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Title: Description of arts therapies practice with adults suffering from depression in the UK: quantitative results from the nationwide survey.

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Note about figures

Please note that all figures are presented in one file, reduced in size and quality, for the purpose of the review. However, if the paper is accepted, they will of course be delivered in a high quality printable format. I would be very happy to send high quality files at any point, if requested. Thank you.

Title

Description of arts therapies practice with adults suffering from depression in the UK: quantitative results from the nationwide survey.

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Keywords

depression, arts therapies, survey, adults, UK, clinical practice

Dear Reviewers,

Note to second revision:

APA style of reporting statistics has now been applied to manuscript. (07/09/13)

I would like to thank you for taking time to review my submission and offer valuable comments and suggestions. Appropriate changes have now been applied to the manuscript to address the points you raised. I trust that you would consider the amendments satisfactory and I am awaiting your final decision on my submission.

Manuscript

1. Abstract now includes a brief definition of arts therapies and lists arts therapies recognised in the UK: “Arts therapies in the UK are the forms of psychotherapy. They use arts media alongside therapeutic relationship as means of therapeutic change and include four disciplines: Art Therapy (AT), Music Therapy (MT), Dance Movement Psychotherapy (DMP) and Drama Therapy (DT).”

2a. The word ‘therapy’ has been added to clarify that the article concerns music therapy and not music only.

2b. While respondents could not be directly contacted by the researcher, opportunities for sending reminders were limited. However, one reminder was sent to the Arts Therapies Associations and this is now included in the text. Also, information about the ways of informing respondents about the results was added: “One invitation to take part and one reminder were sent to the Associations before the survey closed. An option to be informed about the results of this survey was given to the respondents and those who agreed to be contacted and provided their email addresses will receive updates on any publications.”

2c. This research has been approved by the ethics committee of Queen Margaret University and this information is now included in the manuscript.

2d. The survey failed to ask respondents about their ethnic background and this has now been reported in the Limitations.

2e. Unfortunately, data about UK countries from which the respondents come was not collected and cannot be presented. Thank you for this comment, as such data would be valuable and we will add relevant item in future surveys.

2f. The word ‘participants’ was replaced in two cases with either ‘respondents’ or ‘therapists’. The authors decided to speak about ‘participants’ while referring to the population of potential respondents and to speak about ‘respondents’ when referring to the therapists, who actually took part in the survey. Should Reviewers still believe that every occurrence of the word ‘participants’ should be replaced, I would await their recommendation.

2g. While no operational definitions were given to the respondents, the items grouped under each theoretical label specified what was meant by each of them. I acknowledge that this was not explained well in the text and have now amended partially the description of the survey to read: “Items concerning theoretical principles (37 in total) were grouped in six factors (labelled: Humanistic, Psychoanalytic/psychodynamic, Developmental, Artistic/creative, Active/directive, Eclectic/integrative). Between five and seven statements were allocated to each theoretical principle (factor) and required respondents to indicate their agreement or disagreement on a scale of 1 to 5.” I hope it is now clear that the sentences under each label provided a sort of definition and therefore the respondents could not have been biased by their own understanding of the principles.

3a. While no literature relevant to the raised issues is known to the authors, the suggested areas for further research exploration are hypotheses only. Hopefully further research on therapist development would answer some of the raised questions. Acknowledgement of no knowledge about relevant studies was added to the manuscript: “No studies which would explain the raised questions are known to the authors and this interesting and complex subject, which is not in the scope of this project, could well be explored in a separate research”.

Form/Grammar

- 1.** The set of commas has now been removed as advised. Also, additional proofreading helped to identify other overuses of commas, which have been amended.
- 2.** The sentence has now been amended to read: “Although there is anecdotal evidence that arts therapists work extensively with adults affected by depression, their experiences...”
- 3.** The sentence has now been amended, as suggested.
- 4.** The acronyms have been removed from the sentence, as they are now introduced in the Abstract.
- 5.** The sentence has been reworded to read: “Online delivery of this survey was chosen for number of reasons, including cost, need of Associations’ assistance in distribution and willingness for making good use of technology for scientific purposes, wherever this enhances the delivery of the project.” I trust the wording is clearer after the change.
- 6.** The format of multiple authors’ names was amended to include ‘&’ rather than ‘and’. Careful attention has now been given to in-text citations to conform to APA guidelines.
- 7.** The sequence of authors has been reversed.
- 8.** The acronyms have been replaced with full names of associations.
- 9.** Grammar was corrected, as suggested.
- 10.** Two sentences have been restructured to avoid starting with a numeral: “Arts therapists of all disciplines recognised in the UK took part in the survey, a total number of 395.”, “Further 17.0% of arts therapists declared that they worked mainly with depression (D+, n=67), while only 8.6% stated that they did not encounter depression in their practice (D-, n=34).”

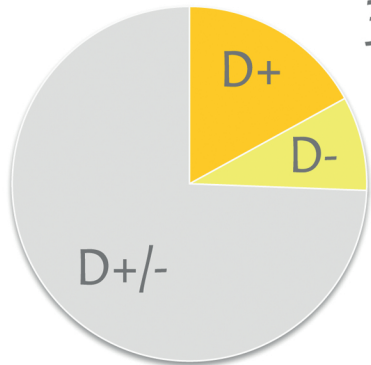
11. The sentence has been amended, as advised.

12. Reference list has been amended to include hanging indents and correct referencing of online publications. I believe it is now consistent with the APA format.

