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A Qualitative Systematic review of service user and service provider perspectives on the acceptability, relative benefits and potential harms of art therapy for people with non-psychotic mental health disorders.

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Abstract

Purpose: This systematic review aimed to synthesise qualitative evidence relating to user and service provider perspective on the acceptability and relative benefits and potential harms of art therapy for people with non-psychotic mental disorders.

Methods: A comprehensive literature search was conducted in 13 major bibliographic databases from May-July 2013. A qualitative evidence synthesis was conducted using thematic framework synthesis.

Results: The searches identified 10,270 citations from which 11 studies were included. 10 studies included data from 183 service users, and two studies included data from 16 service providers. The evidence demonstrated that art therapy was an acceptable treatment. The benefits associated with art therapy included: the development of relationships with the therapist and other group members; understanding the self/ own illness/ the future; gaining perspective; distraction; personal achievement; expression; relaxation and empowerment. Small numbers of patients reported varying reasons for not wanting to take part, and some highlighted potentially negative effects of art therapy which included the evoking of feelings which could not be resolved.

Conclusions: The findings suggest that for the majority of respondents art therapy was an acceptable intervention, although this was not the case for all respondents. Therefore, attention should be focussed on both identifying those who are most likely to benefit from art therapy, and ensuring any potential harms are minimised. The findings provide evidence to commissioners and providers of mental health services about the value of future art therapy services.

Practitioner Points

- Art therapy was reported to be an acceptable treatment for the majority of respondents.
- Art therapy may not be a preferred treatment option for a small number of patients, emphasising the importance of considering patient preference in choice of treatment, and selection of the most suitable patients for art therapy.
- Consideration should be made of adjustments to make art therapy inclusive, particularly for those with physical illnesses.
- Ensuring the competence of the deliverer, providing patients with additional support, such as other therapies if required and ensuring continuity of care should be key considerations in service provision.

Introduction

Mental ill health is the largest single cause of disability in our society (WHO, 2004), with nearly half of all ill health among people under 65 years of age being mental illness in the UK (Layard, 2012). Mental disorders can be broadly categorised as either psychotic or non-psychotic with non-psychotic disorders accounting for most (94%) mental health morbidity in adults (Layard, 2012; Mind, 2014). Non psychotic mental disorders include anxiety disorders such as phobias and obsessive compulsive disorder; mood disorders such as depression and major depressive disorder; and other conditions such as eating disorders and personality disorders. Depression alone accounts for the greatest burden of disease among all mental health problems (Moussavi, Chatterji, Verdes, Tandon, Patel, & Ustun, 2007; Murray & Lopez, 1996). Additionally nearly a third of all people with long-term physical conditions have a co-morbid mental health problem like depression or anxiety disorders indicating an interaction between physical and mental illness (Naylor, Parsonage, McDaid, Knapp, Fossey & Galea, 2012; Unutzer, Schoenbaum, Katon,

Fan, Pincus, Hogan,. et al. 2009; Vamos, Mucsi, Keszei, Kopp, & Novak, 2009). Only one quarter of people with a mental illness receive treatment for it in the UK (Layard, 2012) and it may be that more mental health treatment options are needed, which vary according to the type and severity of mental disorder, rather than a "one-size-fits all" approach across professions. Furthermore, evidence suggests that psychological treatment may be a preferred treatment option over pharmacologic treatment for many who are undergoing treatment for a psychiatric disorder (McHugh, Whitton, Peckham, Welge, & Otto, 2013; van Schaik, Klijn, van Hout, van Marwijk, Beekman, de Haan, et al., 2004). This is particularly important given that patient preference for treatment may impact on adherence and treatment outcome (Van, Dekker, Koelen, Kool, van Aalst, Hendriksen,. et al. 2009; Lin, Campbell, Chaney, Liu, Heagerty, Felker,. et al. 2005). Therefore, evaluation of forms of psychological therapy other than CBT, such as art therapy, is critical in order to inform future recommendations for its use.

Art therapy involves using painting, clay work and other creative visual art-making (including creative digital media) as a form of non-verbal expression, in conjunction with other modes of communication within a therapeutic relationship in an appropriate therapeutic setting. Art therapy is a specific branch of treatment under the umbrella term “arts therapies” used by the Health Care Professions Council (HCPC) which includes drama therapy and music therapy. It is a widely used psychological therapy and has HCPC approval, higher education Quality Assurance Agency (QAA) subject benchmarks, and a professional organisation- the British Association of Art Therapists (BAAT). Art therapy is currently being used in the UK NHS for many non-psychotic mental disorders. There are a number of non-psychotic mental health problems which are typified by a reluctance or inability to communicate feelings verbally. It may be that art therapy is a more appropriate treatment than standard talking therapies for some individuals.

Rigorous evidence on the effectiveness and acceptability of art therapy is limited and, furthermore there is no definitive criterion for who is routinely referred for art therapy and at what point in their care pathway (Wilson, 2002).

The only standardised guidelines for its use are in relation to schizophrenia (National Institute for Clinical Excellence, 2009). However, varied populations are currently treated with art therapy, including people who have been abused and traumatised, are on the autistic spectrum, who have addictions, have dementia, have eating disorders, have learning difficulties, are offenders, are in palliative care, have depression, personality disorders or people displaced as a result of political violence. Therefore, adults are referred from a broad range of diagnostic categories, but they tend not to be referred on the basis of diagnosis alone. They may be referred on the basis of behavioural problems, including problems with engaging with services, or problems with putting distress into words for which talking therapies would not be the preferred option. Other clinicians making referrals to art therapy are often looking to widen the range of treatment options for people who, in addition to having complex, severe and enduring mental health problems, face emotional and socioeconomic deprivation. Furthermore, as seen in the use of art therapy for service users in palliative care, people facing the emotional consequences of serious physical health may also be referred.

