmacology and verbal psychotherapy for patients with severe, prolonged symptoms and activity limitations. Further, several studies indicated that art therapy promotes personal change, facilitates an ability to meet demands and expectations in everyday life, and strengthens the individual's own boundaries.[41,45] In a small, randomized controlled trial, the effects of art therapy on depression levels and locus of control for women diagnosed with HIV were investigated. There was a significant decrease in depression levels found immediately after the art therapy intervention and significant changes in locus of control appeared.[46] An experimental pilot study showed significant decreases in depression levels directly after art therapy and in the follow-up, 11 weeks later.[47] Another study with short-term psychodynamic art therapy showed significantly decreased levels of depression at follow-up directly after treatment and this effect was maintained at a 3-month follow-up.[48]

2.2 Psychiatric care in Sweden

The responsibility for the treatment of mental illness in Sweden is allocated to two main healthcare provider authorities; the municipalities, and the county councils. Municipalities have the principal responsibility for providing living accommodation and occupation for patients, while the county councils have divided their responsibilities for care at different levels of care; primary care, and psychiatric specialist care in hospitals or outpatient care. According to the Regional Medical Guidelines for Depression in Västra Götalandsregionen,[49] the division of responsibilities between primary care and psychiatric specialist care is distributed according to the assumption that primary care has the main responsibility for patients diagnosed with depression, with the possibility to consult specialists in psychiatric care when needed.

This thesis is about patients diagnosed with moderate to severe depression who are cared for in primary care and psychiatric specialist outpatient services.

2.2.1 Depression

Depression is one of our most common population disorders, affecting 5% to 10% of the population at any time. Forty percent of all women and 20% of all men risk needing treatment at least once during their lifetime.[50] The World Health Organization (WHO) predicts that depression will increase in the coming years and estimates that patients with depression have the highest

disability burden of years lived with disability and premature death of all disorders.[51]

Depression has considerable influence on an individual's psychic well-being, self-image, and ability to function in any social context.[50,52,53] Depression, as a medical diagnosis, comprises certain criteria that must be present for a patient to be diagnosed as depressed in the medical sense. The ICD-10 International Classification of diseases,[54] and DSM-5, in the Diagnostic and Statistical Manual of mental disorders,[55] are the diagnostic systems in use in Sweden. Depression is a symptom diagnosis and says nothing about the cause.[53] Major depression is characterized by low mood, lost interests, anxiety, insomnia, changed appetite, restlessness, difficulty concentrating, and suicidal thoughts. Dysthymia is characterized by frequent or constant depression over more than two years, with a weakened interest in doing things, and difficulty in coping with occupation or getting along with others. Depression with atypical features is characterized by the capacity for normal emotional reactions but having significant appetite or weight gain, prolonged sleeping, heaviness in the limbs, and long-lasting patterns of susceptibility to being rejected by others, which leads to social disabilities. Depressive exhaustion, nervous exhaustion, and fatigue exhaustion are characterized by several months of long experience of fatigue and fatigability, concentration problems, and lack of stamina. Seasonal affective disorder (SAD) is characterized by depressive episodes appearing during alterations in the seasons, or so-called spring/fall/winter depression. Depression is associated with organic damage, such as stroke, or illness, such as cancer, or other types of mental illness. The severity of depression varies from mild, to moderate, to severe.[55] Depression has been described as a profound experience of alienation from one's self and others.[56] Depression can also be described as a state of lacking meaning in life. Life itself becomes meaningless and feelings of being trapped in the body can emerge.[57]

The diathesis-stress model contributes by providing an understanding of how depression can evolve.[58] The model describes how an inherited vulnerability, along with a psychological vulnerability, and, in later life, the interaction of stressors, can lead to depression. This psychological vulnerability occurs in early childhood with events providing a low sense of locus of control.[59] Feelings of powerlessness can lead to hopelessness and a reduced ability to use appropriate coping strategies.[60] Low self-esteem has also been connected with depression and low self-esteem has been found to predict depression. Consequently, it is important that interventions support the improvement of self-esteem.[61]

2.2.2 Recovery from depression

According to Anthony,[62] recovery from mental illness is a deeply personal and unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life.[62] The low degree of recovery from depression is a major health problem.[63] Less than 50% of all patients with depression recover despite the development of evidence-based treatment. The patient group is large, recovery takes time, and there is a risk of chronic disorders.[52] This is both a problem at the individual level and a social problem.[53] Depression has been associated with reduced quality of life and functional impairment, in areas such as work, interpersonal relationships, and cognitive function.[64] Improvements in functional outcomes and well-being correlate with improvements of depressive symptoms.[65] Although evidence-based treatments such as pharmacotherapy and psychotherapy are available, not all patients seek, accept, or continue treatment and, if they do, remission is partial for many, even in cases of sequential treatment, in order to optimize treatment outcome.[52] According to Greer, Kurian, and Trivedi,[64] there is a need to develop treatments that specifically aim to improve functional impairments, and may involve the use of novel treatment strategies.

2.3 Manual-based therapy

Manual-based therapies have been used since the middle of the 1960s. The first manuals were developed for behavioural therapy.[66] Since then, manual-based therapies have been used in order to secure validity in supporting clinical research.[67] The reason for developing a manual-based treatment within the context of outcome studies is to provide useful guidelines for conducting and learning treatment methods. Manuals can be considered as a means of implementing scientific knowledge in clinical practice and aim to improve the quality and impact of treatments.[68] Schulte and Eifert[67] showed, in their study, that therapists who performed manual-based interventions had better outcomes in their treatments than did process-oriented therapists.

There are some benefits in using manuals, but the practice also has some disadvantages. Potential shortcomings include difficulties in examining the impact of individual therapists' efforts and skills, with the risk of placing a focus on adherence to the manual instead.[69] The benefits of following a manual-based therapy in research studies is that it allows the researcher to consider the enhanced internal validity of the treatment and provides the possibility to replicate studies.[66]

3 RATIONALE FOR THIS THESIS

Patients with depression often find that the disorder permeates them with negative experiences of their own value, abilities, and relationships with others.[70] Due to depression, both mobility and cognition move in slow motion, concentration deteriorates, and the ability to take the initiative is reduced. What was earlier pleasurable can become pointless, and a sense of meaninglessness can characterize life.[50]

Art therapy has the possibility to engage the whole person, allowing new thoughts and perspectives concerning oneself to evolve.[71] Knowledge relating to the therapeutic factors for developing different therapeutic art tasks used for depressive condition is missing, as well as that related to the main aspects of art therapy for depression. Therefore, the rationale for conducting Studies I and II was to explore the bases for the development of a manual-based programme for art therapy for patients with depression.

There is a lack of studies that evaluate the effect and experiences of art therapy for patients with depression and no study until now has included severe depression.[47,48] Therefore, the rationale for conducting Studies III and IV was to evaluate the manual-based programme for art therapy that was developed for patients with depression in relation to its effects on recovery, and to describe the patients' experiences of participating in the programme.

4 AIM

The overall aim of this thesis was to develop and evaluate a manual-based art therapy programme for patients with depression, and hence, to clarify the treatment effects and to describe participants' experiences of the treatment.

Specific aims

I. To explore and describe how art therapy works in relation to therapeutic factors, clinical application, and circumstances in the experimental situation, for patients with depression.

II. To explore what experts in the field of art therapy consider to be the main aspects of treatment for patients with depression in clinical practice.

III. To investigate the effects of manual-based Phenomenological Art Therapy in addition to treatment as usual (PATd/TAU) compared with only treatment as usual (TAU) for patients diagnosed with moderate to severe depression.

IV. To describe and explore the significance of manual-based Phenomenological Art Therapy as experienced by patients diagnosed with moderate to severe depression.

5 THEORETICAL FRAMEWORK

This thesis is based in the health and care science that focuses on human experiences of illness and distress in conjunction with recovery and the retention and promotion of good health.

The development and application of the manual-based programme for art therapy is influenced by the phenomenological approach that is below presented in brief, together with some main concepts.

5.1 Health

The original meaning of the word "health" is having a sense of wholeness and holiness, but health carries different meanings for different individuals. Being in a state of health can be explained as an absence of identifiable illness and a sense of well-being.[72] The WHO[73] defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Mental health has been defined as a state of well-being where the individual is aware of his or her potential, can cope with normal stressors in life, can work productively and fruitfully, and contributes to her or his community.[74]

An important aspect of health is the presence of protective personal qualities that can contribute to maintaining good health. The WHO has identified that the individual protective factors for mental health are; self-esteem, confidence, the ability to solve problems and manage stress or adversity, and communication skills.[75] The goal with treatments for depression is to support recovery and improve health. If psychological treatment can strengthen the individual's protective factors and support recovery, it can make a great difference for, primarily, the individual, but also for society as a whole.[75]

5.2 Phenomenological worldview

In order to contribute to a theoretically based art therapy programme, phenomenological philosophy and its methodological principles were chosen as a theoretical framework. Therefore, the main concepts of phenomenological philosophy, the lifeworld, intentionality, and lived body theories, are each described below. The methodological principles are described in the methods section.

Phenomenology relates to the perceived world, that is to say, the meanings of different phenomena as they are experienced by a specific subject.[76,77,79] According to the founder of modern phenomenology, Edmund Husserl,[78] the lifeworld is the world in which we live and experience and that we take for granted.[77,78] The past, memories, and experiences, as well as future expectations and hopes, are incorporated in the lifeworld. In the lived world, the human consciousness is always directed towards understanding the meaning of what is experienced, that is, *as something*. As humans, we do not know the world outside of our consciousness. All that we know is how the world appears to us. This happens in a natural and often unreflective way.[76,77]

Maurice Merleau-Ponty (1908-1961) contributed to the phenomenological worldview with his theory of the lived body.[76,79] The lived body is an indivisible/inseparable unit. All experience is expressed through and limited by the body. Distress caused by depression can serve as an example for the lived body, as the symptoms are both physical and emotional.[57]

5.3 Phenomenological-based Art Therapy

Betensky[80] was one of the first to develop art therapy based on phenomenology. Guttman and Regev[81] have continued Betensky's work and have operationalized phenomenology as art therapy practice. Practising art therapy with a phenomenological approach focuses on the individual way in which patients perceive the world, their lives, and themselves. The therapeutic goals are to support patients to: enhance self-awareness; view and evaluate current lives in new ways; increase understanding about their lives; accept their limitations and strengths; and prioritize their lives based on self-knowledge.[81] The therapist's attitude should be characterized by openness, a willingness to understand, and challenging the known. The dialogue about the image in art therapy is based on joint exploration, where the meaning of the image for the patient is the focus.

The basic idea is to promote authentic choices in life; therefore, patients should create their own personal and unique artwork. The goal is to deal with options, acknowledge them, make choices, and manage the consequences of these choices. The phenomenological approach focuses on the "here and now", encouraging the patient to decide how she/he wants to solve the art task, or use the material.[80,81] It is of significance that the therapist tries to curb preconceptions, and avoids adding their own values or theoretical standpoints to what the patient says. The approach suggests that the relationship in a meaningful encounter always is mutual. Therefore, the concept of transference

is problematic in phenomenological-based art therapy. The therapist should be aware of this phenomenon but it should not be made the focus.[81]

Phenomenological Art Therapy contributes by providing an understanding of the importance of openness for experience and the importance of making authentic choices in life.[81] Phenomenological Art Therapy promotes creativity and promotes a reflective distance to the produced artwork in a clinical application.[24]

In the following sections, the methods for the development and evaluation of a manual-based programme for art therapy for patients with moderate and severe depression (PATd) are described.

6 METHODS

The methods section starts with a description and overview of the workflow (Figure 2), and the methods employed (Table 1), which is described in detail in the following sections. In order to develop and evaluate the programme, several scientific methods, drawing on both qualitative and quantitative approaches, were used. To be able scientifically validate the art therapy programme, a manual that included the defined art tasks and guidelines on how to perform them was developed. The work followed the directions for programme development described by Braveman, Kielhofner, and Bélanger.[82] In addition, the work of Long, Kidger, and Hollin[83] contributed by providing insights that are considered important for the implementation stage regarding the need of the therapist to grasp the underlying theoretical approach. The programme development followed four steps:[82]

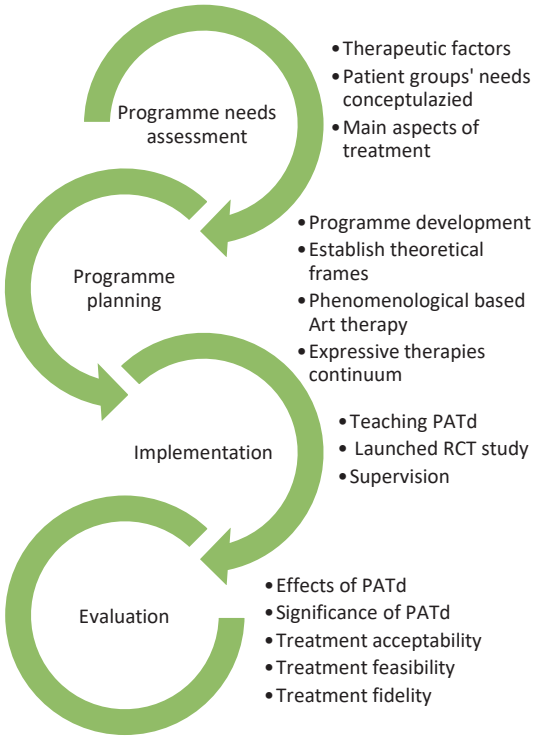

Figure 2. Flowchart of work process

Step 1, Programme needs assessment
Step 2. Programme planning
Step 3. Implementation
Step 4. Evaluation.