Arts Therapies Survey (UK 2011) quantitative analysis

395 responses from arts therapists

3 groups of arts therapists



- D+ working primarily with depression (17.0%)
- D- not working with depression (8.6%)
- D+/- working with depression among other issues (74.4%)

91% respondents encounter client **depression** in clinical practice

D+ more psychodynamically oriented
older and more experienced
work more often with groups
work most often with adults
work most often in health settings

Highlights

- The Arts Therapies Survey was conducted in the UK in 2011; 395 arts therapists participated.
- Over 91% of respondents encounter client depression in their practice.
- Therapists, who work primarily with depression (D+), were compared to those, who do not (D-).
- Arts therapists in group D+: more psychodynamically oriented, older and experienced, work more often with groups, adults and in health settings.
- Qualitative findings will follow to deepen already gained understanding.

Description of arts therapies practice with adults suffering from depression in the UK: quantitative results from the nationwide survey.

Abstract

There is growing evidence that Arts therapies may be under-used treatments for the 'global burden' of depression. However, the experiences of arts therapists, their methods, tools and ways of working with this client group remain unclear. Arts therapies in the UK are the forms of psychotherapy. They use arts media alongside therapeutic relationship as means of therapeutic change and include four disciplines: Art Therapy (AT), Music Therapy (MT), Dance Movement Psychotherapy (DMP) and Drama Therapy (DT). In 2011 all arts therapists registered in the UK were invited to complete an online questionnaire concerning their practice in general and specifically in relation to clients with depression. The Arts Therapies Survey received 395 responses. Arts therapists who work primarily with depression were identified and compared to those who do not work with depression on a range of factors, including preferred theoretical approaches and style of working. Arts therapists who specialize in depression tend to follow psychodynamic principles more often, are more likely to be older and experienced, work with groups, in health settings and with adults more often than children or adolescents. These quantitative findings enable the description of most common practice of arts therapies with depression in the UK and are intended to serve as a reference for arts therapists themselves and other professionals interested in the treatment of depression. Qualitative data gathered in the survey will be presented in a separate paper, with the aim to deepen the understanding already gained.

Introduction

Depression is a broad and heterogeneous diagnosis (NICE guideline 90, 2009) and a “multifactorial illness” (SIGN guideline 14, 2010) with often complex aetiology, characterised by biological, social and psychological factors. The effects of this condition are damaging to the person as a whole involving body, affect, and cognitive processes. Depression not only seriously affects individuals’ wellbeing but is also a ‘global burden’ (WHO, 2010; Scott & Dickey, 2003). By the year 2020 it is predicted to become the second most disabling illness in the world after ischaemic heart disease.

As treatment options commonly available in the UK (antidepressant medication, psychosocial and psychological interventions) present specific disadvantages and are not suitable for all depression sufferers, other treatments are worth investigating, and arts therapies may represent a better option. By considering non-verbal communication in the therapeutic process arts therapies may offer a valuable alternative to talking therapies especially for those, who may find it difficult or impossible to engage on a verbal level.

In the last decade, arts therapists worldwide have acknowledged the importance of research for the field, and Cochrane systematic reviews for depression have been undertaken in the disciplines of music therapy and dance movement therapy (Maratos et al., 2008; Meekums et al., 2010). Nevertheless, more effectiveness studies of high quality (Evans, 2003) are required from other arts therapies disciplines, if arts therapies are to take their place amongst more conventional treatments.

However, any truly meaningful evidence needs to be based on a deep understanding of the intervention examined and arts therapies practice with depression has not yet been comprehensively described and explained. Although there is anecdotal evidence that arts therapists work extensively with adults affected by depression, their experiences, methods, tools and ways of working with this client group remain unclear to themselves and unknown to many health professionals.

A map of the field of arts therapies in the UK has been presented by Karkou and Sanderson (2006) and there are publications available (Cattanach, 1999; Payne, 1996) which give an indication of the patterns of practice of arts therapists in case studies of group work or individual clients' treatment. However, apart from several rather older and more general studies (e.g. Reynolds et al., 2008 and Liebmann, 2007 on Art Therapy; Blatt, 1996 on Dance Movement Therapy; Emunah, 1994 and Dokter, 1996 on Drama Therapy; Odell, 1988 on Music Therapy), little can be found in the literature on how arts therapists work with clients suffering from depression in the UK, and the specifics of treatment of this particular group. There is therefore, a need for a timely review of the state of arts therapies for depression in the UK.

Aims of this research

This research as a whole employs mixed methodology and aims to describe and evaluate arts therapies for adult depression. Descriptive phase (of which quantitative results are presented in this paper) is concerned with providing an account of how arts therapists work with people suffering from depression and identifying patterns emerging from their practice.

More specifically, in the first part of the Arts Therapies Survey, the following research questions have been addressed:

- Do arts therapists work with depression? What is the extent of this work?
- What theoretical backgrounds determine arts therapists' practice with depression?
- What are the characteristics of the therapists who work with depression? Do they differ from the characteristics of those, who do not work with depression?
- Does the practice of arts therapists, who work with depression, differ from the practice of those, who do not work with depression? If so, in which area(s)?

Ethical approval

This research received an ethical approval from Queen Margaret University, Edinburgh, in May 2011.

Method: Survey

A nationwide online Arts Therapies Survey interested in practical and professional aspects of arts therapies practice, including theoretical principles, aims, methodology and evaluation, was launched in June 2011 and closed in September 2011. Responses were coming from arts therapists of all four disciplines recognised in the UK.