This review was part of a larger project and was complementary to a quantitative review of clinical effectiveness and a cost-effectiveness model. The aim of this particular systematic review was to provide an overview of the evidence for service user and service provider perspectives on the acceptability, relative benefits and potential harms of art therapy for people with non-psychotic mental health disorders.

Review methods

Search methods

Searches were conducted between May-July 2013. The databases searched were, Medline and Medline in Process & Other Non-Indexed citations (Ovid), Embase (Ovid), Cochrane Database of Systematic Reviews (Cochrane Library), Cochrane Central Register of Controlled Trials (Cochrane Library), Database of Abstracts of Review of Effects (Cochrane Library), NHS Economic Evaluation Database (Cochrane Library), Health Technology Assessment Database (Cochrane Library), Science Citation Index (Web of Science via Web of Knowledge), Social Sciences Citation Index (Web of Science via Web of Knowledge), CINAHL: Cumulative Index to Nursing and Allied Health Literature (EBSCO), PsycINFO (Ovid), AMED: Allied and Complementary Medicine (Ovid), ASSIA: Applied Social Sciences Index and Abstracts (ProQuest). Date limits or language restrictions were not used on any database. To ensure that the full breadth of literature for the non-psychotic population was included, it was pragmatic to search for all art therapy studies and then subsequently exclude studies manually (through the sifting process) which were conducted in people with a psychotic disorder or a disorder where symptoms of psychosis were reported.

A number of additional sources were searched to identify any relevant grey literature. A hand-search of The International Journal of Art Therapy: Inscape was conducted. Furthermore, reference list checking and citation searching of the included studies was undertaken.

Screening and eligibility

All abstracts, then full papers were read by two reviewers who made independent decisions regarding inclusion or exclusion, and consensus, where possible, was obtained by meeting to compare decisions. Study types included were: (i) Qualitative research reporting the perspectives and attitudes of people with non-psychotic mental health disorders who have

received art therapy in order to examine issues of acceptability; (ii) Qualitative data embedded in trial reports or in accompanying process evaluations, to inform an understanding of how issues of acceptability are likely to affect the clinical effectiveness of art therapy; (iii) Qualitative data either from separately conceived research or embedded within quantitative study reports, reporting the acceptability of art therapy to health care practitioners.

Studies of non-psychotic clinical patients and healthcare practitioners were included, whilst studies of patients with psychosis or healthy participants without mental health symptoms were excluded. Studies of Art therapy as might be delivered in the NHS in the UK, were included whilst Art therapy combined with any other therapy (such as music therapy), and 'The Arts in Health' Movement were excluded. Included studies designs were case series, interviews, and observational studies. However, single case studies were excluded. Studies in all settings were included, although community was the main setting of interest.

Quality assessment strategy

Studies meeting the inclusion criteria were evaluated by two reviewers using the CerQual (certainty of the qualitative evidence) approach (Glenton, Colvin, Carlsen, Swartz, Lewin, Noyes,. et al. 2013) which aims to assess how much certainty could be placed in the qualitative research evidence. A summary assessment was made for each study, based on the methodological quality of each included study and the coherence of the review findings (the extent to which a clear pattern was identifiable across the individual study data). Coherence was assessed by examining whether the review findings were consistent across multiple contexts and incorporated explanations for variation across individual studies. Coherence was strengthened where individual studies contributing to the findings were drawn from a wide range of settings.

The methodological quality of individual studies was appraised using an abbreviated version of the Critical Appraisal Skills Programme (CASP) quality assessment tool for qualitative studies (CASP, 2011). Two reviewers independently applied the set of quality criteria to each included study. Studies were included in the review regardless of study quality.

Review findings were subsequently graded as high, moderate, or low, according to: the CASP assessment; the number and richness of the data in the studies; the consistency of the data within the studies, across study settings and populations; and the relevance of the findings to the review question.

Data extraction strategy

Data extraction from included qualitative studies was undertaken independently by AS using a data extraction tool adapted and tailored for the precise purpose of the qualitative review. All data extractions were checked by LU with any discrepancies being discussed by both data extractors. Where data for included studies were missing, reviewers attempted to contact the authors at their last known email address.

For the purpose of data extraction, two principle approaches to decide what counts as qualitative evidence have been proposed (Noyes & Lewin, 2011). In the first, only data from primary studies which is illustrated by a direct quotation from the respondent is extracted, whereas in the second all qualitative data identified in the primary studies and relevant to the review question are extracted. Given the anticipated paucity of evidence, the latter, more inclusive approach to data type was adopted, together with a selective approach to extract data relevant to the specific research question. A framework for extraction was developed which focussed specifically on data relating to the review question including: how art therapy helped (relative benefits); how art therapy was unhelpful (potential harms); neutral effects (neither

benefits or harms); barriers to participation (acceptability); and recommendations for service delivery (acceptability) from patients and health practitioners.

Data synthesis strategy

Qualitative meta-synthesis was undertaken to provide added value to the quantitative analysis by indicating patient issues around the acceptability of art therapy as a treatment for non-psychotic mental health disorders. Specifically, thematic synthesis was used to aggregate the findings (Thomas & Harden, 2008). The framework developed for data extraction was used to shape the synthesis of the findings.

Results

Figure 1 about here

Description of the included studies

From the 10270 citations identified from the searches, 290 were considered following abstract sift and 42 papers were considered at full paper sift for the qualitative review. The sifting process resulted in the inclusion of twelve studies (13 citations) at full paper sift. All included full papers were published between 2002 and 2013 [although one study was an unpublished manuscript linked to a published abstract within this timescale (Rhondali & Filbet, 2010)]. Two were theses (Collie, 2004; Sharf, 2004) and one of these had an associated peer reviewed paper which constituted the same study (Collie, Bottorff, & Long, 2006). A full list of the included studies and their characteristics including the characteristics of the interventions can be found in the supplementary data (Tables S1 and S2).