6.1 Study designs

Various scientific methods were used in the four studies. An overview of the study designs (I-IV) are shown in Table 1. For an overview of how the studies are interrelated, see Figure 4 in the Results section.

Table 1. Overview of the study designs I-IV

Study	Design	Sample	Procedure	Data analysis	Published
I	Systematic literature review according to Realist Review	16 articles	Matrix containing: theory, aim, participants, design, result. Therapeutic Factors: describing the healing processes.	Qualitative analysis	The Arts in Psycho-therapy 2013; 40(3):322-30.
II	Expert survey according to the Delphi technique	18 experts	Questionnaire with 75 assertions. 3 rounds with questionnaires.	Group medians. Consensus was reached at 70%	Journal of Mental Health 2016; 25(6); 527-35
III	Randomized controlled trial	43 PATd 35 control	Baseline and posttreatment measures. MADRS-S[a], RSES[b], SSI[c] and sickness absence	Statistics based on pre- and post-test.	Submitted
IV	Phenomen-ological approach according to Reflective Lifeworld Research	10 participants	Meaning-oriented interviews 1-2 month posttreatment.	Meaning-oriented analysis with Phenomeno-logical approach	Accepted in; The Arts in Psycho-therapy

[a] MADRS-S, Montgomery Åsberg Depression Rating Scale – Self-rating[84]
[b] RSES, Rosenberg Self-Esteem Scale[85]
[c] SSI Scale for Suicide Ideation[86]

6.2 Selection and procedure

6.2.1 The foundations for the development of PATd

The development of the manual-based art therapy started with a systematic literature review of the therapeutic components of art therapy, and whether art tasks meet depressed patients' needs (I), followed by an investigation of experts' views on the main factors necessary for the treatment of patients with depression with art therapy (II). This comprised step 1 in the development of the programme.[82]

In study I: Four databases were searched from the foundation of the database to February 2012 (AMED, CINAHL, PsychINFO, and PubMed) for Art therapy AND depression OR major depression OR depressive disorder, AND method AND intervention AND outcome, which yielded 1375 articles published in the English language.

Inclusion criteria: Diagnosis of depression declared as possible to be treated with a specific art task. The art tasks should be possible to duplicate. Art tasks for reactive depression were included, provided they could be generalized to patients with other causes of depression. Target group: Adults aged 18 years and older.

Exclusion criteria: Variety of assessments, art-making without therapeutic purpose.

After the sorting process and the elimination of duplicates, 16 articles remained and were included in the study (Table 2). Each selected article was scrutinized regarding: underlying theory, aim of the study, number of participants, design of the study, and results. The information was collected in a matrix and its contents were analysed. The art tasks' connections to International Classification of Functioning, Disability and Health (ICF) core sets[87] were compered and discussed.

Study II was based on the results from the literature review. A questionnaire was developed with 74 statements.[88] The statements related to the main aspects of art therapy for patients with depression. The questionnaire was initially sent to 28 experts in the field of art therapy, of whom 18 participated.

The questionnaire was distributed using the Delphi technique[88] in three rounds in order to obtain consensus and guidance about the main factors in art therapy for patients with depression.

Table 2. Details of study characteristics of studies included in Study I

No	Study	Aim of study	Size	Design	Result
1	*Men's roles and their experience of depression[89]	Describe experiences and visual depictions of males.	5	Quasi experi-mental	A sex role conflict relates to depression.
2	*Individual brief art therapy can be helpful for women with breast cancer: a RCT study[39]	Investigate outcomes in self-image and psychiatric symptoms in women with breast cancer, in 5 sessions of art therapy.	42	RCT[a]	Art therapy showed significant decrease in symptoms of depression, anxiety and somatic symptoms. Control group no significant changes.
3	The TTM an intervention in psychosocial occupational therapy: client acceptability and outcomes[90]	Describe TTM, a case study of a treatment process with follow-up. Examine the therapeutic alliance and	1	Case	Life themes identified. TTM appears suitable in psychosocial occupational therapy. Sig. correlation positive therapeutic alliance.
	The TTM in psychosocial occupational therapy: a case study[42]	client satisfaction, in relation to perceptions of everyday occupation and health-related factors.	35	Quasi experi-mental	Increased occupational performance, self-mastery, sense of coherence and decreased level of psychiatric symptoms and high client satisfaction.
4	Utilizing road drawings as a therapeutic metaphor in art therapy[91]	Description of an art therapy method.	3	Case	Recognize and take responsibility for behaviour. Recognizing cause of behaviour, recognize reparative potential.
5	Utilizing the circus phenomenon as a drawing theme in art therapy[92]	Introduction to art therapy.	5	Case	Recognize coping skills, clarify problems and conflicts, encouraged to master difficulties.
6	*Empirical study on the healing nature of Mandalas[93]	Examine the healing aspects of drawing mandalas.	36	RCT[a]	Significant decreased symptoms of PTSD, depression, anxiety, and physical symptoms and sensations.
7	*Changes in self-image as seen in tree painting[94]	Investigate whether changes in self-image were reflected in tree paintings, and if so, how.	6	Mixed method	Too small a sample for conclusions. Participants made different paintings before and after intervention.
8	*A communication tool for cancer clients with pain: the art therapy technique of the body outline[95]	Describe a simple innovative art therapy intervention, body outline.	70	Various analyses	Visualization of physical pain. Communication of emotions and thoughts. Search for meaning and spirituality.

9	*The symbolic graphic life-line: integrating the past and present through graphic imagery[43]	Compare and match different types of line qualities with emotions.	50	Pilot	Clarify, simplify, emphasize events and feelings during life. Gauge unique feelings, Visual map, Revealing psychological problems.
10	Bilateral art: facilitating systematic integration and balance[96]	Facilitating systematic integration and balance.	12	Case	Positive beliefs same/increased. Negative beliefs decreased. Using colour changes.
	Experience with bilateral art: a retrospective study[97]			Retro-spective	Behaviour changes, improved function, interaction, mood, cessation of complaints.
11	Using both sides of the brain: experiences that integrate art and talk therapy through scribble drawings[98]	Exploration between neuroscience and the integration of verbal and nonverbal discourse in the therapeutic process.	1	Literature review, case	Began to drive car, applied for more selected jobs, task not possible 6 month earlier, manage anxiety better.
12	*Alexithymia- a challenge to art therapy, the story of Rita[99]	Demonstrate art therapy.	1	Case	Provide the client with words and concepts, better equipped to face life.
13	*A randomized, controlled trial of mindfulness-based art therapy (MBAT) for women with cancer[40]	Integrate verbal and non-verbal information processing facilitating self-regulation. Assess the effectiveness.	111	RCT[a]	Sig. decrease symptoms of distress, sig. improvements in health-related quality of life. Sig. decrease in depression compared to control.
14	Clinical application of colour inkblots in therapeutic storytelling[100]	Description of treatment technique.	1	Case	Not applicable.
15	*Art therapy, men and the expressivity gap[101]	Study the visual expression of depressed men in mid-life.	1	Phenome-nology	Illustrating visual expression
16	*Art therapy improves coping resources: a RCT study among women with breast cancer[41]	Investigate psychological response to breast cancer. Explore psychological responses of self-image and psychiatric symptoms.	42	RCT [a, b]	Art therapy sig. improved coping resources compared to control.

[a] Randomized controlled trial. [b] Based on the same sample from study no. 2. * Included in PATd

In each subsequent round, the experts were given their previous estimation and the experts' median estimations for each assertion. Each round provided a new opportunity for the experts to think through their opinions and to delve deeper into their experiences and beliefs.[88]

Studies I and II formed the foundation of the manual-based Phenomenological Art Therapy for patients with depression (PATd) programme.

6.2.2 Development of PATd

In order to fulfil programme planning, stage 2 in the programme development,[82] a manual was developed. A conceptualization of the patient group's needs and common problems guided the clinical application of the programme by matching the need of treatment to specific treatment approaches. The phenomenological approach influenced the encounters with the patients,[81] and the Expressive Therapies Continuum (ETC)[15] guided the development of the programme and its treatment approaches. Art-making can be described as having various levels with different grades of complexity of information-processing. The meeting between the image-maker, the art task, and the art material arise at different levels (Figure 3). All levels are involved in art-making, but different art material and art tasks stimulate the levels in various ways.[102]

The first level, is the Kinaesthetic-Sensory (K-S) level, relating to physical movement, tactility, and experiences of the movement.[15]

The second level is the Perceptual-Affective (P-A) level. The perceptual component deals with the formal elements in art-making, such as line, colour, and form, while the affective component involves the emotions that are aroused. The emotions are accessed and expressed through art-making.[15]

The third level is the Cognitive-Symbolic (C-Sy) level, and includes memories, problem-solving, inner images, and concepts that can be verbalized. The C-Sy component is complex and involves cognitive operations and symbolic thinking in pictures.[15]

The fourth level is the Creative level (Cr). Creativity fuels the other levels and helps to integrate experiences, promote development, and create meaning.[15,33,103]

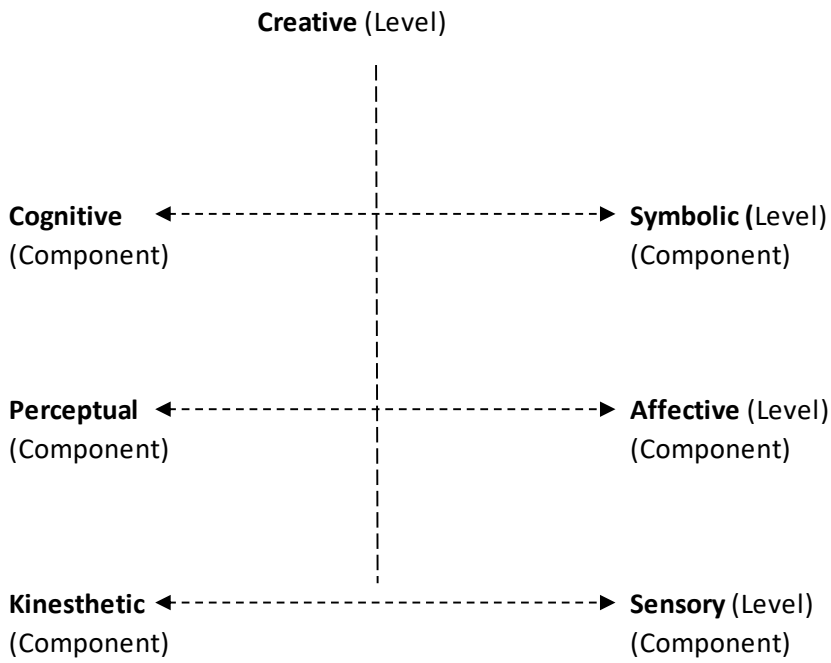

Figure 3. Expressive therapies continuum. Published with permission from Lisa Hinz, as published in 'Expressive therapies continuum - a framework for using art in therapy' [15]

The development of the art tasks is described below. For more details regarding the strategy adopted for the selection of art tasks, developing the guidelines about the treatment principles, and a description of the sessions in PATd, see the Appendix.

Determination of art tasks: the first step in the development of the PATd was to select art tasks best suited to be included. In order to scrutinize the results from Studies I and II, and the ETC, a matrix was developed. The art tasks, labelled as clinical applications in tables, were sorted according to therapeutic factors, and the ETC levels according to the findings in Study I. Then each therapeutic factor and art task was evaluated based on the results in Study II. After the first selection of art tasks, the next step was to select art tasks according to their priority: the art tasks should cover as many therapeutic factors as possible, and all therapeutic factors should be represented.

Determination of relaxation exercises: When the selection of art tasks was complete, the selection of relaxation exercise was conducted. The relaxation

exercises act as preparation for the art exercise and therefore the inclusion criterion was that the relaxation exercise should not last longer than 10 minutes. The literature and the internet were searched for suitable exercises. The selection of the relaxation exercises was made according to the aim of each specific session (Table 4).

Developing guidelines for clinical practice: A phenomenological approach[80,81,83] was chosen as the theoretical frame for the guidelines, based on the central principles of openness, intentionality, and reversibility.

A first draft was written with a focus on practical issues, such as the length of the sessions, the goal, and adopting a therapeutic approach toward patients and images. The instructions contain practical advice about how to execute the relaxation exercises and instructions for the art tasks. No guidance emerged from Study II about adequate numbers of sessions. In other therapies, such as Cognitive behaviour therapy, 10-15 sessions is reported to be a sufficient number.[50] Thus, ten sessions were judged to be a sufficient and manageable number of sessions. Questions that arose when the therapist carried out the treatment, and the treatment guidelines, were developed and evaluated consecutively to clarify the different aspects of the treatment.

Example questions were added to the manual by request from the therapists, as guidance. Examples of such questions were: Could you tell me about your picture and your process? What do you take with you from today's practice? One relaxation exercise was removed because the therapists reported that the exercise was too complicated for some patients.

6.2.3 Evaluating PATd

Implementation and evaluation of the programme, stages 3 and 4 in the programme development,[82] was conducted in Studies III and IV. Permission to conduct the studies was obtained from the authorities responsible for health care in the Region of Västra Götaland in Sweden. Information was provided at staff meetings to the team members at the outpatient clinics involved in the studies.