The questionnaire was developed by Karkou in 1996 (Karkou & Sanderson, 2006) and revised in 2009. It consisted of multiple choice, single choice and open type questions, concerning: general information about practice (8 items), theoretical influences (2 items),

assessment and evaluation (4 items) and biographical information (6 items). Items concerning theoretical principles (37 in total) were grouped in six factors (labelled: Humanistic, Psychoanalytic/psychodynamic, Developmental, Artistic/creative, Active/directive, Eclectic/integrative). Between five and seven statements were allocated to each theoretical principle (factor) and required respondents to indicate their agreement or disagreement on a scale of 1 to 5.

The questionnaire was adapted to the purpose of this research in 2011 to include three additional items aiming to identify respondents who worked with depression. Also, an online version of the questionnaire was developed for the purpose of this study using Bristol Online Surveys system. To ensure the quality of the questionnaire after those changes (additional items and new mode of delivery), it was firstly evaluated in a pilot among arts therapists at Queen Margaret University. All of the participants ($N=29$) accepted the online mode of delivery with a majority clearly preferring this to the traditional paper mode. The structure, content and presentation of this questionnaire were generally positively evaluated. Respondents also provided other positive feedback including comments on the valuable opportunity to take time to think about their practice.

Online delivery of this survey was chosen for number of reasons, including cost, need of Associations' assistance in distribution and willingness for making good use of technology for scientific purposes, wherever this enhances the delivery of the project.

Participants

The study included arts therapists who were qualified to practise within the UK (having completed relevant training at postgraduate level, either in the UK or overseas) and/or who had acquired licence to practise as arts therapists from the relevant professional associations (British Association of Art Therapists, Association for Dance Movement Psychotherapy UK, British Association for Music Therapy or The British Association of Dramatherapists).

The survey was intended to reach all arts therapists registered in the UK (estimated number in 2010: 3 000, according to Health Professions Council's statistics). As personal details of arts therapists could not be made available to the researcher, support for this study was sought from Arts Therapies Professional Associations. All four Associations offered their help with advertising of the survey (via newsletters, e-Bulletins and members' areas on the websites). Other relevant associations, networking groups, clinical and educational settings were also contacted. One invitation to take part and one reminder were sent to the Associations before the survey closed.

An option to be informed about the results of this survey was given to the respondents and those who agreed to be contacted and provided their email addresses will receive updates on any publications.

Trustworthiness

The survey used a questionnaire that had been previously devised and checked for its validity and reliability (Karkou, 1998). Factor analysis revealed that each of the six factors presented acceptable internal consistency (alpha ranging from 0.56 to 0.71) and could be utilised as a valuable tool for description of complex aspects of arts therapists' practice.

Conducting the pilot of the online survey ensured that this new mode of delivery was very well received by the therapists and that the new items were easily understandable and their meanings were clear.

In addition, while the researcher had relatively little control over the recruitment process, high quality of the sample in terms of suitability had been assured. Contacts through professional Associations and other respected and trusted networking groups ensured that only qualified and registered practitioners had been invited to take part.

Quantitative data analysis was conducted using SPSS19 software for descriptive and inferential statistics (IBM, 2012).

Results

Arts therapists of all disciplines recognised in the UK took part in the survey, a total number of 395. Art therapists / psychotherapists formed the largest group ($n=243$, 62% of the total $N=395$) followed by dramatherapists ($n=59$, 15%), music therapists ($n=50$, 13%) and dance movement psychotherapists as the smallest group ($n=36$, 9%). According to the Health & Care Professions Council (HCPC, 2011) and ADMP UK, art psychotherapists form the largest group (AT=52%) amongst the total number of arts therapists in the UK, followed by music therapists (MT=23%), dramatherapists (DT=18%) and dance movement psychotherapists (DMP=7%). Results showed that while the proportion of ATs and MTs within the sample and within the total population of arts therapists was statistically different (95% confidence interval; ATs: $z=2.8$, MTs: $z=2.0$), DTs and DMPs were similarly represented. Therefore, results and

conclusions offered for ATs, DTs and DMPs in this paper might represent reasonably those that could be expected from the total population of arts therapists whereas those for MTs who were underrepresented, should be interpreted with more caution.

The sample consisted of 84% female and 16% male respondents. According to HCPC (2011) statistics, the total percentage of female arts therapists (ATs+MTs+DTs) is 83%, and male arts therapists, 17%. Dance movement psychotherapists were not part of the HPC in 2011 and not represented in these statistics, however, and even stronger predominance of females is presumed for this specialty group. With regards to gender, this sample can therefore be treated as representative for the whole population of arts therapists in the UK. *[Figure 1 around here]*

For the purpose of this study, the questionnaire included two specific items to allow for identification of three exclusive groups of arts therapists (see Figure 1): those, who work primarily with depression (group D+), those, who do not work with depression (group D-) and those, who have people with depression among their clients, but do not consider them to be their main client group (D+/-). In the analysed sample, group D+/- was the largest, with 74% of therapists meeting the criteria. Further 17% of arts therapists declared that they worked mainly with depression (D+, $n=67$), while only 9% stated that they did not encounter depression in their practice (D-, $n=34$). More generally, over 91% of arts therapists ($n=361$) stated that there were people suffering from depression among their clients.

In order to increase understanding of how arts therapists work with depression, the described groups were compared on various factors, derived from the questionnaire.