Eleven studies assessed patients' attitudes and 2 studies assessed health practitioner attitudes to the intervention (GPs = 1; art therapists = 1). The studies contained qualitative data from

188 patients and 16 health practitioners. The primary diagnoses of the patient populations studied included: cancer (n=6); depression/anxiety/stress (n=3); PTSD (n=1); and obesity (n=1). The symptoms being treated by art therapy included: depression; stress; anxiety; psychological distress; low self-esteem; fatigue; and fear.

Three studies were conducted in the UK (Turnbull & Omay, 2002; Lobban, 2012; Wood, Low, Molassiotis & Tookman, 2013). One of these studies provided data from patients (Lobban, 2012) and the other from GPs who referred to art therapy (Turnbull & Omay, 2002). Four studies were conducted in the US (Collie, 2004; McCaffery, 2007; Ferszt, Hayes, DeFedele & Horn, 2004; Sharf, 2004) with one of these studies also including participants from Canada (Collie, 2004). Three of these studies provided data from patients (Collie, 2004; McCaffery, 2007; Ferszt, Hayes, DeFedele & Horn, 2004) and the final study providing data from art therapists (Sharf, 2004). The remaining five studies were conducted in European countries, Sweden (Oster, Astrom, Lindh, & Magnusson, 2009), Germany (Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011), France (Rhondali & Filbet, 2010), Italy (Forzoni, Perez, Martignetti, & Crispino, 2010), Switzerland (Anzules, Haennl, & Golay, 2007), and provided data from patients.

In seven studies the art therapy took place in secondary care (Rhondali & Filbet, 2010; Anzules, Haennl, & Golay, 2007; Sharf, 2004; Forzoni, Perez, Martignetti, & Crispino, 2010; Lobban, 2012; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Oster, Astrom, Lindh, & Magnusson, 2009), in primary care in one study (Turnbull & Omay, 2002), in a state correctional facility (US) in one study (Ferszt, Hayes, DeFedele, Horn, 2004), participants had taken part in art therapy in varied settings including secondary care and private sessions in one study (Collie, 2004). The setting was not reported in two studies (McCaffery, 2007; Wood, Low, Molassiotis, Tookman, 2013)

Quality of the included studies

Our inclusion criteria specified that qualitative research or qualitative data within mixed methods studies was acceptable for inclusion, however of the twelve included studies only three could be described as qualitative research (Collie, Bottorff, & Long, 2006; Collie, 2004; Oster, Astrom, Lindh, & Magnusson, 2009; Sharf, 2004). Researcher reflexivity can be described as awareness of the researcher's contribution to the construction of meanings throughout the research process and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Few studies (n=5) made reference to researcher reflexivity, and in those which did these descriptions were often brief. Most studies provided descriptions of the context and aims of the study (n=9), recruitment methods (n=8), and data collection methods (n=8), although these tended to be brief. The study methods used were interview methods in most studies (n=10) (semi-structured interviews (n=7), in-depth interview (n=1), interview (n=2). One study used the focus group method, one used patient diaries, one used field notes, and one used the transcription of a video recorded group discussion which had been used for a television programme. Only around half of the included studies provided an adequate description of data analysis methods (n=7), and in only a few studies were in-depth, detailed and rich data presented (n=5). It should be noted that this may have been, in part, due to limitations imposed by journals. Furthermore, the level of evidence that was included was extended to include data identified in both the results section and the discussion and will include author comments and interpretation. By limiting to data from participants it was feared important data may be missed.

Certainty of the review findings

As described in the methods section the CerQual approach to assess the certainty of the review findings was applied. The CASP quality assessment finding together with the number of studies contributing to the finding, and an assessment of the consistency of study setting and

population was assessed. Each finding could potentially be graded as either high, moderate of low certainty. For the evidence from patients, there were a total of 38 findings: 20 were assessed as moderate certainty and 18 were assessed to be of low certainty. For the evidence from service providers, as only two studies contributed to the evidence, there were a total of 25 findings: 19 were assessed as moderate certainty and 6 were assessed to be of low certainty. Due to the limited number of studies contributing to each finding together with the fact that the majority of the individual studies included in the review were of low to moderate quality, no findings were assessed as being of high certainty.

Thematic findings

The thematic findings generated from the included studies were organised by respondent, patient or service provider, and by the framework categories developed for the data extraction. The themes generated for each category together with the assessments of certainty around each finding are presented below and summarised in tables 1-6 and figures 2 & 3.

Benefits of art therapy as perceived by patients

Relationships

A number of respondents across several studies talked about relationships as important in art therapy (McCaffery, 2007; Forzoni, Perez, Martignetti, & Crispino, 2010; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Lobban, 2012; Rhondali & Filbet, 2010; Turnbull & Omay, 2002; Wood, Low, Molassiotis & Tookman, 2013). They suggested that art therapy was effective when a relationship with the art therapist was established (McCaffery, 2007; Forzoni, Perez, Martignetti, & Crispino, 2010; Wood, Low, Molassiotis & Tookman, 2013). A good relationship with the art therapist was seen as a requirement for an optimal art therapy programme (Collie, 2004; Turnbull & Omay, 2002), and that the art therapist should act as a

guide (Collie, 2004). However, it was also noted by a patient that art therapy could be unhelpful if the art therapist was not skilled enough to deal with emotions, such as anxiety in the patients that may result from the therapy or during therapy sessions (Collie, 2004).