After the completion of the programme, eight occupational therapists agreed to participate in an education course aimed at teaching them PATd and to prepare for Study III. The course was held over 3 days, and comprised both theory and practice application. The therapists had to try all the art tasks during the course to acquire personal experience of what it meant to carry out the exercises. The therapists took part in supervision meetings every six weeks

during the data collection period. The data collection was conducted from May 2014 to December 2016. The author supervised the therapists.

In Study III, patients with moderate to severe depression were invited to participate in a randomized controlled trial. Patients were recruited consecutively from primary care and specialist psychiatric care, and 96 patients were referred. Exclusion criteria were: recent traumatic events needing trauma treatment; bipolar syndrome; ongoing addiction; psychosis; and cognitive disability.

A power calculation, made to calculate a minimum sample size,[69] showed the need of a minimum sample of 90 patients to ensure a significance level of 5%, and an effect size of 0.6 sigma, with a three-point difference, was assumed to be the cut-off for change.

A registered psychotherapist informed the intended participants about the study and of its implications. If agreeing to join the study, the participants were asked to sign a written consent form. Before definite inclusion, an interview about the participant's diagnosis and suicide risk took place. The interviews followed a checklist with suicidal risk factors (Södra Älvsborgs Hospital), and the rating levels of the Montgomery Åsberg Depression Rating Scale – Self-rating (MADRS-S)[84] established the depth of the depression. Participants with a score of 20 and above were included. Further, self-assessment questionnaires measuring socio-demographic data, self-esteem, measured with the Rosenberg self-esteem scale,[85] and suicide risk, measured with the Scale for Suicide ideation (SSI),[86] were conducted at baseline. These measurements were followed up after the participants completed treatment with PATd, and, for the control group, after 13 weeks.

To assess the therapists' compliance with the programme, they documented which part of the treatment they changed, and why, after each PATd session on a four-point Likert scale.

The randomization of group allocation was made by drawing an opaque envelope that specified the allocation. Allocations were concealed from the research group.[104] The intervention group received PATd in addition to treatment as usual (TAU) (n=43). The control group (n=36) received only TAU, for example, pharmacological treatment, psychotherapy, support therapy, or physical training. Seventy-nine patients participated in the study.

Table 3. Overview of characteristics of participants in Studies III and IV

	Study III		Study IV
Variable	**ATD/TAU (*n*=43)**	**TAU (*n*=36)**	**ATD/TAU (*n*=10)**
Age group			
18-25	5(11.6%)	4(11.1%)	2(20%)
26-35	9 (20.9%)	11(30.6%)	0
36-45	14(32.6%)	6(16.7%)	(50%)
46-55	13(30.2%)	10(27.8%)	2 (20%)
56-65	2 (4.7%)	5 (13.9%)	1 (10%)
Gender			
Men	10(23.3%)	13(36.1%)	2 (20%)
Women	33(76.7%)	23(63.9%)	8 (80%)
Depression diagnoses			
Major depressive disorder, single episode, moderate	16(37.2%)	16(44.4%)	5 (50%)
Major depressive disorder, single episode, severe without psychotic features	7 (16.3%)	2 (5.6%)	1 (10%)
Major depressive disorder, single episode, unspecified	6 (14.0%)	8 (22.2%)	0
Major depressive disorder, recurrent, moderate	10(23.3%)	7 (19.4%)	3 (30%)
Major depressive disorder, recurrent, severe without psychotic features	4 (9.3%)	3 (8.3%)	1 (10%)
Forms of social life			
Single	12(27.9%)	11(31.4%)	2 (20%)
Single parent	2 (4.7%)	4 (11.4%)	0
Cohabiting (spouses, partners)	12(27.9%)	9 (25.7%)	4 (40%)
Partners with children	12(27.9%)	7 (20.0%)	2 (20%)
Collective	0 (0.0%)	2 (5.7%)	0
Live-apart	1 (2.3%)	1 (2.9%)	0
Other	4 (9.3%)	1 (2.9%)	2 (20%)
Employment			
On a temporary basis	2 (5.1%)	3 (10.7%)	2 (20%)
With conditional tenure	18(46.2%)	12(42.9%)	5 (50%)
Other forms	12(30.8%)	11(39.3%)	0
Not applicable	7 (17.9%)	2 (7.1%)	3 (30%)
Level of education			
Incomplete education	1 (2.3%)	1 (2.9%)	0
Elementary school	1 (2.3%)	3 (8.6%)	0
High school	20(46.5%)	15(42.9%)	6 (60%)
Vocational school	3 (7.0%)	4 (11.4%)	0
College or university	18(41.9%)	12(34.3%)	4 (40%)

Relative frequencies (%) in parentheses

The participants in Study IV were recruited from Study III. Inclusion of the participants was made in a strategic way in order to obtain as much variation of experiences of the examined phenomenon as possible. This was achieved by including participants who varied in socio-demographic circumstances (Table 3). Ten participants who took part in PATd were interviewed about their experiences according to the lifeworld phenomenology approach.[77] The meaning-oriented interviews were carried out 1 to 2 months after completing the PATd. The phenomenon, meanings of PATd experienced by patients with moderate to severe depression, ruled and guided the interviews.

The interviews began with an opening question: Can you describe how it was for you to participate in PATd? Follow-up questions to deepen the answers were based on each patient's narrative and were guided by the phenomenon. To capture experiences, descriptions of actual situations were sought. The interviews were recorded with a digital recorder and lasted from 50 to 90 minutes in length. The audio-files were transcribed verbatim.

6.3 Analysis methods

6.3.1 Literature review

In study I: therapeutic factors, clinical application, and circumstances in the experimental situation were searched for in the literature review according to the Realist review method.[105] The 16 included articles were scrutinized for words and phrases describing these themes. An overview of the included articles and the studies included in PATd are marked with an asterisk (Table 2). The themes were ordered and described by their contents. The meaning-bearing units were labelled accordingly so their apparent meaning formed various clusters. The clusters were labelled, similar meanings were combined together, then the material was analysed again, and the labels were modified. Each article was reviewed again to ensure that the labelling was correctly applied. This process continued iteratively until the number of labels was reduced to eight and all meaning-units were clustered.

6.3.2 Expert survey

In study II was conducted according to the Delphi technique.[88] Consensus was defined in advance at 70% or higher. The questionnaires consisted of 74 assertions about the main aspects of art therapy for patients with depression. When the questionnaires were returned, the median value was calculated for each assertion. The experts were given feedback about their total estimated score, and the whole group's estimated scores. This procedure was followed to

help the experts consider the assertions again and to ponder more over each assertion. In the final calculation of the medians, missing items were allocated to the experts' previous opinion on each particular assertion. The medians were calculated from the final responses. Where answers were equally divided to the response options, it was not possible to achieve consensus. Therefore, the responses were dichotomized into two subgroups: response options 1 and 2 formed the subgroup "disagree," and response options 3 and 4 formed the subgroup "agree." The consensus level was changed to 100%, and two more assertions were added to the results. The assertions were grouped consistent with their contents in an iterative process and were given headings accordingly.

6.3.3 Statistics

In study III, the characteristics of the sample were examined with a chi squared analysis in order to determine whether the randomization was successful.[106] For analysing changes within groups, paired sample *t* tests were used, and for comparing differences between only TAU and PATd/TAU at baseline and follow-up, two-tailed independent sample *t* tests were used. The effect of various variables on MADRS-S, RSES, and SSI were analysed by using linear regression models. In order to determine whether high levels of personal encounters in TAU affected the results, an explorative analysis was conducted with linear regression and logistic models. All tests were two-tailed and were conducted at a 0.05 significance level. For interactions, a *p*-value of <0.10 was considered significant. All analyses were performed by using SAS Software version 9.4.[107]

6.3.4 Qualitative analysis

In study IV, a study with lifeworld phenomenology analysis was conducted.[77] The analysis transformed descriptions of the participants' experiences to gradually become more abstract. The steps of analysis consisted of moving between the whole; to the parts; to the new whole. The first step was to read all of the interviews and grasp the whole content. The second step was to identify the parts, the meaning-bearing unit, and form clusters from their differences, similarities, patterns, and the relationships between the related meanings. These steps were repeated several times during the analysis. The third step was to describe the whole, that is to say, the essence, and then what constituted the essence.[79,109]

6.4 Methodological considerations

According to Kazdin,[69] the research questions should govern the study design. Because the thesis aimed to develop and evaluate a manual-based art-therapy

programme, it started with a systematic literature review to obtain a picture of the research base in the field. The systematic literature review was completed according to a Realist review method. Realist review was chosen because it provides answers to questions relating to how the programme works, for whom, and under what circumstances.[105]

In order to enhance the programme's validity and to ascertain that the suggested art tasks were adjusted for patients with depression, an expert review was carried out according to the Delphi technique. The choice of using the Delphi technique was based on the assumption that group opinion is more valid and reliable than individual opinions and can guide decision-making. One of the advantages of the Delphi technique is that the experts answer the assertions without any interaction between them and all opinions are equally important.[88,108] Focus groups or interviews could have been an alternative method to explore the main aspects of art therapy. The benefits of the Delphi method were judged to be preferable; the area is extensive and the Delphi method enabled a larger question area to be covered. In a study conducted by Hohman,[109] the Delphi technique was scientifically compared with focus groups and no significant differences were detected; at the end they reached the same conclusions.

In order to investigate the effect of PATd, a randomized controlled trial was conducted. The primary outcomes were defined as depression levels and self-esteem. Secondary outcomes were sick leave and suicide ideation. The study was performed with an intention-to-treat design to maintain the integrity of the randomization process and to strengthen the trial's internal validity. That means that all participants are included in the analysis, regardless of whether they drop out before the study is finished, to prevent loss of data.[110] Including all participants preserves the randomization process, and bias due to selection becomes unlikely. It is also the most conservative analysis model when the data from the dropouts remain unchanged. Any effects will have to come from strong intervention effects from other participants' data.[69] The limitations are that there is an enhanced risk of underestimating the treatment effect.[111]

To explore the programme's significances for the participants, the Reflective Lifeworld Research (RLR) approach, according to Dahlberg et al.,[77] was used. RLR is based on the principles of openness, intentionality, and reversibility. Openness relates to being open to the phenomenon as it presents itself. This is in line with the phenomenological approach, which also includes openness, and awareness, bridling the researchers own preunderstanding. Reversibility is about understanding the whole in light of the parts, and the reverse. Before this study began, several qualitative methods were considered, such as Grounded

Theory, and the Hermeneutic approach. Qualitative research methods have many characteristics in common, but each differs in its aims and philosophy. In Grounded Theory, according to Glaser and Strauss,[112] the primary purpose is to generate theory. This was not the focus when Study IV was designed. The Hermeneutic approach shares the same origin as phenomenology, but the analysis is conducted through a chosen theory.[77] This was not aligned with the aim of the study. Because the interest was to examine and describe the participants' lived experiences, Reflective Lifeworld Research methodology was chosen for the study.[77]

6.5 Ethical considerations

The Declaration of Helsinki has guided the planning and implementation of Studies III and IV, which addresses the ethical implications of involving patients who are in a vulnerable situation in research projects. The Declaration of Helsinki stresses the importance of meeting the health needs of vulnerable persons and that the group will benefit from the results of the research. Special care must be taken when conducting research with vulnerable persons and the patient's interests must always come first.[113] The Swedish Research Council has highlighted the need to protect participants' interests by informed consent, confidentiality, and rules about how the research can be used. The research should yield knowledge relevant to the vulnerable group's health needs that could not be obtained by other means.[114]

PATd was evaluated in the intervention group in addition to treatment as usual and compared with a control-group who only received treatment as usual. The decision to add PATd to treatment as usual originated from an ethical consideration. Because PATd was not previously scientifically investigated and had only been tested in clinical practice, it seemed unethical to withhold ordinary evidence-based treatments as usual from the patients. Research design with treatment as usual means that all participants have contact with healthcare professionals, and that the patients continue with the care that was planned from the beginning.[69]

It is common that distressing emotions can arise in treatment for mental illness.[115] Usually such reactions are inevitable and short-lived. The therapists conducting PATd in Study III had extensive experience of working with mental health problems and were trained to manage patients' distress. They worked in a health care context together with a team who had either psychiatric competence or the possibility to consult a physician in primary health care, and they had the possibility of getting support for themselves if needed during the programme. Supervision provided an opportunity to address issues concerning

PATd and the patients. Supervision and the possibility to consult a psychiatric team also contributed to reducing potential risks of harm.

Depression affects the ability to think, leading to a common problem in making decisions.[115] In designing Study III, it was important to consider this problem by providing clear information about the study, both about what it expected to achieve and about the implications of participating. Information was provided, both verbally and in writing, with an opportunity to ask questions.[114] Time for reflection was considered essential for the decision-making process, so an additional opportunity to ask questions was offered where ambiguity remained after the first information was provided.

There were risks of disappointment if the allocation to the respective group (intervention or control) did not correspond to the participant's wishes. However, only one participant clearly expressed disappointment to their allocation.

Depression is highly linked to suicidal thoughts and wishes, and there is almost always a risk of suicide, which must be attended.[116] During the study, three patients had severe symptoms and acknowledged persistent suicidal thoughts. The psychiatrist in the research group or the professional team to which the patient was enrolled, was consulted in these cases. The patients were attended to according to the health care routines, and received support to manage their symptoms. No suicide attempts were made during this study.