Biographical information of arts therapists (sex, age, experience)

The proportion of female to male therapists was roughly the same in all three groups of respondents, while age of therapists differed between groups (see Figure 2). Nearly 30% of arts therapists in group D- were under 30 years old, while only under 5% of therapists from group D+ belonged to this age group (in group D+/- this figure was nearly 7%). The difference between groups D+ and D- is statistically significant. *[Figure 2 around here]*

Also, respondents in group D- reported fewer years of experience than in group D+; 50% of therapists in group D- claimed that they had less than three years experience in comparison to 19% in group D+ (and exactly the same, 19%, in group D+/-). These findings seem consistent with the common notion that the amount of experience naturally increases with age.

Arts therapists' style of working (work environment, group vs individual work, work alone vs in a team)

Therapists in all groups stated that they worked on their own as well as in a team with other professionals equally often, and both styles of working were reported by between 47 and 66% of therapists, regardless of whether they work with depression or not. In addition, between 27 and 33% of therapists in all groups work in a team with other arts therapists (proportions were not statistically different). Working alone or in a team with other professionals seemed to be equally prevalent styles within arts therapies practice, while working with other arts therapists was reported to be fairly often present but a less common practice. *[Figure 3 around here]*

In contrast, therapists' answers to the question about main working environment differed largely, depending on whether they worked with depression or not. Arts therapists in group D+ reported that health service was their main working environment most often (55%), while only under 12% of therapists in group D- chose this option (difference significant, $z=5.2$). On the contrary, 32% of therapists from group D- and only under 8% from group D+ worked within educational setting (difference significant, $z=2.8$). No significant differences between groups D+ and D- were found in relation to working in voluntary sector, social services or private practice. Responses of therapists from group D+/- may be placed somewhere in between (54% work in health service, 14% in educational setting) but closer to group D+ (no significant differences between D+/- and D+) than D- (differences between D+/- and D- statistically significant, see Figure 3 for details).

This finding seems to be somehow related to the age of clients with whom therapists worked. Most therapists in group D-, not surprisingly, while working in educational setting stated that their clients were children (62%) and adolescents (56%). They worked with young adults (32%) and adults (47%) less often and very rarely worked with older people (6%). Exactly the opposite was true for group D+, where therapists much more often worked with adults (80%) and young adults (52%) than with children (18%) or adolescents (28%). This last group also worked with older people relatively often (28%). Differences between groups D+ and D- are statistically significant at 99% confidence interval in most cases (see Figure 3 for details). Group D+/- is again in the middle, with less defined differences between the frequency of working with different age groups. However, adults and young adults remained the main client group (significant difference in relation to group D-), with work with children and adolescents

happening often (significant difference in relation to group D+) and work with older people being the least common (again, differently to group D-).

Therapists in all three groups agreed that they worked with individual clients most often (between 82 and 85%), while work with families or couples was the least common (between 21 and 24%). However, work with groups was reported by 72% of therapists in group D+ and only 50% therapists in group D- (difference significant, $z=2.1$), with group D+/- being again in between, but much closer to group D+ (69%, significant difference in relation to group D-, $z=2.0$).

Arts therapies disciplines in three groups of arts therapists

Arts therapists of various disciplines were represented in the three groups in different proportions, with group D+/- being most similar to the total sample (see Figure 1 for reference). Groups D+ and D-, however, differed significantly, with art therapists (ATs) being overrepresented in group D+ (73%) and underrepresented in group D- (47%) in relation to the total sample (62%). The presence of ATs in groups D+ and D- was statistically significantly different at 95% confidence interval ($z=2.5$), as it was in groups D+ and D+/- ($z=2.1$). Dramatherapists (DTs), on the other hand, were better represented in group D+ (19%) than in any other group, including the total sample (result not statistically significant), while music therapists (MTs) were significantly underrepresented in group D+ (under 2%) in comparison to their presence in other groups, including total sample, which varied between 13% and 15% (significant difference at 95% confidence interval and $z=2.1$ between groups D+ and D-, at 99% confidence interval and $z=5.3$ between D+ and D+/-). While proportion of dance movement

therapists (DMPs) in group D+/- (nearly 9%) was nearly the same as in the total sample (just over 9%), it was lower in group D+ (nearly 5%) and much higher in group D- (just over 20%). The difference between DMPs presence in groups D+ and D- was statistically significant at 95% confidence interval ($z=2.2$). *[Figure 4 around here]*

For clarity and increased understanding, the same data has also been looked at from a different perspective. Figure 4 illustrates the percentage of therapists from different groups (D+, D- and D+/-) within each of arts therapies disciplines. This suggests that working with depression specifically was relatively more common among art therapists and dramatherapists (20% and 22% of total sample, respectively) than it was among music and dance movement therapists (2% and 8% of total sample, respectively). The difference was statistically significant (at either 95% or 99% confidence interval) between ATs and MTs ($z=5.5$), ATs and DMPs ($z=2.3$), DTs and MTs ($z=3.5$) and DTs and DMPs ($z=2.0$), while it was not significant between ATs-DTs and MTs-DMPs.

Moreover, other differences between groups of therapists seem apparent. While particularly low percentage of music therapists worked with depression specifically (2%), they still worked with clients who have symptoms of depression (88%) very often. In comparison, dance movement therapists seemed to be the group working with non-depressed clients most often (20% of DMPs) in relation to other disciplines (between 7% and 10% among ATs, MTs and DTs). The difference in the frequency of working with non-depressed clients between ATs and DMPs was statistically significant at 90% confidence interval ($z=1.9$).