In situations where art therapy was delivered in a group setting respondents also discussed relationships with other group members and felt that art therapy was beneficial when these relationships could be established (McCaffery, 2007; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Lobban, 2012; Wood, Low, Molassiotis & Tookman, 2013). These findings were observed in studies across a range of settings and in a range of populations.

Respondents also felt that art therapy had the effect of facilitating improved relationships with family members, friends and caregivers (Rhondali & Filbet, 2010). This finding was observed in only one study in which respondents had cancer, and therefore this finding may not be generalizable to other populations. In one study respondents with anxiety, depression and stress suggested that art therapy could serve to reduce isolation (Turnbull & Omay, 2002).

Understanding

Several studies included data concerning the importance of increased understanding as a beneficial result of art therapy (McCaffery, 2007; Forzoni, Perez, Martignetti, & Crispino, 2010; Anzules, Haennl, & Golay, 2007; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Lobban, 2012; Oster, Astrom, Lindh, & Magnusson, 2009; Turnbull & Omay, 2002; Rhondali & Filbet, 2010). More specifically respondents talked about an increased understanding of self (McCaffery, 2007; Forzoni, Perez, Martignetti, & Crispino, 2010; Anzules, Haennl, & Golay, 2007; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Lobban, 2012) and that art therapy promoted thinking about the future (McCaffery, 2007; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Rhondali & Filbet, 2010; Oster, Astrom, Lindh, & Magnusson, 2009; Turnbull & Omay, 2002). These findings appeared consistent across different populations. In

two studies, one in patients with obesity (Anzules, Haennl, & Golay, 2007) and the other in people with breast cancer (Collie, 2004), art therapy was felt to facilitate understanding of these illnesses, as such this finding may be specific to people with a diagnosis of a physical illness.

Perspective, Distraction, Personal achievement

A further beneficial effect of art therapy was the provision of strength and giving perspective on feelings and emotions (McCaffery, 2007; Oster, Astrom, Lindh, & Magnusson, 2009). However, it should be noted that this finding was judged to be of low certainty due to the finding being seen across only two studies of overall low quality.

Respondents highlighted distraction as a beneficial aspect of art therapy (Rhondali & Filbet, 2010; Collie, 2004; Anzules, Haennl, & Golay, 2007). More specifically respondents pointed to distraction from pain (Rhondali & Filbet, 2010), and distraction from the illness or escapism (Rhondali & Filbet, 2010; Collie, 2004; Anzules, Haennl, & Golay, 2007). As might be expected, these findings were restricted to cancer and obesity populations, and were therefore rated as low to moderate certainty.

Several studies included data reflecting that the provision of art therapy gave participants a sense of personal achievement. In a number of studies respondents commented that art therapy provided pleasure, satisfaction, accomplishment and a sense of pride (Rhondali & Filbet, 2010; Collie, 2004; Anzules, Haennl, & Golay, 2007; Ferszt, Hayes, DeFedele & Horn, 2004; Forzoni, Perez, Martignetti, & Crispino, 2010). In one study of women with cancer it was reported that art therapy provided an opportunity to leave a legacy for loved ones (Rhondali & Filbet, 2010).

Expression, Empowerment, Relaxation

Freedom of expression emerged as important across a range of studies (Ferszt, Hayes, DeFedele & Horn, 2004; Oster, Astrom, Lindh, & Magnusson, 2009; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Lobban, 2012; Turnbull & Omay, 2002; Wood, Low, Molassiotis & Tookman, 2013). Specifically art therapy was thought as of a safe place to express emotions, such as fear (Ferszt, Hayes, DeFedele & Horn, 2004; Oster, Astrom, Lindh, & Magnusson, 2009; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Lobban, 2012; Turnbull & Omay, 2002) and anger (Collie, 2004), via a non-verbal medium. Recipients of art therapy expressed that it gave them a sense of empowerment. This came in the form of control over emotions (Oster, Astrom, Lindh, & Magnusson, 2009; Collie, 2004; Turnbull & Omay, 2002; Wood, Low, Molassiotis & Tookman, 2013). Art therapy also promoted control over real life situations (Oster, Astrom, Lindh, & Magnusson, 2009) and it was also cited as raising self-esteem (Ferszt, Hayes, DeFedele & Horn, 2004).

A number of studies reported data suggesting art therapy provided a healing experience, comfort, encouragement support, and relaxation (Ferszt, Hayes, DeFedele & Horn, 2004; Collie, 2004; Geue, Gotze, Buttstadt, Kleinert, & Singer, 2011; Turnbull & Omay, 2002; Wood, Low, Molassiotis & Tookman, 2013).

Acceptability and potential harms of art therapy as perceived by patients

Although recipients in most of the studies indicated a high level of acceptability of art therapy, some studies also described less positive attitudes. Some respondents made comments that indicated that although they did not feel art therapy would be harmful, they did not feel it would be beneficial. In one study (Forzoni, Perez, Martignetti, & Crispino, 2010), a participant commented that art therapy was superficial, in another (Turnbull & Omay, 2002), a participant felt it was self-indulgent and in a final study (Ferszt, Hayes, DeFedele & Horn, 2004) a

participant simply had a preference for other therapies. These findings were seen across only three studies of low to moderate quality.

More serious concerns included art therapy causing anxiety (Rhondali & Filbet, 2010), increasing pain, (Rhondali & Filbet, 2010), and it resulting in the activation of emotions which were not resolved (Collie, 2004). In one study a participant was also concerned that art therapy may be harmful if the art therapist was not skilled (Collie, 2004). A final concern was that it may be harmful if art therapy is suddenly terminated (Collie, 2004). These findings were seen across only two studies, both in patients with cancer.