For Studies III and IV, ethical approval was sought and was approved by the Ethics Review Board in Gothenburg, Sweden (Dnr 072-14).

7 RESULTS

In this section, the results of each study component are presented. The section concludes with a presentation of the final programme developed for art therapy based on the results of Studies I-IV. An overview of the relationship between the four individual studies is presented in Figure 4.

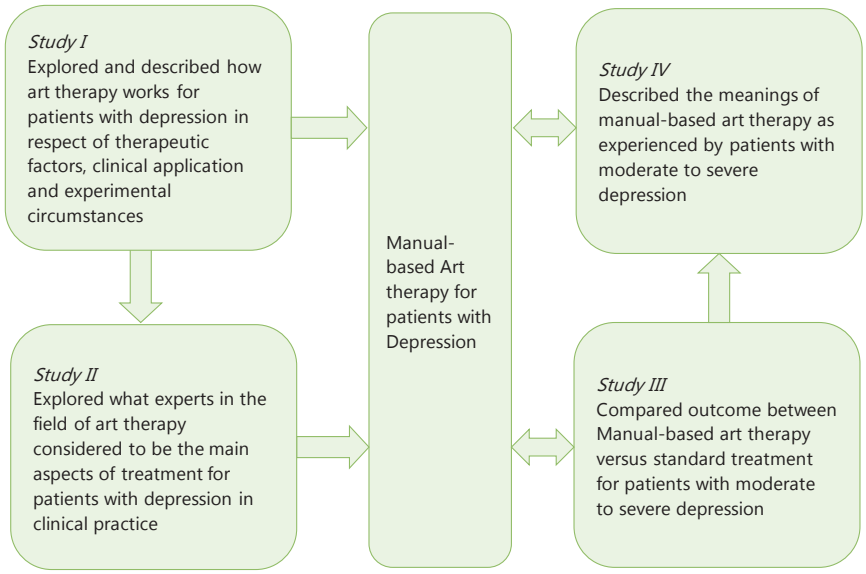

Figure 4. Overview of relationships between studies and the programme.

7.1 Therapeutic factors in art therapy

The systematic literature review (Study I) provided deeper knowledge of therapeutic factors in art therapy for patients with depression. Eight therapeutic factors were identified, where one factor was *self-exploration* in terms of art-making providing techniques for self-exploration which, in turn, can have an impact on self-awareness.

Another factor was that making art is a way of *self-expression* in different ways, such as by using colour and shapes, through physical movement, and by verbalisation the art-making experience.

The therapeutic factor of *communication* is promoted both verbally and non-verbally in symbolic forms.

Further, art-making leads to a deeper *understanding and explanation* of emotional experience and difficult life experiences can be highlighted, processed, and *integrated* through image-making and verbal expressions.

Art therapy *communicates* in symbolic ways and gives shape to experiences, emotions, or thoughts. Reflecting about oneself through art promotes a connection between the conscious and unconscious mind.

Art-making is a *creative* activity and stimulates our mind. The art tasks stimulate the imagination, creativity, and problem-solving skills, each of which are involved in the interpretation and performance.

The *senses* are stimulated through body movement, by looking at the image, by verbal expression and through the relationship between patient and therapist.

The eight therapeutic factors were conceptualized to meet the suitability of specific art tasks for the patient group. The conceptualization was discussed by comparing the art tasks with the International Classification of Functioning, Disability and Health (ICF) core sets for depression.[87]

7.2 Clinical applications of main factors in art therapy for patients with depression

The results in Study II are presented in two main areas; the theoretical frame of references, and clinical applications.

The *Theoretical frame of references* consist of two domains; therapeutic factors, and the effects of different aspects of art therapy on treatment outcomes. The experts agreed with the assumptions that can be made in the results of the questionnaire that relate to therapeutic factors and their influences on treatment outcomes. The experts' opinions differed more in relation to the clinical applications.

Clinical applications were divided into: aims and goals, therapeutic alliance, processing art therapy, clinical practice, art tasks, art material, and impact of surroundings.

The results from Study II had an impact on the development of the programme, not only in relation to which art tasks to include, but also regarding other aspects, such as the notion that individual treatment was preferred to group treatment, and the importance of including art tasks that promote the expression of thoughts, emotions, and experiences.

Another result was the divided meaning about using metaphors among the experts. That led to excluding art tasks using metaphors. On the other hand, despite the divided meanings among the experts in relation to the use of relaxation technique, these were included in the programme based on the results of a research trial with mindfulness that revealed a significant symptom reduction in the intervention compared to the control group.[40]

7.3 The effects of PATd

The results of the RCT study, conducted to evaluate the effects of the manual-based PATd in addition to TAU, showed significant reduction of depression levels and depressive symptoms. This is in contrast to the patients who only received TAU, who showed no significant change of depression levels. This indicates that the reduction of depression can be attributed to participating in PATd/TAU.

In addition, the degree of self-esteem also showed a significant improvement after treatment in both groups.

Another finding was that sickness leave significantly decreased for the participants who took part in the manual-based PATd. This finding is in contrast to those for the participants who received only TAU, who showed a slightly increase in sickness leave.

The results relating to suicide intentions showed no change in either of the two groups, which could be imply that there is no enhanced risk of suicide in relation to participating in PATd.

No significant differences were found between participants who received only TAU and participants who received PATd/TAU at baseline.

7.4 The experiences of PATd

The essence of the patients' experiences of conducting the manual-based PATd means meeting oneself in an inner dialogue between the evident and the concealed. Art-making and the ensuing narrative makes inner life visible, and

can open and alter the understanding of oneself and one's situation. When an image is created in a therapeutic context, the image gives a visual response and acts as a mirror to the creator. An interaction emerges between the image-making, the material, and the image itself. Through the image, the meeting, and an interchange with oneself, an inner dialogue occurs (see Figure 5).

Choosing colours and textures of paint, and nuances in hues, becomes part of the inner dialogue. The selection of materials is done consciously or intuitively as a response to an essential need at any given moment. In PATd, the different tasks support art-making, but they also allow new viewpoints to arise, which, in turn, promote the possibility to discover new aspects of the unconscious. The art tasks provide something to reflect upon. The different art tasks can be seen as pieces of a puzzle that can be put together to promote understanding of oneself and one's reactions. The narrative about the image clarifies and deepens the inner dialogue. The therapist becomes part of the inner dialogue by being the one who receives and responds to the narrative. The essence is constituted by the inner dialogue taking place at various levels, and by overcoming challenges by perceiving and accepting oneself. The frameworks enable the inner dialogue and the narrative, and changes in understanding entail changes in life.

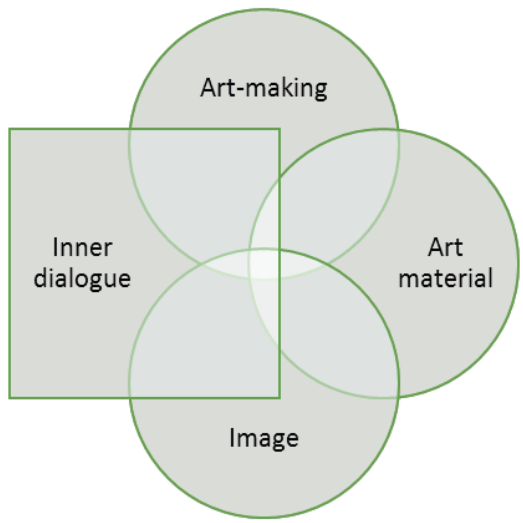

Figure 5. Relations to promote inner dialogue

7.5 Manual-based Phenomenological Art Therapy for patients with depression

The results from Studies I-IV together acted as the foundation for the development of the different aspects in the manual-based PATd programme. Figure 6 represents an overview of the contribution of each study to the programme.

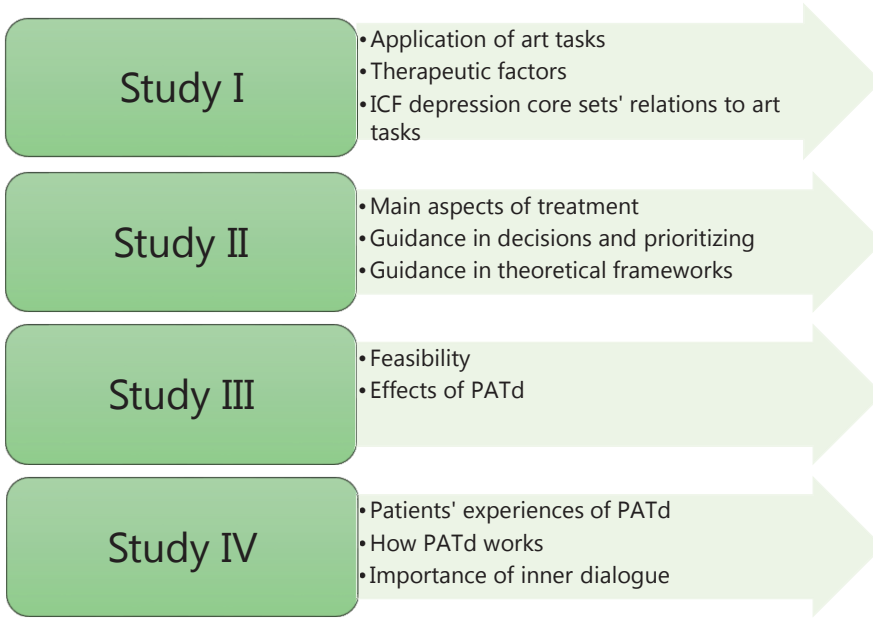

Figure 6. Overview over the studies' contribution to the development of PATd

The sequence of the art tasks followed the levels determined by ETC, except the first session. Consequently, after the introduction and goal-setting sections, the first session in the programme starts with art tasks designed to stimulate the kinetic and sensory levels. These are followed by facilitating the perceptual and affective levels, and, finally, the cognitive and symbolic levels. Session 2-9 starts with reflections about the previous session, then a relaxation exercise, followed by art-making, then reflections about art experiences, and, finally, reflections about what the participant found useful from the session. Session 10 consist of reflections about the treatment period and a review of all of the images. The programme is designed as an overview that describes the content

and aim (Table 4). For specified instructions for each session, see the Appendix (p. 66-69).

Table 4. Overview of content in the Manual-based art therapy for patients with depression

Session	Content	Aims
I	Introduction Goal-setting Exercise: Body scan Art task: Description of the current situation. Draw a picture of yourself.	To describe the current situation. The image serves as the starting point. Experience of self and problems are in focus
II	Exercise: Here and now Art task: Mindful exploration of art material	Awareness of bodily and emotional responses elicited by sensory stimulation
III	Exercise: Breathing anchors Art task: Body image before and after the exercise	Raise awareness and explore how breathing affects body experience
IV	Exercise: Breathing-space Art task: Drawing analogue pictures	Explore and raise the awareness of emotional reactions
V	Exercise: Body scan Art task: Colour and emotions	In-depth exploration of emotions and state of mind. Alternative continuation of Session IV
VI	Exercise: Inner and outer attention Art task: Stressful, pleasant event pictures	Enhance awareness for reactions to stressful situations and find strategies to handle reactions
VII	Exercise: One thing at a time Art task: Graphic life-line	Awareness of behaviour patterns and strategies
VIII	Exercise: Breathing Exercise Art task: Roles	Awareness of behaviour patterns and roles
IX	Exercise: Body scan Art task: Description of the current situation. Draw a picture of yourself.	Evaluation of treatment and process. The patient's interpretation of meanings are in focus
X	Review of all images Art task: Mandala Follow-up goal	Gather impressions and conclusions from treatment

8 DISCUSSION

8.1 General discussion of major findings

The main contribution of this thesis is the introduction of a systematically developed evidence-based art-therapy programme for patients with depression. The PATd programme is operationalized from phenomenological theory described by Betensky,[80] Guttmann, and Regev,[81] and the ETC practice model.[15]

This thesis has proven that it is possible to evaluate treatment effects for patients despite them being affected by complex psychiatric illnesses such as severe depression. So far, very few studies have include patients with severe depression due to difficulties with patient allocation and compliance with the treatment, similar to those with patients suffering from cognitive decline such as dementia, who are also very often excluded from research studies. It is stigmatizing and unfair to withdraw certain groups in society from the benefits of taking part in new knowledge development and it is therefore important to invite all people to take part in research projects, despite severe illness, according to the principles of justice in research.[117]

> *WHO strongly believes that every person with a mental health problem, whatever the mental health problem is, has a right to the same opportunities as everyone else in every aspect of their life.*[118]

The evaluation of the PATd indicates that the treatment has a positive effect on depression. The programme only experienced a few dropouts by the invited patients, suggesting that they found that the treatment worked well for them and was of importance. Another important finding was that PATd did not increase suicide ideation, which is a crucial factor when implementing a new treatment.

Art therapy is conducted in many ways, and the clinical application is often based on the therapist's personal preferences, and this was evident in both Studies I and II. Other studies have indicated that a high level of adaption to personal preference is not always the best treatment to offer.[66-68] It became clear that the experts provided art therapy based on a large variety of theoretical frameworks. Despite this, they were surprisingly unified in their opinions regarding the therapeutic factors that make up art therapy for patients with depression, a result that is in line with the findings of the systematic literature

review. This indicates a unique core in art therapy which is still not sufficiently articulated and clarified.[27]

For this reason, the need for a common theoretical base was apparent and this has been addressed in the development of the manual-based art therapy programme. The phenomenological approach was found to be suitable as a theoretical framework in that some concepts have been more prominent than others. For instance, the phenomenological principle of being open-minded towards the phenomenon has affected the content of the programme relating to how to execute the verbal dialogue.