It should be noted that since the sample might not be representative of the total population of music therapists (see Limitations), the preceding results need to be considered with caution.

Severity of depression as reported by arts therapists

Therapists who had stated that there were depressed people among their clients (groups D+ and D+/-), were also asked to estimate the severity of majority of their clients' condition. Arts therapists, who considered themselves to have specialised in working with depression (group D+), tended to respond that their clients' condition was severe more often than those who worked with depression alongside other conditions (group D+/-). In group D+, nearly 60% of respondents described the depression of majority of their clients as severe, 37% as moderate and only 3% as mild. For comparison, nearly 50% of the therapists in group D+/- described their clients' condition as moderate, 40% as severe and 10% as mild. The difference between two groups was statistically significant at 95% confidence interval in all levels of the severity of depression: severe ($z=3.0$), moderate ($z=2.0$) and mild ($z=2.6$).

Preferences for particular theoretical approaches in two groups of arts therapists

Two groups of arts therapists (D+, $n=66^*$ and D-, $n=34$) were compared to determine whether there was a difference between them (and if so, in what direction) in relation to preference for specific theoretical approaches (six factors identified by Karkou in 1998). Results revealed that preferences for theoretical approaches differed between groups. *[Figure 5 around here]*

Arts therapists in group D+ agreed more strongly than arts therapists in group D- with the following theoretical principles: Humanistic, Psychoanalytic and Artistic/Creative. Arts therapists in group D- agreed more strongly than those in group D+ on other principles, that is: Developmental, Eclectic/Integrative and Active/Directive. An independent samples t-test was conducted to examine whether there was a significant difference between the two groups of arts therapists in relation to their preferred theoretical approaches (see Figure 5). The test revealed a statistically significant difference between group D+ and group D- in relation to Psychoanalytic factor ($t=-2.1$, $df=98$, $p<0.05$). Arts therapists, who worked mainly with depression (D+, $M=2.1$, $SD=0.6$) agreed more strongly with Psychoanalytic principles than arts therapists, who did not work with depression (D-, $M=2.4$, $SD=0.7$).**

Other theoretical influences in two groups of arts therapists

The two groups of arts therapists (D+ and D-) were also compared on other self-reported theoretical influences (see Figure 6). Data appeared to indicate similarities in both groups, with strongest influences (reported by at least 40% of respondents) in 'Psychodynamic theory', 'Attachment theory', 'Work of Winnicott', 'Specific arts therapies tradition', 'Object relation theory' and 'Developmental theories'. The least popular influences (chosen by less than 10% respondents) included: 'Gestalt', 'Transactional analysis theory' and 'Kelly's personal construct'. *[Figure 6 around here]*

Statistical analysis was performed to determine whether groups D+ and D- differ in their self-reported theoretical influences. The Pearson Chi-Square test confirmed that arts therapists in group D- regard Play therapy as one of their theoretical influences statistically more often

than therapists in group D+ ($p < 0.05$). In addition, analysis of proportions revealed statistically significant differences between groups at 95% confidence interval in Play therapy ($z = 2.3$) and two other influences: Specific artistic tradition ($z = 2.1$) and Kelly's Personal Construct theory ($z = 2.0$).

Overall, while certain theoretical influences were more popular among arts therapists in general, they seemed not to significantly differentiate between those therapists who worked mostly with depression and those who did not.

Limitations

Exact number of arts therapists who received invitation to the survey cannot be known and although efforts were made to reach all arts therapists practicing in the UK, the actual number of potential participants contacted is most likely significantly smaller. Cook et al. (2000: 833) suggest that number of pre-contacts and reminders are the factors associated with higher response rate in online surveys, while Kaplowitz et al. (2004) report positive effect of surface mail pre-notice and reminders. In this study reminders could not have been sent to potential respondents and the advertising had to rely on the Associations' regular way of contacting their members. As e-Bulletins and newsletters require additional subscription, some (or possibly most) of the arts therapists do not receive them and thus had less chance to get to know about the research. Therefore, the fact that music therapists were underrepresented in the sample

could originate from a relatively uncontrollable recruitment procedure rather than from those therapists' lower willingness to take part. It could be that the professional online networking and marketing channels were simply more effective in the environments of art, drama and dance movement therapists. While the reached audience is not known, the response rate cannot be assessed making it difficult to comment on the effectiveness of the online survey in comparison to the paper-based distribution (as in Karkou, 1998).

Should this survey be replicated, it would be valuable to receive additional information from the Associations, which could help establish the numbers of therapists they could reach and the ratio of these numbers to the total population of arts therapists in the UK (e.g. number of therapists on records, who subscribe to newsletters or who receive e-bulletins). In addition, should the research budget be more substantial, adverts could be placed in professional journals, potentially reaching a wider audience.

The survey did not ask respondents about their ethnical background and it is recommended that such data is collected in any subsequent surveys.

Discussion

The proportions of arts therapists of different disciplines within groups indicate that drama and art therapists were more likely to work with depression than music and dance movement therapists. No other studies or data which could relate to this finding is known to the researchers.