Patients' recommendations for the provision of art therapy

Across several studies recommendations for art therapy were made. In one study a participant expressed that it was important that their privacy be respected during art therapy. (Oster, Astrom, Lindh, & Magnusson, 2009) Also emotional support (Collie, 2004), a good relationship with the art therapist (Collie, 2004; Turnbull & Omay, 2002) and that the art therapist should act as a guide (Collie, 2004), were important aspects of art therapy. Suggested improvements for art therapy were made in one study (Ferszt, Hayes, DeFedele & Horn, 2004), including the need for further sessions of art therapy and for additional input from other therapies, such as individual counselling.

Barriers to participation as perceived by patients

Barriers to participation in art therapy were reported in three studies (Rhondali & Filbet, 2010; Forzoni, Perez, Martignetti, & Crispino, 2010; Wood, Low, Molassiotis & Tookman, 2013). Respondents commented that they thought they were too ill to take part in the therapy (Rhondali & Filbet, 2010), and in a further study respondents reported that art therapy was restricted to people with certain medical conditions. (Wood, Low, Molassiotis & Tookman, 2013) Other barriers included a fear of not being 'good at art' (Wood, Low, Molassiotis &

Tookman, 2013) and in two other studies participants commented that a lack of understanding of what art therapy could be a barrier to participation. (Forzoni, Perez, Martignetti, & Crispino, 2010), (Wood, Low, Molassiotis & Tookman, 2013).

Qualitative synthesis: evidence from patients

Table 1 about here

Table 2 about here

Figure 2 about here

Benefits of art therapy as perceived by service providers

In many ways the data from the two studies examining service provider views of art therapy mirrored those of the patients. GP's felt art therapy was beneficial when patients have time invested in them. (Turnbull & Omay, 2002) Art therapists felt that art therapy was most helpful when the therapist examines the effect of art making process with clients (Sharf, 2004). Furthermore, it was seen as beneficial when clients can communicate through artwork (Sharf, 2004), when art therapists help clients improve their ability to manage anger (Sharf, 2004), when it increases pride and self-esteem, and when thoughts and feelings are expressed more effectively (Sharf, 2004). Finally, on a more practical level, art therapists felt that art therapy could be beneficial when it provides an opportunity for clients to do something better with their time (Sharf, 2004).

Acceptability and potential harms of art therapy

Service providers made a number of observations about the acceptability and potential harms of art therapy. The study which examined the perspectives of GPs referring to art therapy (Turnbull & Omay, 2002), reported the findings regarding art therapy that whilst they did not indicate they felt art therapy could be harmful, they did not regard it as beneficial and this was reported by GP's as a lack of undertaking of art therapy and in some cases they viewed the art aspect of the therapy as 'irrelevant'. They felt it was unlikely to help everyone (Turnbull &

Omay, 2002), and on a more practical note they felt that art therapy provided them with an opportunity to take time back, 'Leaves me free for more medical care.' (Turnbull & Omay, 2002). It should be noted that all of these neutral findings were generated from only one study of low quality, which looked at the opinions of general practitioners referring to art therapy and therefore cannot be generalised across other groups.

In terms of more serious detrimental effects of art therapy (Sharf, 2004), reported findings from art therapists. These potential harms included, when administrative decisions lead to poor treatment outcomes, for example when a client is not allowed to continue with art therapy; when the client lacks commitment or is non-compliant; and when the client is resistant to art therapy.

Service providers' recommendations for the provision of art therapy

Both types of service providers (GPs and art therapists), like patients, felt that a good relationship with the art therapist was important (Turnbull & Omay, 2002; Sharf, 2004). GPs also reported that they felt the one to one contact was an important aspect of the therapy (Turnbull & Omay, 2002). Art therapists also felt that client commitment to recovery; the client to enjoy art therapy; a safe environment to express thoughts; feelings and experiences; matching techniques and materials to clients; displaying artwork; and to create art along with clients, were important aspects of effective art therapy (Sharf, 2004).

Barriers to the provision of art therapy as perceived by service providers

Art therapists felt that art therapists were not respected as professionals by members of other professional groups (Sharf, 2004), and that this created a barrier to patients being referred to art therapy. Art therapists went on to suggest that in situations where art therapists and other professionals were able to work together improvements to the service, patient outcomes and accessibility of art therapy were made.

Qualitative synthesis: evidence from service providers

Table 4 about here

Table 5 about here

Table 6 about here

Figure 3 about here

Discussion

The aim of the systematic review was to provide a detailed user perspective on the acceptability and relative benefits and potential harms of art therapy. Overall art therapy was viewed as an acceptable treatment across the populations of participants studied.

A number of beneficial aspects of art therapy emerged together with a relatively smaller number of harmful aspects of art therapy, with relative harms being reported in only two studies (Rhondali & Filbet, 2010; Collie, 2004). An important theme emerging from the data was the relationship with the art therapist. This was raised as both a positive and beneficial aspect of art therapy but also as a potentially harmful aspect, and a recommendation for the service provision of art therapy. A good relationship between the patient and art therapist was viewed as essential for successful, effective art therapy. However, harm could be caused, in situations where a positive relationship was not achieved, the therapist was viewed as unskilled, when emotions activated through therapy could not be resolved, or the therapist was suddenly unavailable through sudden termination of the service. This finding was seen in evidence reported by patients and by service providers who also stressed the importance of a good therapeutic relationship.

Some themes, such as the importance of the relationship with the art therapist and with other group members, facilitation of an increased understanding of self, and expression were consistent across populations, whilst a small number of themes appeared to apply to populations in which a diagnosis of a pre-existing physical condition was present. These themes included the facilitation of an improved relationship with family, friends and caregivers, identified in one study of a cancer population (Rhondali & Filbet, 2010), facilitation of an understanding of the illness in two studies, one of obesity (Anzules, Haennl, & Golay, 2007), and one of cancer (Collie, 2004), distraction from pain in one study of a cancer population (Rhondali & Filbet, 2010), distraction from the illness/escapism in two studies of cancer populations (Rhondali & Filbet, 2010; Collie, 2004) and one of an obesity population (Anzules, Haennl, & Golay, 2007), and providing the opportunity for legacy in a study of a cancer population (Rhondali & Filbet, 2010).