The use of the ETC allowed the examining of the art tasks based on their complexity, which affected their sequence in the programme. ETC levels follow children's cognitive development, starting from basics kinaesthetic and sensory levels to become increasingly complex.[102] In depression, the higher cognitive levels first become affected and, when the depression becomes more severe, it gradually affects the lower levels.[119] By starting from the lower levels, PATd enables the gradual engagement of higher cognitive levels that can contribute to the understanding of how PATd works.

Seventy-nine patients participated in the RCT study, which is probably slightly underpowered. Nevertheless, the difference in treatment effect between the control group and the intervention group who followed the PATd was larger than we had calculated in the power calculation. The difference was nearly 5 points in favour of PATd in the self-assessment of depression level.

By listening to the patients' voices, we learnt how they perceived PATd and their experiences of how PATd worked for them. The importance of the inner dialogue that occurs when engaging in art-making became clear and emphasized the important role for the therapists to support and direct the patients' attention to the inner dialogue.

The findings from the preceding studies of the literature search and experts' opinions on crucial factors in art therapy all came together in the final study when the participants described their experiences of going through the programme. An illuminating citation comes from one of the participants in the interviews:

> *My artwork is exactly as a mirror, I am so curious when I see myself. I think every time; I want to know more about myself.*

This citation tells us something about what can happen when you experience yourself, looking at yourself through the self-made picture with some distance, as in a mirror. It seems as though it becomes possible to experience yourself simultaneously from within and from a distance. This finding is in line with those of Lidbom, Bøe, Kristoffersen, Ulland, and Seikkula,[120] who found that the inner dialogue contributed to the outer dialogue by providing new perspectives, new words, and new meanings of words. This indicates that it is the dynamic process that occurs in the interplay between the outer dialogue and the participants' inner dialogues that can be understood as the therapeutic components in art therapy, as supported by the interaction between the image, the painter, and the material.

8.2 Methodological discussion

Validity and credibility: The effectiveness of a treatment that lacks structure is difficult to evaluate. There is an obvious risk that it is the individual therapist's means of performing the therapy that will be evaluated instead of the actual therapy itself.[69] This knowledge led to the demand to develop a manual-based art-therapy programme for patients with depression. The art therapy programme was examined regarding the connection to depression through the ICF core sets for depression.[87] This was an important strategy to adopt in order to confirm that the art tasks met the need for treatment of the patients with depression and thereby strengthens the validity and credibility of the results.

In Sweden, education in art therapy varies, both in length and in theoretical frame of reference, implying that clinical practices vary and no homogeneous group of professionals exists. Very few educated art therapists are employed in the health care system in Sweden. Occupational therapists are employed in psychiatric care, and many have a long experience of using art-based therapy. Therefore, to be able to perform Studies II and III, occupational therapists were invited to take part as either experts (II) or therapists (III). A further study is necessary, one which only includes trained art therapists, to compare whether the results would differ.

Because the same person developed PATd and evaluated the programme, there was a risk of positive attitude in favour of PATd. This risk has been eliminated in Study III, by employing a research assistant to inform the participants, perform the data collection, and to enter the data into the statistical computer programme. In Study IV, this led to extra awareness and lingering questions about the participants' negative experiences of PATd. This awareness of negative experiences gave important insight into the difficulties that

participants had in comprehending the meaning of the treatment and some understanding in how to overcome these initial difficulties. This must be examined further in relation to whether, and how, PATd helped participants to quickly overcome struggles and to become able to gain the potential advantages in participating in PATd. To strengthen the credibility of the research, the methods and analyses were discussed among the research team as well as during research seminars.

Study III was challenging in several ways. Recruiting participants took longer time than planned, where one explanation given by the staff was that they found it difficult to ask patients to participate in the study. This observation is in line with a study examining stakeholders' perceptions of the implementation of art therapy. The study showed that stakeholders valued their own choice of intervention more highly than the patients' right to self-determination.[121] The fact that the staff felt reluctant to ask the patients to participate in the study means that probably not all suitable patients were included, which adds the risk of the sample not being fully representative. A plausible effect of that could be that patients who did not respond to treatment as usual were referred to the study more frequently than patients who responded well to treatment as usual.

In Reflective Lifeworld Research, trustworthiness is strengthened by an openness to the phenomenon, which means that the researcher sees the phenomenon as it is. It involves the challenging of well-known theories and prior experiences to set previous knowledge and assumptions aside, and to be open and aware of new aspects or explanations.[77] The "bracketing" or "bridling" of assumptions is a process that is intertwined with reflexivity, and, in this process, something of a dialectical dance occurs, according to Finlay.[122] Further, it is a process of continually reflecting upon our understandings of both our experience and the phenomena we study, and to move beyond our previous understandings and our investment in specific research outcomes.[122]

Openness also characterized the development of PATd, where several assumptions were challenged. An example is that the decision was made to not include exercises with metaphors, despite my own positive experiences, when the experts disagreed about their usefulness.

Reliability and dependability: According to the Medical Research Council (MRC),[123,124] when developing a programme, the first step is to identify the evidence base in a literature review, which was the search conducted in Study I. This study revealed how little research has been completed about art therapy in the area of depression. When so few articles exist in the area, the reliability or dependability of the research needed to be considered. This issue was

managed by only including articles where the art therapy was reported to include only depressed patients and could be generalized to be relevant for the patient-group.

The Delphi technique has been criticized for not allowing in-depth answers and therefore the consensus level is perhaps not as high as it appears.[125] In Delphi studies, dependability can be achieved by including a representative sample of experts, a strategy that was followed in this thesis.[108]

Confirmability: can be assessed by maintaining a detailed description of methods and the analysis process so that other can judge its trustworthiness.[108] Gabel, and Robb[126] have compared therapeutic factors in art therapy in a meta review and described overlapping factors with those found in Study I, with Czamanski-Cohen, and Weihs'[127] body mind model, which describes mechanisms of change. The findings from these studies confirm the therapeutic factors described in Study I, and indicate that the findings in Study I can be transferred to other contexts.

Transparency was achieved, both in the published articles and in the description of development of PATd in this thesis. It is possible to follow the decision stages in the development of PATd (see Appendix table 5), adding to the transparency of the research.

Transferability and generalization: PATd was developed for patients with depression and the effect and significance was evaluated with a specific group of depressed participants. It is likely that the results can be generalized to other patients with depression, but whether the results can be generalized to other patient groups remains to be investigated.

Treatment acceptability: PATd seemed to be accepted by most of the participants and the therapists in Study III. Only three participants dropped out during the treatment with PATd, one because of difficulties coping with the psychiatric symptoms, one due to starting an extensive neuropsychological assessment, and the third without explanation.

In Study IV, the participants gave their views about what they experienced as significant. The impressions varied, from enthusiastic to being more hesitant. Negative treatment experiences are equally important to investigate and highlight as positive.[128]

Feasibility: All art tasks originated from Study I, and were described in scientific journals, either by their effect, or in case studies, and had already

been scientifically or clinical tested. The feasibility of the treatment was investigated before the RCT study was executed. All art tasks and the relaxation exercises were tested in clinical practice. The patients had the possibility to share their experiences of the art tasks and relaxation exercises with the author. No serious negative effects were reported.

Treatment fidelity: It is important to examine to which degree the intervention was implemented as intended.[69] In study III, the therapists' adherence to the treatment described in PATd was examined. After each session, the therapists estimated their compliance with the programme. In general, the therapists reported a high level of treatment fidelity; for 92% of the sessions, no changes were made regarding the content of the PATd, and 390 of 430 (91%) possible sessions were measured. The most prominent changes were in relation to the relaxation exercises, where the therapists preferred some exercises over others. Some alterations were made due to specific life events for some of the participants who needed attention.

8.2.1 Strengths and limitations

This is a comprehensive work; it is not common to both include the development and the evaluation of a treatment in the same thesis. Its strength is that the reader is given the opportunity to take part in the development of the foundations of the treatment and thus provides the possibility to evaluate the programme's trustworthiness. At the same time, the thesis adds knowledge about the effects of the programme with the RCT study, as well as its significance for patients with depression in that it followed the principles of Reflective Lifeworld Research.

Another strength is that the art tasks in the programme are collected from research presented in scientific papers before they were included in the PATd, which strengthens the validity of the research. The art tasks were derived from various theoretical backgrounds. This limitation was remedied by using ETC as an overall theoretical framework when the art tasks were included in PATd, and by using phenomenological art therapy as a foundation for the guidelines for how to execute PATd.

The thesis has shown that it is possible to include patients with severe depression and high illness burden in research. It also shows that it is possible to conduct research in regular clinical practice.

There are some limitations in this thesis. One limitation is that the selection process in Study I was limited by the small amount of published art tasks that had been used for patients with depression. The decision to choose art tasks

that were published was derived from the assumption that these tasks were tested and were found to give good results.

PATd was tested in clinical practice but no pilot study was performed before Study III. A pilot study could have given indications of which questionnaires would best capture the possible effects of PATd.

The power calculation indicated that 90 participants would be sufficient as a minimum. It was not possible to achieve this number due to dropouts. Despite this, Study III indicated that PATd is effective.

8.3 Clinical implications

The occupational therapists each had some form of art therapy education but not all held a diploma in art therapy. The occupational therapists in Study II were highly experienced in using art therapeutically, with an average of 19 years between them. These therapists can be seen as pioneers. In my opinion, PATd has been developed as an art therapy intervention and, if you use the programme as an art therapist, it is art therapy; if you have long experience of using art in therapy but lack formal education, you may call the intervention art-based therapy. However, Study III indicates that PATd is effective on its own, regardless of the type of education possessed by the therapist. If art therapist with other occupations had been included, and whether this may have had any impact on treatment, is something that needs to be examined in future studies.

One of the therapeutic challenges for the therapists who performed PATd was to become aware of and understand when the patients needed more support to activate the inner dialogue and when the same approach was becoming disruptive. It is important to be faithful to the guidelines when practicing PATd, which is in line with former studies.[67]

Education in PATd is needed before applying it for use in clinical practice. Art therapists need to embrace the phenomenological principles on which PATd is based. This thesis has shown that the programme can be executed by other professional categories. The programme supported and guided the treatment, but it is also necessary to have extensive experience of working with patients with depression and a qualified education in psychological treatment as a foundation.

9 CONCLUSION

It is possible to develop a manual-based programme for patients with severe mental illness such as depression. This thesis has contributed with transparency regarding how a manual-based PATd was developed. Transparency gives the reader the chance to judge the validity and reliability of the research. To know what the programme consists of is important in several ways. It gives the patients the possibility to obtain information and the opportunity to consider whether to participate, as well as an understanding of what to expect before engaging in PATd.

A manual-based programme secures the quality of the treatment and is in line with evidence-based treatment.

There were very few patient dropouts during treatment and the therapists showed high compliance with the programme, which indicates that PATd works as intended and seems to be acceptable to the users.

This thesis contributes with understandings of therapeutic factors in art therapy for patients with depression. The studies contribute with insights into how art therapy facilitates reflection and inner dialogue.

This thesis also gives an insight into the importance of the selection of particular art material, attributing the material with different qualities and adapting the material to the situation.

The findings needs to be further examined and confirmed in other studies.

10 FUTURE PERSPECTIVES

Some work remains in the evaluation of the manual-based PATd. In Studies III and IV, the programme as a whole was examined, but we do not know enough about the specific art tasks, separately. This observation is in line with Snir and Regev,[129] who suggest the use of a self-report questionnaire, the Art-Based Intervention (ABI), which was developed to examine the creative process of art-making experience. Using ABI in future research related to PATd would add important knowledge.

Therefore, there is a need to further investigate the art therapy process to gain knowledge about how specific art tasks contribute to self-reflection and recovery. Another remaining question is whether the sequence in which the art tasks are conducted is an important factor. There is also a need to gain deeper understanding of the reasons for when the meeting with oneself does not occur. Can the therapists do something to make it easier? Perhaps an enhanced awareness about the importance for the inner dialogue can contribute to a change in focus for the dialogue between the therapist and the patients.

This thesis provides knowledge on how to perform art therapy in clinical practice for patients with depression. The clinical application needs to be further investigated with scientific methods to fill the need of evidence-based treatment for this patient group.

The manual-based PATd has not been published in a scientific journal and this is desirable in order to strengthen the validity of the programme. Whether the results from this research can also be transferred to patients with other diagnoses remains to be investigated. The promising results from Study III support the ambition to implement PATd in health care to enrich the access to treatment for patients with depression.

Protective factors against psychiatric vulnerability, as stated by the WHO,[75] are important to address when developing and evaluating a treatment programme. There is a need to follow up the long-term effect of PATd and investigate whether the programme affects the patient's ability to perform activities in daily life and to develop coping-strategies.

11 ACKNOWLEDGEMENTS

There are many people who have contributed to the completion of this thesis. I want to express my gratitude to all of you who have helped and supported me in this work. In particular, I wish to thank:

The participants of the studies, for your time and commitment.

I wish to thank my supervisor, Helle Wijk, for your ability to always see possibilities. And for your kindness and your commitment. You are a role model for me in how to be a supervisor.