Findings also seem to indicate that working with depression generally requires more experience from the therapists. Such result may as well be dictated by the notion that experience (and therefore time) is generally needed for a clinician to specialise in certain condition or approach. However, the last interpretation would need to be rejected, since therapists from group D+/- were more similar to group D+ in terms of age and experience. It seems therefore significant that among participating therapists, who did not encounter depression in their practice, 50% were relatively inexperienced. It may be that this results from the difficulties with the diagnosis of depression, e.g. less experienced therapists may miss depression; or it may be that younger and less experienced therapists are more likely to ignore co-morbidities and attribute certain dominant condition, other than depression, to their clients. Would older and more experienced therapists be more prone to look at their clients holistically and therefore detect depression more often, even when other problems appear more superficially salient? No studies which would explain the raised questions are known to the authors and this interesting and complex subject, which is not in the scope of this project, could well be explored in a separate research.

Also, interestingly, arts therapists in groups D+ and D+/- were most (and equally) likely to work in a health service, while therapists in group D- worked mostly in educational setting or private practice. Therefore, arts therapists' practice with depression seems to be often required within health services while it is very rarely present in educational settings. The two analysed criteria (main working environment and the age range of clients) suggest that tackling depression is a very common theme in arts therapists' work with adult clients, while it appears much less often in the work with children or adolescents. This may be an implication of a fact

that prevalence of depression is highest among adults aged 25 to 64 (Rait et al., 2009; CDC, 2012). Alternatively, it may indicate that in the work with children and adolescents other themes are likely to dominate, with depression presumably 'hidden' or covert in some cases. The possible reasons for this finding may be explored further in future research.

Although individual therapy (as a therapy mode) was offered most often by arts therapists from all groups, the therapists who did not work with depression were more likely to work on one-to-one basis, while group work was much more common when depression was being addressed. Such result indicates that arts therapists who specialised in working with depression especially valued the benefits of group work for their clients. Group work, therefore, seems to have additional benefits for depression specifically. While in other psychotherapies studies no differences were found between the effectiveness of group and individual therapy (McDermut et al., 2001; Hodgkinson et al., 1999), some highlight that evidence of effectiveness of group therapies not based on CBP is particularly limited (Huntley et al., 2012). Comparison of group and individual arts therapies for depression may be worth considering in future research.

Arts therapists, who encountered depression among their clients, tended to consider their clients' condition to be severe quite often and rarely evaluated it as mild. It is important to acknowledge that these were subjective judgements made by arts therapists, not necessarily confirmed by clinical diagnoses. The perception of severity of depression may differ quite significantly among various groups of professionals according to separate criteria, based on, for example, behaviour, social functioning, psychological condition or combination of these factors in various proportions. There may be several reasons for the more severe depression estimated

more often by group D+ than D+/-, which this project cannot explore further. It seems natural that therapists who considered themselves specialists in working with depression would choose to work with more severe cases, for which their experience was suitable. However, it may also be true that those who work mainly with depression are highly sensitive towards its symptoms, which they tend to notice more often, while other therapists may remain relatively unaware of them. These and other reasons could be explored further in future research.

Conclusion

The group of arts therapists who took part in the study (n=395) is a representative sample of the population of the art, drama and dance movement therapists in the UK, while it is not necessarily representative of the music therapists. The responses confirm that depression is a largely common condition, present in the clients of over 91% of therapists, who took part. Only small group of therapists reported that they did not encounter depression in their practice. While co-morbidity of depression with other conditions is high (Hammen & Watkins, 2007; Taylor & Fink, 2006), it does not usually present itself as a dominant disorder and often appears in the practice of therapists who do not consider themselves specialists in depression. However, for some respondents this condition is the main area of professional interest and clinical experience. These therapists' answers helped to shape, with certain limitations, the picture of current arts therapists' practice with depression in the UK.

The quantitative analysis revealed that the therapists in the three identified groups differed significantly on a number of factors, including experience, age, main working environment, clients' age group, theoretical backgrounds and style of working. While common theoretical influences were generally indicated by the therapists in groups D+ and D-, analysis of factors identified by Karkou (1998) revealed stronger agreement of group D+ with Psychoanalytic principles. Arts therapists who worked primarily with depression also tended to be older and more experienced and work mainly with adults and rarely with children or adolescents. They most often provided individual therapy but tended to work with groups significantly more often than arts therapists who did not encounter depression among their clients.

Further research in the area would be advantageous and qualitative data could provide added depth to the quantitative findings presented here. It should be noted that specific parts of the presented Survey allowed for more in-depth qualitative analysis, which will be presented elsewhere. Also, interviews with arts therapists specialising in working with depression would strengthen the understanding and remain a recommendation for future research projects. While this study involved arts therapists practising in the UK only, it is possible that similar projects in other parts of Europe would reveal different or additional findings, as has already been observed in other comparative studies of arts therapies practice (Karkou et al., 2009), and they may therefore be recommended for a more universal understanding of the field.

Footnotes:

* Responses of one of the therapists in group D+ were excluded from the analysis, as over 50% of data was missing and therefore n=66 rather than 67 as in initial dataset.

** Note that lower means indicate higher level of agreement, on a 5 point scale, where 1=strongly agree and 5=strongly disagree.