Additionally, some barriers to participation were reported with patients reporting they thought they were too ill to take part in the therapy (Rhondali & Filbet, 2010), or that art therapy was restricted to people with certain medical conditions (Wood, Low, Molassiotis, Tookman, 2013), Some respondents with physical illnesses were concerned that art therapy may cause them anxiety (Rhondali & Filbet, 2010), increased pain (Rhondali & Filbet, 2010), and that it may result in unresolved activation of emotions (Collie, 2004). A small number of participants reported that they simply did not wish to take part in art therapy. Respondents also expressed concerns about the competence of the deliverer (Collie, 2004), and continuity of the service (Collie, 2004).

Limitations

Overall the evidence base was small (n=12), with only two studies examining service provider views and furthermore only one study examining art therapists' views. The majority of the

included studies were of low or moderate quality. Limitations on word limits imposed by journals may have contributed to this as theses and grey literature provided better quality evidence. Lack of rich data was the main limiting factor relating to the qualitative evidence base. Other significant limitations in the evidence base include the fact that the vast majority of studies only reported positive findings. This may have been due to researcher bias (Cohen & Crabtree, 2008), in that most of the authors of the reports were art therapists and the method of investigation in a number of studies appears to be biased toward the reporting of positive findings. There was also a lack of evidence comparing art therapy to other treatment options, therefore we are unable to make comparisons regarding the acceptability of art therapy compared to other potential treatments patients might be offered.

Conclusions

From the small number of qualitative studies identified, art therapy was reported to be an acceptable treatment for the majority of respondents. The benefits associated with art therapy included: the development of relationships with the therapist and other group members; understanding the self/ own illness/ the future; gaining perspective; distraction; personal achievement; expression; relaxation and empowerment. Small numbers of patients reported varying reasons for not wanting to take part, including cases that highlighted potentially negative effects of art therapy such as the evoking of feelings and emotions which could not be resolved. The implications of these findings are that art therapy may not be a preferred treatment option for everyone and emphasises the importance of considering patient preference in choice of treatment, selecting the most suitable patients for art therapy, and consideration of adjustments to make art therapy inclusive, particularly for those with physical illnesses. Furthermore, attention should be paid to how the service is provided, particularly ensuring the competence of the deliverer, providing patients with additional support, such as other therapies if required and ensuring continuity of care.

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Figure 1: PRISMA flow chart of studies included in the review