Marie Rusner, my mentor and supervisor. You were the one who supported me to take on the mission of being a PhD student. I will always be grateful for your support and belief in me. I am looking forward to the day when we can start to plan an upcoming project.

Suzanne Guregård, you have been with me the whole time during this journey. I am grateful that you have taken the time for me and for your valuable insight into research and for always letting me look at things a little bit more deeply.

My employer, first and foremost, Bengt-Arne Andersson, head of the psychiatric clinic at Södra Älvsborgs Hospital, who supported this project and gave me the possibility to be PhD student. Without your support it would never have been a thesis.

All the chiefs of departments who supported the work of this thesis.

All research leaders and assistants at the Research Department at Södra Älvsborgs Hospital and the PhD students associated with the Department. Thank you for your valuable comments during my article seminars and during all of our discussions. Especially I give my thanks to Ewa Carlson Lalloo and Angela Bångsbo for being there.

Thanks to the Occupational therapists in Studies II and III, especially Annika, Anne-Marie, Bente, Karin, Kristina, Marita, Mona, and Sanna, for your contribution in carrying out PATd and for your professional know-how.

Friends, thanks for your patience, and I will soon start to socialize again!

Thanks to my colleagues and former colleagues at the Psychiatric clinic at Södra Älvsborgs Hospital for their support and interesting discussions about all and nothing.

Both of my parents passed away during my time as a doctoral student. This has influenced me deeply but has also given me a greater understanding of what people are struggling with in their own lives. My parents were always supporting. Thanks, mom and dad, for your great support, which I continue to feel, even though you are no longer among us.

Thanks to my sisters, Helene and Annelie, along with your families, for your support, understanding and many laughs.

Finally, to my spouse and dearest, Per, who has been my greatest support throughout this journey. His support has been invaluable, giving me time and patience, easing my workload, but also the one who I turn to when I need to discuss psychological processes and the one who gives me perspective on human behaviour. Thanks, Per, because you exist. Thanks, Per, for all the cups of tea when I needed them most.

This thesis was carried out at and supported by Gothenburg University, Sahlgrenska Academy, Institute for Health and Caring Sciences. Thank you Ingela Lundgren, Head of Department, and Karin Mossberg, Research assistant.

REFERENCES

1. Blomdahl C, Gunnarsson AB, Guregård S, Björklund A. A realist review of art therapy for clients with depression. The Arts in Psychotherapy. 2013;40(3):322-330.
2. Blomdahl C, Gunnarsson BA, Guregård S, Rusner M, Wijk H, Björklund A. Art therapy for patients with depression: expert opinions on its main aspects for clinical practice. Journal of Mental Health. 2016;25(6):527-535.
3. Blomdahl C, Guregård S, Rusner M, Wijk H. A manual-based Phenomenological Art therapy for patients with moderate to severe depression (PATd) – a randomized controlled study. Submitted.
4. Blomdahl C, Wijk H, Guregård S, Rusner M. Meeting oneself in inner dialogue: a manual-based art therapy as experienced by patients with moderate to severe depression. The Arts in Psychotherapy. 2017; in press.
5. British Association of Art Therapists. What is art therapy? 2017; http://www.baat.org/About-Art-Therapy. Accessed August 5, 2017.
6. Miller CL. The effects of art history-enriched art therapy on anxiety, time on task, and art product quality. Art Therapy. 1993;10(4):194-200.
7. Education EECfATi. About ECArTE. 2017 http://www.ecarte.info/about/. Accessed August 7, 2017.
8. Broderick S. Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts. Arts & Health: An International Journal for Research, Policy and Practice. 2011;3(2):95-109.
9. International Expressive Arts Therapy Association. Who we are. 2017; http://www.ieata.org/who-we-are.html. Accessed August 7, 2017.
10. Sigurdson O, Priebe G, Sager M, Bernhardsson K, Brodén D. Kultur och hälsa. Ett vidgat perspektiv [Culture and Health. A broader perspective]. Institutionen för litteratur, idéhistoria och religion, Göteborgs universitet; 2014.
11. Benedek M, Jauk E, Sommer M, Arendasy M, Neubauer AC. Intelligence, creativity, and cognitive control: the common and differential involvement of executive functions in intelligence and creativity. Intelligence. 2014;46(1):73-83.
12. Seligman ME, Csikszentmihalyi M. Positive psychology. An introduction. The American Psychologist. 2000;55(1):5-14.
13. Forgeard MJC, Elstein JG. Advancing the clinical science of creativity. Frontiers in Psychology. 2014;5(613):1-4.
14. Runco MA, Jaeger GJ. The standard definition of creativity. Creativity Research Journal. 2012;24(1):92-96.
15. Hinz LD. Expressive therapies continuum – a framework for using art in therapy. New York: Routledge; 2009.

16. Lindqvist G. Vygotsky's Theory of Creativity. Creativity Research Journal. 2003;15(2-3):245-251.

17. Ivcevic Z, Brackett MA. Predicting creativity: interactive effects of openness to experience and emotion regulation ability. Psychology of Aesthetics, Creativity, and the Arts. 2015;9(4):480-487.

18. McCrae RR. Social consequences of experiential openness. Psychological Bulletin. 1996;122(3):323-337.

19. Tshivhase M. On the possibility of authentic self-expression. Communicatio. 2015;41(3):374-387.

20. Paek SH, Abdulla AM, Cramond B. A neta-analysis of the relationship between three common psychopathologies—ADHD, anxiety, and depression—and indicators of little-c creativity. Gifted Child Quarterly. 2016;60(2):117-133.

21. Flood M. Exploring the relationships between creativity, depression, and successful aging. Activities, Adaptation and Aging. 2006;31(1):55-71.

22. Scott G, Leritz LE, Mumford MD. The effectiveness of creativity training: a quantitative review. Creativity Research Journal. 2004;16(4):361-388.

23. Morriss-Kay GM. The evolution of human artistic creativity. Journal of Anatomy. 2010;216(2):158-176.

24. Betensky M. The phenomenological approach to art expression and art therapy. Art Psychotherapy. 1977;4(3–4):173-179.

25. Malchiodi CA. The art therapy sourcebook. NewYork: The Mcgraw-Hill Companies; 1998.

26. Zubala A, MacIntyre DJ, Gleeson N, Karkou V. Description of arts therapies practice with adults suffering from depression in the UK: quantitative results from the nationwide survey. The Arts in Psychotherapy. 2013;40(5):458-464.

27. Rubin AJE. Approaches to art therapy. Philadelphia: Brunner-Routledge; 2001.

28. Edwards D. Art therapy. London: SAGE; 2004.

29. Arnheim R. For Margaret Naumburg. The Arts in Psychotherapy. 1984;11(1):3-5.

30. Liebmann M. Art therapy for groups: a handbook of themes and exercises. 2nd ed. Florence: Taylor and Francis; 2004.

31. Van Lith T, Fenner P. The practice continuum: conceptualising a person-centred approach to art therapy. Australian and New Zealand Journal of Arts Therapy. 2011;6(1):17-21.

32. Schaverien J. Art within analysis: scapegoat, transference and transformation. Journal of Analytical Psychology. 1999;44(4):479-510.

33. Kagin SL, Lusebrink VB. The expressive therapies continuum. Art Psychotherapy. 1978;5(4):171-180.

34. Holmqvist G, Persson CL. Is there evidence for the use of art therapy in treatment of psychosomatic disorders, eating disorders and crisis? A comparative study of two different systems for evaluation. Scandinavian Journal of Psychology. 2012;53(1):47-53.

35. Umeå University. Magisterprogram i bildterapi [Master of Science in Art therapy]. 2017; https://www.umu.se/utbildning/program/magisterprogram-i-bildterapi. Accessed June 8, 2017.

36. Niarte. Bildterapiutbildning till Bildterapeut [Art therapy education to art therapist]. 2013; http://www.niarte.se/. Accessed June 22, 2017.

37. Atelje för bildterapi. Jungiansk bildterapiutbildning [Art therapy education according to Jung]. 2017; http://www.bildterapi.com/. Accessed Jun 22, 2017.

38. Van Lith T, Schofield MJ, Fenner P. Identifying the evidence-base for art-based practices and their potential benefit for mental health recovery: a critical review. Disability and Rehabilitation. 2013;35(16):1309-1323.

39. Egberg Thyme K, Sundin EC, Wiberg B, Öster I, Åström S, Lindh J. Individual brief art therapy can be helpful for women with breast cancer. Palliative & Supportive Care. 2009;7(1):87-95.

40. Monti DA, Peterson C, Shakin Kunkel EJ, Hauck WW, Pequignot E, Rhodes L. A randomised, controlled trial of mindfulness-based art as therapy (MBAT) for women with cancer. Psycho-Oncology. 2006;15(5):363-373.

41. Öster I, Svensk AC, Magnusson E, et al. Art as therapy improves coping resources: a randomized, controlled study among women with breast cancer. Palliative & Supportive Care. 2006;4(1):57-64.

42. Gunnarsson B, Eklund M. The tree theme method as an intervention in psychosocial occupational therapy: client acceptability and outcomes. Australian Occupational Therapy Journal. 2009;56(3):167-176.

43. Martin E. The symbolic graphic life-line: integrating the past and present through graphic imagery. Art therapy: Journal of the American Art Therapy Association. 1997;14(4):261-267.

44. Körlin D, Nybäck H, Goldberg F. Creative arts groups in psychiatric care - development and evaluation of a treatment alternative. Nordic Journal of Psychiatry. 2000;54(5):333-340.

45. Öster I, Magnusson E, Egberg Tyme K, Lindh J, Åström S. Art therapy for women with breast cancer. The therapeutic consequences of boundary strengthening. The Arts in Psychotherapy. 2007;34(3):277-288.

46. Field W. The effect of an art psychotherapy intervention on levels of depression and health locus of control orientations experienced by black

women living with HIV. South African Journal of Psychology. 2008;38(3):467-478.

47. Zubala A, MacIntyre DJ, Karkou V. Evaluation of a brief art psychotherapy group for adults suffering from mild to moderate depression: pilot pre, post and follow-up study. International Journal of Art Therapy. 2017;22(3):1-12.

48. Egberg Thyme K, Sundin EC, Stahlberg G, Lindstrom B, Eklof H, Wiberg B. The outcome of short-term psychodynamic art therapy compared to short-term psychodynamic verbal therapy for depressed women. Psychoanalytic Psychotherapy. 2007;21(3):250-264.

49. Västra Götalandsregionen. Regional medicinsk riktlinje: depression [Regional medical direction: depression]. 2017; http://www.vgregion.se/halsa-och-vard/vardgivarwebben/vardriktlinjer/regionala-medicinska-riktlinjer/amnesomraden/alla-regionala-medicinska-riktlinjer/. Accessed August 25 2017.

50. Åsberg M, Bengtsson F, Hagberg B, Henriksson F, Håkansson I, Karlsson I. Behandling av depressionsjukdomar. En systematisk litteraturöversikt. [Treatment of affective disorders. A systematic review]. In. SBU rapport nr 166. Vol 1 & 3. Stockholm: SBU; 2004.

51. Wittchen HU, Jacobi F, Rehm J, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. European Neuropsychopharmacology. 2011;21(9):655-679.

52. Rush AJ, Trivedi MH, Wisniewski SR, et al. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. American Journal of Psychiatry. 2006;163(11):1905-1917.

53. Ekselius L. Diagnostik och uppföljning av förstämningssyndrom: en systematisk litteraturöversikt [Diagnostics and follow-up of affective disorder: a systematic literature review]. Vol 212. Stockholm: Statens beredning för medicinskt utvärdering (SBU); 2012.

54. World Health Organization. International statistical classification of diseases and related health problems: 10th revision, Vol 2, 5 ed. Geneva: WHO; 2016. http://apps.who.int/classifications/icd10/browse/Content/statichtml/ICD10Volume2_en_2016.pdf?ua=1&ua=1. Accessed 2017 August 12.

55. American Psychiatric Association. Mini-D 5: diagnostiska kriterier enligt DSM-5 [Mini-D 5: diagnostic criteria according to DSM-5]. Stockholm: Pilgrim Press; 2014.

56. Stigsdotter Nyström ME, Nyström M. Patients' experiences of recurrent depression. Issues in Mental Health Nursing. 2007;28(7):673-690.

57. Aho KA. Depression and embodiment: phenomenological reflections on motility, affectivity, and transcendence. Medicine, Health Care and Philosophy. 2013;16(4):751-759.

58. Coyne JC, Whiffen VE. Issues in personality as diathesis for depression: the case of sociotropy-dependency and autonomy-self-criticism. Psychological Bulletin. 1995;118(3):358-378.

59. Barlow DH. Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. American Psychologist. 2000;55(11):1247-1263.

60. Orth U, Robins RW, Meier LL. Disentangling the effects of low self-esteem and stressful events on depression: findings from three longitudinal studies. Journal of Personality and Social Psychology. 2009;97(2):307-321.

61. Sowislo JF, Orth U. Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. Psychological Bulletin. 2013;139(1):213-240.

62. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990's. Psychosocial Rehabilitation Journal. 1993;16(4):11-23.

63. Mathers CD, Loncar D. Projections of global mortality and burden of disease from 2002 to 2030. PLoS Medicine. 2006;3(11):e442.

64. Greer TL, Kurian BT, Trivedi MH. Defining and measuring functional recovery from depression. CNS Drugs. 2010;24(4):267-284.