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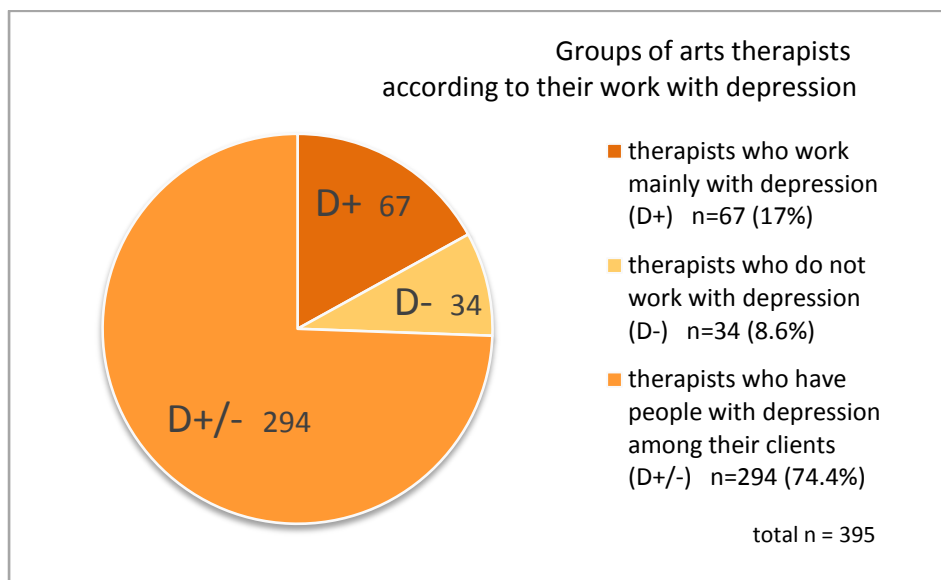


Figure 1: Groups of arts therapists, according to frequency and/or intensity of work with depression.

| Biographical information of arts therapists | | D+ | D- | D+/- | z value (D+ : D-) |
|---|-------|---------|---------|-----------------------|-------------------|
| sex | F | 88.1% | 85.3% | 83.0% | |
| | M | 11.9% | 14.7% | 17.0% | |
| age | < 30 | 4.5%** | 29.4%** | 6.8%** ^{D-} | z = 2.9888 |
| | 31-40 | 19.4% | 23.5% | 23.5% | |
| | 41-50 | 34.3% | 14.7% | 28.9% | |
| | 51-60 | 28.4% | 20.6% | 31.3% | |
| | >60 | 13.4% | 11.8% | 9.5% | |
| years of experience | < 3 | 19.4%** | 50.0%** | 19.0%** ^{D-} | z = 3.0685 |
| | 4-7 | 20.9% | 8.8% | 15.0% | |
| | 8-11 | 22.4% | 11.8% | 16.7% | |
| | 12-15 | 4.5% | 8.8% | 14.3% | |
| | > 15 | 32.8% | 20.6% | 35% | |

Figure 2: Biographical information of arts therapists in three groups (highlighted areas of statistically significant difference: ** at 99% confidence interval; based on z-test).

| Arts therapists' style of working | | D+ | D- | D+/- |
|-----------------------------------|----------------------------------|---------|---------|-----------------------|
| lone and/or team work | on my own | 65.7% | 61.8% | 54.2% |
| | team -with other arts therapists | 26.9% | 26.5% | 33.2% |
| | team -with other professionals | 58.2% | 47.1% | 59.7% |
| | Other | 2.9% | 5.9% | 7.5% |
| main working environment | health service | 55.2%** | 11.8%** | 54.1%** ^{D-} |
| | educational setting | 7.5%** | 32.4%** | 13.9%** ^{D-} |
| | private practice | 17.9% | 23.5% | 11.2% |
| | voluntary agency | 10.4% | 14.7% | 7.5% |
| | social service | 3.0% | 5.9% | 7.1% |
| other | 6.0% | 11.8% | 6.1% | |
| age range of clients | children <11 | 17.9%** | 61.8%** | 44.4%** ^{D+} |
| | adolescents 11-16 | 28.4%** | 55.9%** | 40.0% |
| | young adults 17-25 | 52.2% | 32.4%* | 52.2%** ^{D-} |
| | adults 26-65 | 80.6%** | 47.1%** | 70.8%** ^{D-} |
| | older people >65 | 28.4%** | 5.9%** | 25.8%** ^{D-} |
| one-to-one and/or group work | one-to-one | 85.1% | 85.3% | 82.4% |
| | families/couples/dyads | 20.9% | 23.5% | 23.1% |
| | groups | 71.6%* | 50.0%* | 68.5%** ^{D-} |

Figure 3: Arts therapists' style of working in three groups of respondents (highlighted areas of statistically significant difference: * at 95% confidence interval, ** at 99% confidence interval; based on z-test).

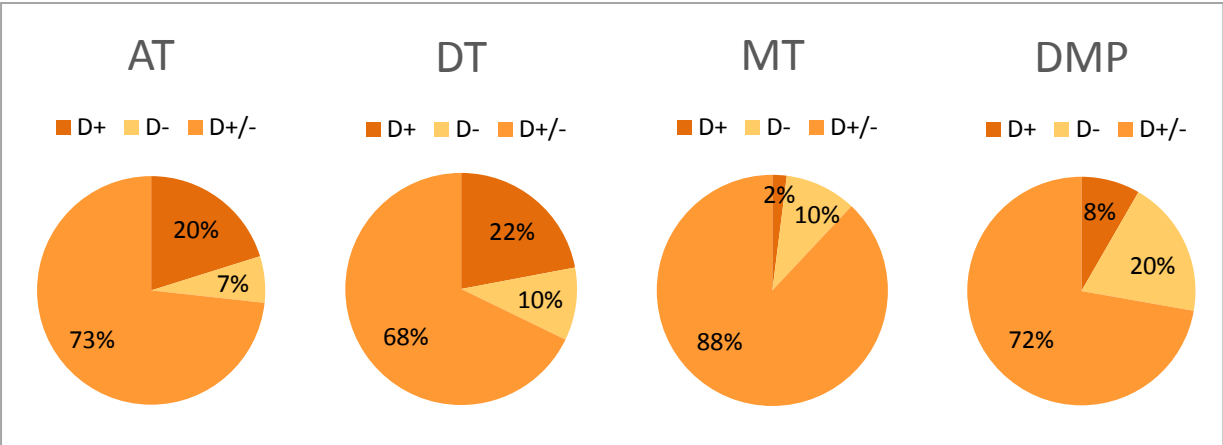


Figure 4: Percentage of arts therapists from different groups (D+, D- and D+/-) within each of arts therapies disciplines.