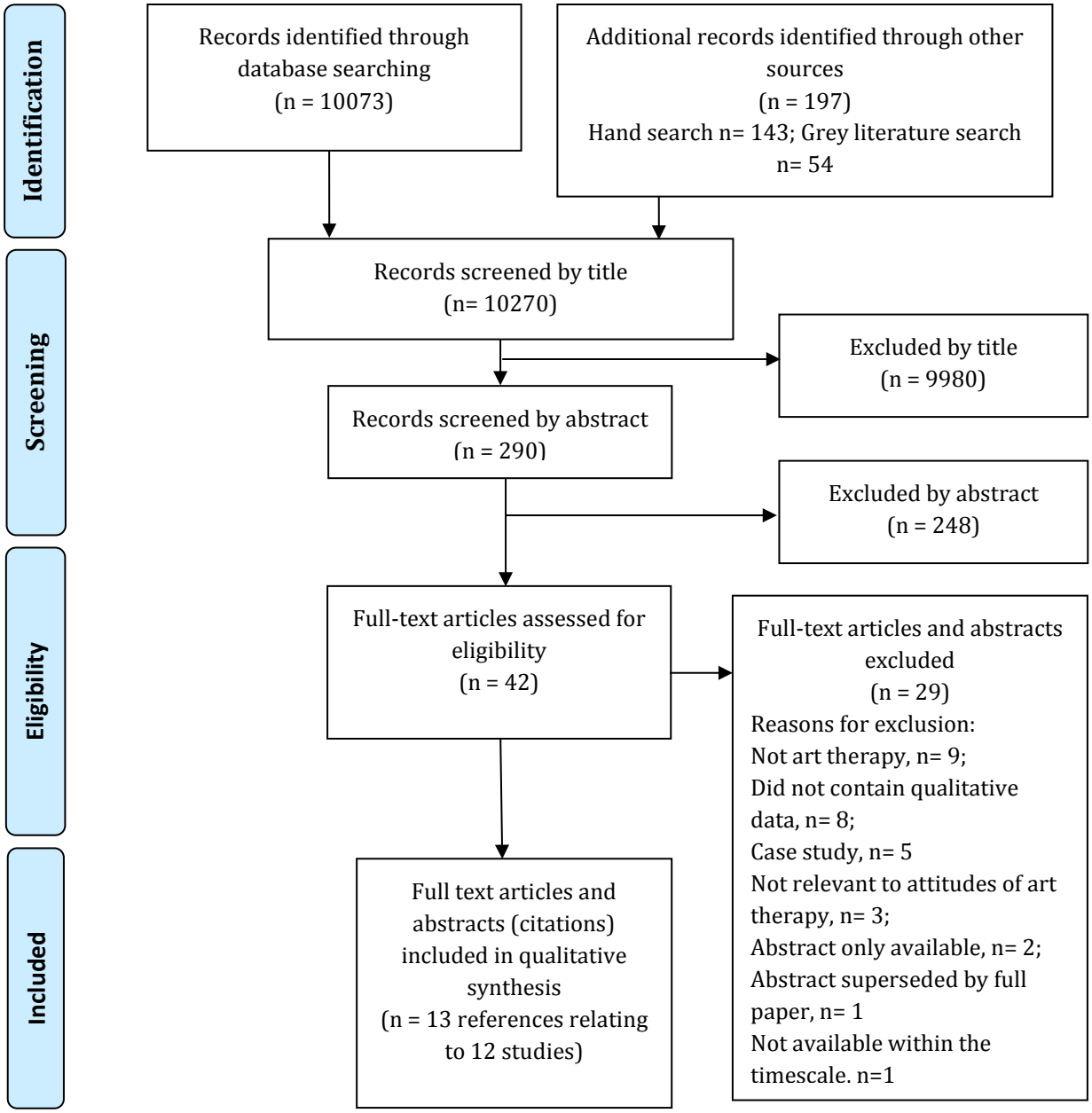

Table 1: Patient views regarding how art therapy helped (relative benefits)

Synthesised finding – Art therapy is effective when:		**Certainty in the evidence &**
Meta theme	Subtheme	**Explanation of certainty in the evidence assessment**
Relationships	A relationship with the art therapist is established	Moderate certainty - The studies overall were of moderate quality. The finding was seen a moderate number of studies (n=3), settings and populations.
	Relationships with other group members can be established	Moderate certainty - The studies ranged in quality from low to high. The finding was seen across several studies (n=5), in different settings and populations (cancer and PTSD).
	It facilitates an improved relationship with family, friends and caregivers	Moderate certainty - The finding was seen in only one study of high quality, specific to the cancer population.
	It counters isolation	Low certainty - The finding was seen in only one study which was of low quality.
Understanding	It facilitates increased understanding of self	Moderate - In general the studies were of moderate quality. The finding was seen across several studies (n=6), settings and populations.
	It facilitates understanding of illness	Low certainty - This finding was observed in only two studies: one of high quality and one of low quality, and in different populations
	It promotes future thinking	Moderate certainty - In general, the studies were of moderate quality, and the finding was seen across several studies (n=6), settings and populations.
Perspective	It give strength / provides perspective	Low certainty - The studies were of low and moderate quality, and in only two studies although across different settings, and populations (cancer v depression).
Distraction	It provides distraction from pain	Low certainty - The finding was seen in only one high quality study.

Synthesised finding – Art therapy is effective when:		**Certainty in the evidence &**
	It provides distraction from the illness / escapism	Moderate certainty - In general, the studies were of moderate quality, although the finding was seen in only a moderate number of studies (n=3) they had similar populations and settings(e.g., cancer, obesity)
Personal achievement	It provides pleasure / satisfaction/ accomplishment / pride	Moderate certainty - In general the studies were of moderate quality. The finding was seen across several studies (n=5), settings and populations.
	It provides the opportunity for legacy	Low certainty - The finding was seen in only one study, although this was of high quality.
Expression	It allows participants to express their feelings	Moderate certainty - In general, the studies were of moderate quality and the finding was seen across several studies (n=7), settings and populations.
Relaxation	It provides a healing experience / comfort encouragement and support / relaxation	Moderate certainty - In general the studies were of moderate quality, and the finding was seen across several studies (n=5), settings and populations.
Empowerment	It promotes empowerment	Moderate certainty - In general the studies were of moderate quality. The finding was seen across four studies in different settings and populations.
	It raises self-esteem	Low certainty - The finding was seen in only one study, and this was rated as low quality.

Table 2: Patient views regarding how art therapy was unhelpful (relative harms and neutral effects).

Themes	**Certainty in the evidence** **Explanation of certainty in the evidence assessment**
Patients reported that art therapy was unhelpful when:	
It caused anxiety	Moderate certainty - Although each of these findings was seen in a study of high quality, it was reported in only one study.
It increased pain	
It resulted in the activation of emotions which were not resolved	
The art therapist was not skilled	
Art therapy was suddenly terminated	
Neutral effects of art therapy:	
Superficial	Low certainty - The finding was seen in only one study of moderate quality.
Childish	
Preference for other therapies	Low certainty - The finding was seen in only one study of low quality.
Self-indulgent	

Table 3: Service delivery recommendations

	Certainty in the evidence & Explanation of certainty in the evidence assessment
Important considerations for art therapy. Patients wanted:	
Their privacy to be respected	Low certainty - The finding was seen in only one study of moderate quality.
Emotional support	Moderate certainty - The finding was seen in only one study of high quality.
A good relationship with the art therapist	Moderate certainty- The finding was seen in only two studies of which one was high quality.
The art therapist as a guide	Moderate certainty - The finding was seen in only one study of high quality.
Barriers to participation in art therapy. Patients felt they could not participate in art therapy:	
When they thought they were too ill to do so	Moderate certainty - The finding was seen in only one study of high quality.
When art therapy was restricted to certain medical conditions.	Low certainty - The finding was seen in only two studies of moderate quality.
When they lacked an understanding of art therapy	Low certainty - These findings were seen in only one study of moderate quality.
When they feared not being 'good at art'.	
Suggested improvements Patients felt:	
They needed further sessions of art therapy	Low certainty - These findings were seen in only one study of low quality.
They need additional input from other therapies (e.g. individual counselling)	

Figure 2: Overall synthesis of patients' views regarding the relative benefits, harms and acceptability of art therapy