65. Guico-Pabia CJ, Fayyad RS, Soares CN. Assessing the relationship between functional impairment/recovery and depression severity: a pooled analysis. International Clinical Psychopharmacology. 2012;27(1):1-7.

66. Dobson KS, Shaw BF. The use of treatment manuals in cognitive therapy: experience and issues. Journal of Consulting and Clinical Psychology. 1988;56(5):673-680.

67. Schulte D, Eifert GH. What to do when manuals fail? The dual model of psychotherapy. Clinical Psychology: Science and Practice. 2002;9(3):312-328.

68. Castonguay LG, Schut AJ, Constantino MJ, Halperin GS. Assessing the role of treatment manuals: have they become necessary but nonsufficient ingredients of change? Clinical Psychology: Science and Practice. 1999;6(4):449-455.

69. Kazdin AE. Research design in clinical psychology. Vol 4. Boston, MA: Allyn and Bacon; 2003.

70. Henderson M, Harvey SB, Øverland S, Mykletun A, Hotopf M. Work and common psychiatric disorders. Vol 104. London: SAGE Publications; 2011:198-207.

71. Van Lith T, Fenner P, Schofield M. The lived experience of art making as a companion to the mental health recovery process. Disability and Rehabilitation. 2011;33(8):652-660.

72. Wärnå-Furu C. Hälsa [Health]. In: Wiklund Gustin L, Bergbom I, eds. Vårdvetenskapliga begrepp i teori och praktik [Caring science concepts in theory and practice]. Lund: Studentlitteratur; 2013.

73. World Health Organization. Milestones in health promotion. Statements from global conferences. Geneva: WHO; 2009. http://www.who.int/healthpromotion/milestones/en/. Accessed 25 August, 2017.

74. Herrman H, Saxena S, Moodie R. Promoting mental health: concepts, emerging evidence, practice. Geneva: WHO; 2005. http://whqlibdoc.who.int/publications/2005/9241562943_eng.pdf. Accessed 25 August, 2017.

75. World Health Organization. Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO secretariat for the development of a comprehensive mental health action plan. Geneva: WHO; 2012. http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf?ua=1. Accessed 25 August, 2017.

76. Bengtsson J. Med livsvärlden som grund [The lifeworld as foundation]. *Lund: Studentlitteratur; 2005.*

77. Dahlberg K, Dahlberg H, Nyström M. Reflective lifeworld research. Lund: Studentlitteratur; 2008.

78. Husserl E. Idéer till en ren fenomenologi och fenomenologisk filosofi [Ideas for a pure phenomenology and phenomenological philosophy] Stockholm: Thales; 2004.

79. Merleau-Ponty M. Kroppens fenomenologi [Phenomenology of Perception]. 1st ed. Göteborg: Daidalos; 1999.

80. Betensky M. What do you see? Phenomenology of therapeutic art expression. London and Philadelphia: Jessica Kingsley Publishers; 1995.

81. Guttmann J, Regev D. The phenomenological approach to art therapy. Journal of Contemporary Psychotherapy. 2004;34(2):153-162.

82. Braveman B, Kielhofner G, Bélanger R. Program development. In: Kielhofner G, ed. Model of human occupation: theory and application. 4th ed. Philadelphia: Lippincott, Williams & Wilkings; 2008.

83. Long CG, Kidger T, Hollin CR. The evolution of an evidence-based programme for problem drinking: treatment components. Clinical Psychology and Psychotherapy. 2001;8(6):458-467.

84. Fantino B, Moore N. The self-reported Montgomery-Åsberg Depression Rating Scale is a useful evaluative tool in major depressive disorder. BMC Psychiatry. 2009;9:26.

85. Rosenberg M, Schooler C, Schoenbach C, Rosenberg F. Global self-esteem and specific self-esteem: different concepts, different outcomes. American Sociological Review. 1995;60(1):141-156.

86. Beck AT, Brown GK, Steer RA. Psychometric characteristics of the Scale for Suicide Ideation with psychiatric outpatients. Behaviour Research and Therapy. 1997;35(11):1039-1046.

87. Cieza A, Chatterji S, Andersen C, et al. ICF Core Sets for depression. Journal of Rehabilitation Medicine, Supplement. 2004;36(0):128-134.

88. Keeney S, Mckenna H, Hasson F. The Delphi technique in nursing and health research. Chichester: Wiley-Blackwell; 2010.

89. Barbee M. Men's roles and their experience of depression. Art Therapy: Journal of the American Art Therapy Association. 1996;13(1):31-36.

90. Gunnarsson B, Jansson JA, Eklund M. The Tree Theme Method in psychosocial occupational therapy: a case study. Scandinavian Journal of Occupational Therapy. 2006;13(4):229-240.

91. Hanes MJ. Utilizing road drawings as a therapeutic metaphor in art therapy. American Journal of Art Therapy. 1995;34(1):19.

92. Hanes MJ. Utilizing the circus phenomenon as a drawing theme in art therapy. The Arts in Psychotherapy. 1997;24(4):375-384.

93. Henderson P, Rosen D, Mascaro N. Empirical study on the healing nature of mandalas. Psychology of Aesthetics, Creativity, and the Arts. 2007;1(3):148-154.

94. Isaksson C, Norlén A-K, Englund B, et al. Changes in self-image as seen in tree paintings. Arts in Psychotherapy. 2009;36(5):304-312.

95. Luzzatto P, Sereno V, Capps R. A communication tool for cancer patients with pain: the art therapy technique of the body outline. Palliative & Supportive Care. 2003;1(2):135-142.

96. McNamee CM. Bilateral art: facilitating systemic integration and balance. The Arts in Psychotherapy. 2003;30(5):283-292.

97. McNamee CM. Experiences with bilateral art: a retrospective study. Art Therapy. 2006;23(1):7-13.

98. McNamee CM. Using both sides of the brain: experiences that integrate art and talk therapy through scribble drawings. In. Art Therapy: Journal of the American Art Therapy Association. 2004;21(3):136-142.

99. Meijer-Degen F, Lansen J. Alexithymia—a challange to art therapy: the story of Rita. The Arts in Psychotherapy. 2006;33(3):167-179.

100. Sakaki T, Ji Y, Ramirez SZ. Clinical application of color inkblots in therapeutic storytelling. The Arts in Psychotherapy. 2007;34(3):208-215.

101. Trombetta R. Art therapy, men and the expressivity gap. Art Therapy. 2007;24(1):29-32.

102. Lusebrink VB. Art therapy and the brain: an attempt to understand the underlying process of art expression in therapy. Art Therapy: Journal of the American Art Therapy Association. 2004;3(27):125-135.

103. Lusebrink VB. A systems oriented approach to the expressive therapies: The expressive therapies continuum. The Arts in Psychotherapy. 1991;18(5):395-403.

104. Mother D, Hopewell S, Schulz KF, et al. CONSORT 2010 Explanation and elaboration: updated guidelines for reporting parallel group randomized trial. BMJ. 2010;340(c869):1-28.

105. Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review-a new method of systematic review designed for complex policy interventions. Journal of Health Services Research & Policy. 2005;10(1):21-34.

106. Borg E, Westerlund J. Statistik för beteendevetare: Faktabok [Statistics for Behaviour scientists: Factual study book]. Vol 3. Malmö: Liber; 2012.

107. SAS 9.1.3 Help and Documentation [computer program]. SAS Institute Inc.; 2002-2004.

108. Hasson F, Keeney S. Enhancing rigour in the Delphi technique research. Technological Forecasting and Social Change. 2011;78(9):1695-1704.

109. Hohman JE. Comparative analysis of focus and Delphi techniques using occupational tasks [Ph.D. dissertation]. Ann Arbor, Capella University; 2006.

110. Polit DF, Gillespie BM. Intention-to-treat in randomized controlled trials: recommendations for a total trial strategy. Research in Nursing & Health. 2010;33(4):355-368.

111. Hernán MA, Hernández-Díaz S. Beyond the intention-to-treat in comparative effectiveness research. Clinical Trials. 2012;9(1):48-55.

112. Glaser A, Strauss B. The discovery of grounded theory: strategies for qualitative research (observations). New York: Aldine de Gruyter; 1967.

113. World Medical Association. WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects. 2013; https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/. Accessed 25 August, 2017.

114. Hermerén G. God forskningssed [Good science practice]. Stockholm: Vetenskapsrådet; 2011. 9173071897.

115. Herlofsson J, Ekselius, L., Lundh, L-G. Lundin, A., Mårtensson, B., Åsberg, M., eds. Psykiatri [Psychiatry]. 1:3 ed. Lund: Studentlitteratur; 2010. Åsberg M, Mårtensson, B., ed. Förstämningssyndrom.

116. DeJong TM, Overholser JC, Stockmeier CA. Apples to oranges?: A direct comparison between suicide attempters and suicide completers. Journal of Affective Disorders. 2010;124(1-2):90-97.

117. National Institutes of Health. The Belmont Report: ethical principles and guidelines for the protection of human subjects of research. Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Washington, DC: Department of Health, Education and Welfare;1979.

118. World Health Organization. Stigma and discrimination. Geneva: WHO; 2017. http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/stigma-and-discrimination. Accessed August 14, 2017.

119. Papazacharias A, Nardini M. The relationship between depression and cognitive deficits. Psychiatria Danubina. 2012;24(Suppl. 1):179-182.

120. Lidbom PA, Bøe TD, Kristoffersen K, Ulland D, Seikkula J. A study of a network meeting: exploring the interplay between inner and outer dialogues in significant and meaningful moments. Australian and New Zealand Journal of Family Therapy. 2014;35(2):136-149.

121. De Vecchi N, Kenny A, Kidd S. Stakeholder views on a recovery-oriented psychiatric rehabilitation art therapy program in a rural Australian mental health service: a qualitative description. International Journal of Mental Health Systems. 2015;9(1):11.

122. Finlay L. A dance between the reduction and reflexivity: explicating the phenomenological psychological attitude. Journal of Phenomenological Psychology. 2008;39(1):1-32.

123. Anderson R. New MRC guidance on evaluating complex interventions. BMJ. 2008;337(7676):944-945.

124. Craig P, Dieppe P, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. International Journal of Nursing Studies. 2013;50(5):587.

125. Goodman CM. The Delphi technique: a critique. Journal of Advanced Nursing. 1987;12(6):729-734.

126. Gabel A, Robb M. (Re)considering psychological constructs: a thematic synthesis defining five therapeutic factors in group art therapy. Arts in Psychotherapy. 2017;55:126-135.

127. Czamanski-Cohen J, Weihs KL. The bodymind model: a platform for studying the mechanisms of change induced by art therapy. Arts in Psychotherapy. 2016;51:63-71.

128. Rankanen M. Clients' positive and negative experiences of experiential art therapy group process. The Arts in Psychotherapy. 2014;41(2):193.

129. Snir S, Regev D. ABI - Art-based Intervention Questionnaire. Arts in Psychotherapy. 2013;40(3):338-346.

APPENDIX

Appendix contains:

Table 5. Selection procedure of the art tasks in PATd.

Guidelines about treatment principles in PATd.

Description of sessions in PATd.

Table 5. Selection procedure of the art tasks in PATd

Therapeutic factor	Study No.	ETC	Decision strategy based on findings, Study II	Art tasks 1:st selection	Art tasks after removing duplicates	Art tasks selected from distribution of therapeutic factors
Self-exploration	1	C/S	Strong support to express thoughts about themselves and situation. Inconsistencies in support for using metaphors. Support for the tasks at several levels, ECT. 1. The task focuses on the relationship with others. Strong support. 13. The only tasks at K/S level at self-exploration. Several tasks are possible. 15. Strong connection to depression.	1 12 [1, 2, 3, 5] 13 [1, 5, 6] 15	1 2/16 [1] 4 5 6 7 [1, 10] 8 9 10 11 12 [1, 2, 3, 4, 5] 13 [1, 2, 3, 5, 6] 14 15	2/16 [1], Self-expression, Communication, Integration, Sensory stimulation 6. Self-expression, Communication, Understanding and explanation, Integration 8. Self-expression, communication, integration. 9. Understanding and explanation, Integration, Symbolic thinking, Creativity. 12 [1]. Self-exploration, Self-expression, Communication, Symbolic thinking, Creativity
	12	P/A C/S				
	13	K/S P/A				
	14	P/A C/S				
	15	P/A C/S				
Sensory stimulation	2/16	K/S P/A C/Sy	There is consensus to express body symptoms through image-making. 11. Uses the body. 13. Strong support for sensory stimulation.	11. 13 [2]		
	11	K/S P/A C/Sy				
	13	K/S P/A				
Self-expression	2/16	K/S P/A C/Sy	Strong support for expressing feelings, and thoughts. Somewhat weaker support to express experience es. Less support to use symbols.	2/16 [1] 8 12 [1, 4] 13 [1, 3, 5, 6]	*N*=23	
	6	P/A C/Sy				

	8	K/S P/A C/Sy	8. and 2/16, are basically the same task except size. There is also a timeframe to consider. Therefore, chose 8. 11. Indirect method consists of several steps. Can be difficult to implement as not all have developed the ability to think symbolically. 12. Strong support to express feelings. 13. Tasks that most clearly are about self-expression. No support for free painting.		13 [1, 4, 5, 6]. Self-exploration, Self-expression, Understanding and explanation, Integration, sensory stimulation, creativity
	11	K/S P/A C/Sy			
	12	P/A			
	13	K/S P/A			
	14	P/A C/Sy			
Understanding and explanation	6	P/A C/Sy	6. Strong support for understanding and getting explanation of reactions, reactions to relationships and reactions to life events. 9. Strong support for exploring relationships. 13. Strong support for exploring emotions and life events. Support for using the same task as the starting and final image.	6 9 13 [1, 6, 8]	
	9	C/Sy			
	13	K/S P/A			
Symbolic thinking	4	C/Sy	Weak support for metaphors. 7. Support for the same art theme at first session and last session. 9. Uses symbolic thinking without specific symbol.	7 [1,10] 9 12 [1]	
	5	C/Sy			
	7	C/Sy			
	9	C/Sy			
	11	K/S P/A C/Sy			
	12	P/A			
Communication	6	P/A C/Sy	Strong support for communication, both verbal and non-verbal. All tasks	8 16 [1]	

	8	K/S P/A C/Sy	encourage communication. Weak support using symbols. Choices based on ETC and that the tasks are on several levels.	
	11	K/S P/A C/Sy		
	12	P/A		
	14	P/A C/Sy		
	16	K/S P/A C/Sy		
Integration	6	P/A C/Sy	Very strong support for integration of difficult life events. 6 and 9, the tasks are developed to promote integration.	6 9 13 [6]
	8	K/S P/A C/Sy		
	9	C/Sy		
	10	K/S P/A C/Sy		
	13	K/S P/A		
Creativity	10	K/S P/A C/Sy	Support for creativity. All tasks promote creativity. Did not choose tasks based on metaphors. Selection based on the content of multiple levels of ECT.	10 11 14
	11	K/S P/A C/Sy		
	12	P/A		

	13	K/S
		P/A
	14	P/A
		C/Sy

No. square brackets refers to different art task described in the studies (see study I, table 3).