| Theoretical factors | | N | Mean | Std. Deviation | Std. Error Mean |
|----------------------|----------|----|--------|----------------|-----------------|
| Humanistic | group D+ | 66 | 2.0238 | .54244 | .06677 |
| | group D- | 34 | 2.0672 | .47215 | .08097 |
| Psychoanalytic* | group D+ | 66 | 2.0811 | .60390 | .07434 |
| | group D- | 34 | 2.3529 | .67321 | .11545 |
| Developmental | group D+ | 66 | 2.3409 | .75304 | .09269 |
| | group D- | 34 | 2.2088 | .62686 | .10751 |
| Artistic/Creative | group D+ | 66 | 2.4465 | .50866 | .06261 |
| | group D- | 34 | 2.6618 | .60648 | .10401 |
| Active/Directive | group D+ | 66 | 2.8355 | .86960 | .10704 |
| | group D- | 34 | 2.8035 | .74813 | .12830 |
| Eclectic/Integrative | group D+ | 66 | 2.1545 | .60744 | .07477 |
| | group D- | 34 | 2.0974 | .68777 | .11795 |

Figure 5: Comparison of two groups of arts therapists (D+ and D-) in relation to factors (significant difference highlighted, $p=0.043$).

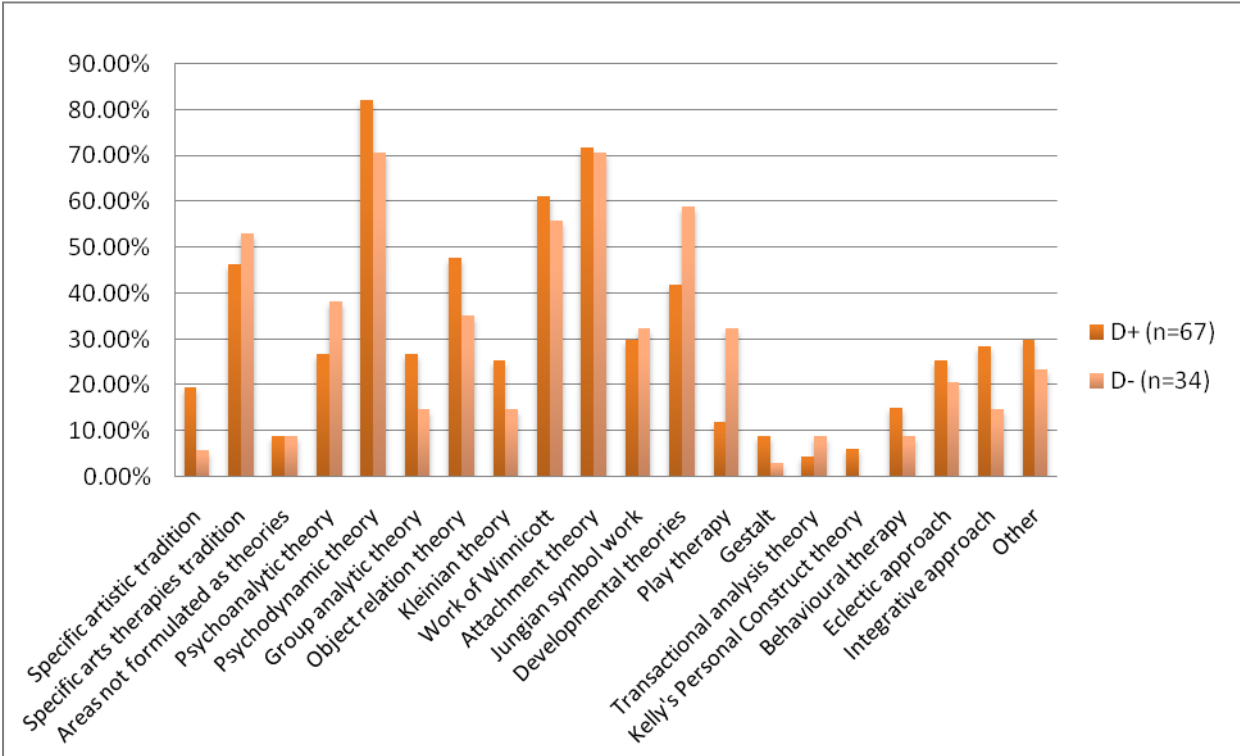


Figure 6: Theoretical influences in two groups of arts therapists (D+ and D-).

Figures

Figure 1: Groups of arts therapists, according to frequency and/or intensity of work with depression.

Figure 2: Biographical information of arts therapists in three groups (*highlighted areas of statistically significant difference: ** at 99% confidence interval; based on z-test*).

Figure 3: Arts therapists' style of working in three groups of respondents (*highlighted areas of statistically significant difference: * at 95% confidence interval, ** at 99% confidence interval; based on z-test*).

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