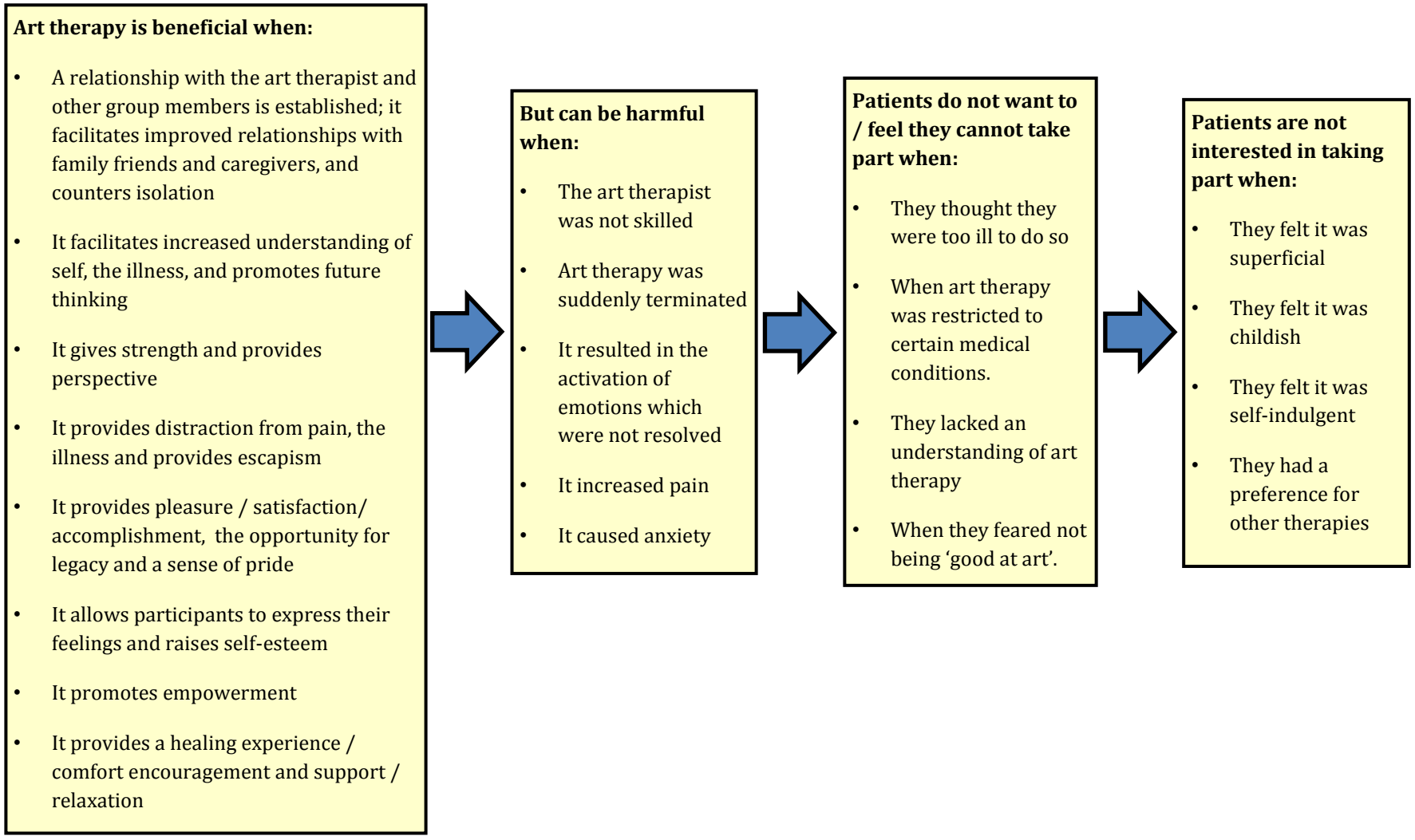

Table 4: Service providers' views regarding how art therapy was helpful (relative benefits)

Art therapy is effective when:	**Certainty in the evidence & Explanation of certainty in the evidence assessment**
Patients have time invested in them	Low certainty - The finding was seen in only one low quality study.
Patients like it / felt they benefitted	Moderate certainty - The finding was seen in only two studies of which one was high quality.
The therapist examines the effect of art making process on clients	Moderate certainty- These findings were seen in only one high quality study.
Clients can communicate through artwork	
Art therapists help clients improve their ability to manage anger	
it increases pride and self-esteem	
Thoughts and feelings are expressed more effectively	
Provides an opportunity for clients to do something better with their time	

Table 5: Service providers' views regarding how art therapy was unhelpful (relative harms or neutral effects)

Service providers reported that art therapy was unhelpful when:	**Certainty in the evidence & Explanation of certainty in the evidence assessment**
Administrative decisions led to poor treatment outcomes	Moderate certainty - These findings were seen in only one high quality study.
The client lacks commitment or is non-compliant	
The client is resistant to art therapy	
Neutral effects of art therapy – themes:	
Lack of understanding of art therapy	Low certainty - These findings were seen in only one low quality study.
The art bit is irrelevant	
Doesn't help everyone	
Time back / pressure off	

Table 6: Service delivery recommendations

	Certainty in the evidence & Explanation of certainty in the evidence assessment
Important considerations for art therapy:	
A good relationship with the art therapist /strong therapeutic relationship	Moderate certainty - The finding was seen in only two studies of which one was high quality, the other low quality.
One to one contact	Low certainty - The finding was seen in only one low quality study.
Client commitment to recovery	Moderate certainty - The finding was seen in only one high quality study.
Client to enjoy art therapy	
Safe environment to express thoughts, feelings and experiences	
Match techniques and materials to clients	
To display artwork	
Create art along with clients	
Barriers to participation in art therapy. Service providers felt patients were not able to participate in art therapy when:	
Art therapists were not respected as professionals by members of other professional groups	Moderate certainty - The finding was seen in only one high quality study.
Suggested improvements. Service providers felt:	
Art therapist and other professionals working together	Moderate certainty - The finding was seen in only one high quality study.

Figure 3: Overall synthesis of service providers' views regarding the relative benefits, harms and acceptability of art thera