Guidelines about treatment principles in PATd

These guidelines are based on Guttmann, and Regev,[81] and Betensky's[80] Phenomenological Art Therapy. The guidelines have evolved and were clarified during the evaluation of PATd.

The therapeutic contract

If possible, schedule times for all 10 sessions right from the start. Schedule once a week for one hour. When patients make a cancellation, try to be active to catch up on why it has been cancelled. By agreement, call the patient and follow-up.

Regular follow-up of suicidal intentions are recommended. Suicidal thoughts and intentions, depending on severity, are managed in accordance with the local routines.

The role of the therapist

PATd aims to help patients to find their own ways to live authentic lives. The therapist is responsible for creating the therapeutic space and atmosphere for art-making, arranging the art materials, and observing the process of art-making. The therapist seeks to promote a reflective dialogue, aiming at obtaining the patient's story about the image and experiences. This should be a balance between silence and supporting the dialogue with questions.

The dialogue between the patient and therapist is based on a phenomenological approach. The focus is on the patient's experience of the phenomenon or the image from a lifeworld perspective. The therapist should not be too quick to draw conclusions about the image and the patient's story and can promote this by bridling the understanding and lingering in the experience. To allow effects to linger will promote a relaxed approach to the phenomenon and experience. The therapist’s attitude should be kind and characterized by openness. Try to understand the patient’s experience in a different way. Challenge the known. Strive to be immediate, present, and in the here-and-now. Meet the patient's experience with wonder and be as open-minded as possible.

Manual-based Phenomenological Art Therapy

The basic idea in PATd is to promote authentic choices in life; therefore, patients should create their own artwork in their own way. The goal is to deal

with options, acknowledging them, allow them to make choices and cope with the consequences.

In general, try to be present and give support when practical issues appear. To solve practical issues, first let the patients suggest their ways of dealing with the problem. If needed, make suggestions for possible solutions.

Present in the moment

The phenomenological approach focuses on the here-and-now. Dwelling on the past and/or speculating about the future are discouraged. The creative work occurs in the here-and-now, and should encourage the patient to feel for how she/he wants to solve the task, or how she/he wants to use the art material.

Relaxation exercises: Ask the patient whether they have tried similar exercises in the past. Ask for reactions. Explain the exercises. Make an agreement on how to cope if anxiety increases. In exercises where patients are lying on the floor, ask first whether they want to be on the floor or if they prefer to sit on a chair.

Customize the text so that it feels good for you. If you become short of breath, you are reading too quickly. When reading the exercise, try to do the exercise simultaneously. It is important that the patient is present and alert before you proceed to the next step.

Asking questions

Avoid asking “why” questions. The rationale for this rule is, in answering this type of question, patients need to speculate on reasons and on their past, while they should focus on their immediate experience. Questions should be of the “what” and “how” type, centring on the present. In this way, the patient is encouraged to notice what is at the centre of their attention or ponderings.

Questions allow self-reflection and exploration of experiences in relation to the image. Dialogue around the image is based on joint exploration, where the image's meaning for the patient is the focus. The dialogue is promoted through in-depth questions. Seek a living dialogue where the image is an aid. The patient's need is to be governed, e.g., the first art task is about self-presentation, and their present life: "Make a picture of you, right now in your life." It provides an opportunity to talk about issues, resources, and struggles. Included in the manual is an overview of the purpose of the session specified. Consult the purposes, but be aware that the purposes are indicative and not absolute.

Participants in PATd can have completely different topics that need to be addressed, and these can be followed-up in a joint exploration.

The questions in the manual are developed only to support the therapist to find an entrance to the dialogue. Rehearse the questions before the session starts; you should not read the questions directly from the manual.

The dialogue between the patient and therapist is characterized by open questions – How you perceive the image? What do you see? What does it mean to you? How does it affect your life? What aroused this particular image? Help the patient to discuss problems and find solutions. Avoid asking leading questions that might direct the patients away from the image. Consult the programme each time you start a new session.

Follow-up questions: Try to remain in an area for quite some time, as new experiences can emerge. Ask questions such as: That was interesting, is it possible to tell me more? Can you tell us about an example? Can you tell me about when you experienced the opposite? Confirm but bridle your own perceptions, it is not certain that you will understand the meaning.

Interpretation

Do not interpret the dialogue in the traditional way. The therapist encourages the patient to stay in the here-and-now and should relate whatever comes up in the session to the present experiences. It is taken into account that the full meaning of a phenomenon may be hidden at first from the patient and therapist alike, and that a "deeper" exploration is needed. This is achieved by the patient and can only be guided by the therapist. The therapist should try to bridle their preconceptions. It is important to not add your own values or theories of what the patient says and not to interpret what the patient says; instead, keep a reflective distance.

If the patient wants the therapist's interpretation of the image, communicate that it is not how we work, but instead, stress the patient's experience as being important.

Transference

The use of transference as a concept is problematic in phenomenological art therapy. The phenomenological approach suggests that the relationship in a meaningful encounter is always mutual; to extract and characterize an aspect of it as transference is pointless. Because transference has theoretical

importance, therapists should be familiar with its meaning, although they should not encourage it or make it the focal point of the therapeutic process.

The therapist's attitude to silence

The use of silence is relevant to phenomenological art-therapy. Do not break silence in the art-making phase; allow patients to focus on themselves, their thoughts and feelings, the creative process in which they are engaged, and the meaning of it. During the verbal processing phase, allow space for reflection but avoid letting the silence grow and create anxiety. Break the silence if the patient appears to have increased anxiety caused by the silence.

The therapeutic session

The instructions for the art tasks are triggers, i.e., the patient's interpretation of the art task is completely individual, and there are no rights or wrongs. Try to follow the programme in the first instance, but if the patient does not want to do the exercise as it is proposed, be open to variations. Ask for the patient to suggest other subjects in line with the aim of the session that would be meaningful to explore through art-making. Note the adjustment on the form for *Estimation of the session*.

If the patient has trouble getting started with art-making, they could need some assistance. One way is to choose colour first, and then start based on the choice of colour. "Choose a colour that you like, a colour that feels good."

All time specifications in the manual are estimated. Customize the time needed for each patient.

The therapy room

The room should be big enough for both the patient and the therapist to be comfort in, and to able to observe the artwork from some distance. The materials should be organized in such a way that the patient has choices. The room should be arranged so that it gives the patient a feeling of tranquillity, stability, and privacy. It should allow for some flexibility for the patient and therapist to manoeuvre to suit the circumstances and to position themselves comfortably during the session. Let the patient choose whether she/he wants to sit or stand when painting. Support the patient to make a new decision in each session, in order to feel what is true in the given moment.

Materials

Because different materials have different implications and meaning for the patients, it is of particular importance that they are able to choose freely from a large variety of materials. The patients should be allowed to choose the materials they want to work with, just as they should have the opportunity to make their own choices in life. Dealing with options, acknowledging them, making choices, and coping with their consequences are one of the main goals of PATd.

Clues to selecting materials are that providing smaller paper gives a clearer framework and may be safer to use. Crayons and solid materials are more secure, and provide more structure and control. A liquid colour is more challenging to work with, but stimulates emotional flow. To paint with fingers is more tactile, while using a brush provides greater emotional distance than that created with sponges or fingers[15].

Sessions in PATd

Session 1

Introduction 25 min: Art-making and goal-setting. Goal-setting: What do you need help with? What do you want to achieve? The goal is not to paint beautifully, but to paint true. Paintings do not have to be tangible. Lower your performance expectations, and take care of what comes to mind, and perform short tasks where we can learn to be in the present.

Relaxation exercise 10 min: Body scan

Art task 10 min: Description of the current situation. Draw a picture of yourself.

Narrate about the picture 10 min: How did the image appear? What was important to draw on the paper? When you look at the picture at a little distance, distance yourself from the picture; is there any difference in how you perceive the image? What does the image convey to you? How do you deal with the difficulties that exist? Do you need to change something in your life?

Disclosure 5min: Reflection – what will you take with you from today's practice?

Session 2

Introduction 5min: Reflections since last time.

Relaxation exercise 10min: Here and now

Art task 20min: Conscious exploration of art colours, nuances in hues, and choice of different art material, such as crayons, or liquid colour.

Narrate about picture 20min: Can you talk about the image and your process? How did your emotional reactions change when you explored various art materials? Are your reactions typical for how you usually react?

Disclosure 5min: Reflection – what will you take with you from today's practice?

Session 3

Introduction 5min: Reflections since last time.

Art task 10min: Body image before exercise with breathing anchors

Relaxation exercise 10 min: breathing anchors

Art task 10 min: Body image after exercise with breathing anchors

Narrate about picture 20 min: Would you tell us about your pictures and your process? Do you see any difference between the first and the second picture? How did you experience your body during the breathing exercises? How does your body feel after the breathing exercise?

Disclosure 5 min: Reflection – what will you take with you from today's practice?

Session 4

Introduction 5 min: Reflections since last time.

Relaxation exercise 10 min: Breathing space

Art task 20 min: Drawing analogue pictures ”Emotion scribble”

Narrate about picture: 20 min: What emotion scribble did you chose to immerse yourself in? If you look at the scribbles, are there scribbles that have more in common than others do? Were there any scribbles that were extra easy or difficult to do? Do you see any connection with them and your own life?

Disclosure 5 min: Reflection – what will you take with you from today's practice?

Session 5

Introduction: 5 min: Reflections since last time.

Relaxation exercise 10 min: Body scan

Art task 10 min: Colours and emotions

Narrate about picture 20 min: Can you talk about the picture and your process? If you take a step back, can you describe what you see? What raises this/these feelings? Where are the sensations in your body? How does it feel in your body? Can you describe changes in your experience when viewing your image?

Disclosure 5min: Reflection – what will you take with you from today's practice?

Session 6

Introduction 5min: Reflections since last time.

Relaxation exercise 10 min: Inner and outer attention

Art task 20 min: Stressful, pleasant event pictures.

Narrate about picture 20 min: Can you talk about the picture and your process? How did it feel to remain in an uneasy feeling? What do you usually do when unpleasant feelings emerge? How is it for you then? What do you usually do to calm yourself?

Disclosure 5 min: Reflection – what will you take with you from today's practice?

Session 7

Introduction 5 min: Reflections since last time.

Relaxation exercise 10 min: One thing at a time

Art task 20 min: Graphic life-line

Narrate about picture 20 min: Can you talk about the picture and your process? How do you describe your life-line? Key events that influenced you? And if so, in what way? How do you deal with change? Can you identify pattern/events that are repeated?

Disclosure 5 min: Reflection – what will you take with you from today's practice?

Session 8

Introduction 5 min: Reflections since last time.

Relaxation exercise 10 min: Breathing exercise

Art task 20 min: Roles – at home, with next of kin, with others and in the future.

Narrate about picture 20 min: Can you talk about the picture and your process? Can you match your roles with how you want them to be? Is there anything that you want/need to change? What do you need to manage your roles?

Disclosure 5 min: Reflection – what will you take with you from today's practice?

Session 9

Introduction 5 min: Reflections since last time.

Relaxation exercise 10 min: Body scan

Art task 20 min: Description of the current situation. Draw a picture of yourself.

Narrate about picture 20 min: Are there any differences from the first time you did the task? If so, what are the differences? What is unchanged?

Disclosure 5 min: Reflection – what will you take with you from today's practice?

Session 10

Review of all images 45 min: Putting up all images, reflection on tasks, patterns, experiences, and conclusions. Take a fresh perspective: what are your impressions from the treatment? Have you discovered something new about yourself?

Follow-up of goal setting

Art task 10 min: Mandala

Disclosure 5 min: Reflection – what will you take with you from the treatment?