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Title

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

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Abstract

Objective

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

Method

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

Results

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

Conclusions

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

Keywords

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

Introduction

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

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

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

depression. Moreover, by responding to the universally human need for self-expression, arts therapies could potentially address the common withdrawal within depression and encourage sharing.

Although numerous case studies confirm that arts therapies are used extensively to address depression (Dokter, 1996; Payne, 1996; Cattanach, 1999; Reynolds, Lim & Prior, 2008), the effectiveness, and to some extent the nature of these interventions remain unclear and significant differences in available evidence may be observed within individual arts therapies disciplines. It is apparent when considering arts therapies for depression that there are more studies of music therapy than any other type of arts therapies, and in particular the research on dramatherapy and depression is very limited. Relevant good quality studies include: Erkkilä et al., 2011 on music therapy, Jeong et al., 2005 on dance movement therapy, and Thyme et al. 2007 on art therapy. In general, quantitative research on primary depression in adults is sparse, but there are significant studies which consider depression outcomes in people suffering from other conditions: art therapy has been examined in cancer patients (Ando et al., 2013; Thyme et al., 2009), while music therapy has been studied in older adults with dementia (Chu et al., 2013; Guetin et al., 2011; Myskja & Nord 2008), as well as in the cases of substance abuse (Albornoz, 2011; Silverman, 2011).

Despite relatively low numbers of research studies and mostly small samples, the mentioned projects undertaken worldwide offer promising results and suggest that arts therapies interventions result in a significant positive change in mood, a decrease of depressive symptoms and an improvement of general wellbeing. However, arts therapies and depression still remain an underresearched area with not enough high-level evidence to support their effectiveness (Evans, 2003). Although research activity among arts therapists may be increasing, and the need for high quality projects seems to be recognised, many of

the studies to date lack scientific integrity and the two available Cochrane reviews (Maratos et al., 2008, Meekums et al., 2012) have confirmed the methodological inadequacy of the majority of the research studies evaluating the effectiveness of arts therapies for depression.

The gap in knowledge remains and more effectiveness studies of high quality are required, if arts therapies are to take their place amongst more conventional treatments. However, the authors believe that evaluations in the field pose specific challenges as they should reflect the creative nature of the disciplines (Meekums, 1996) and focus equally on the outcomes and the process (Gilroy, 2006). While outcomes are commonly associated with a quantitative approach and it may be argued that process is best explored through qualitative methodologies, the two paradigms are rarely combined in individual research studies. The current state of research in arts therapies and depression indicates a growing need for quality pilot studies (Thabane et al., 2010; Lancaster et al., 2004) to enrich our understanding of the mechanisms of therapy and to enable further assessment of effectiveness. Researching outcomes alongside the process of therapy seems vital in exploratory studies and this is the approach taken in the current report.

Aims of this research

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

1. What is the value of an art therapy group in the treatment of adult depression?
2. Is a larger RCT feasible with available resources? What adjustments would a larger study require?

The current paper focuses on question 1., while a detailed assessment of feasibility is available from the first author's PhD thesis (Zubala, 2013). The first research question demanded addressing more specific objectives, which were:

- to identify any changes in depression levels (primary outcome)
- to identify any changes in anxiety levels and general wellbeing (secondary outcomes)
- to collect participants' evaluation of the experience of an art therapy group.

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

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

Ethical approval

Specific measures have been put in place to ensure participants' safety and wellbeing. Suitability of those measures was thoroughly assessed by the Research Ethics Committee at Queen Margaret University as well as the local NHS Research Ethics Committee and the NHS Research and Development Office, from which suitable ethical approvals were obtained in September 2012. An Honorary Research Contract, enabling the researcher to access NHS premises for the purpose of the project, was obtained in February 2013.

Methodology

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

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

Intervention

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

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

Several approaches underpinned the intervention, which was: a) brief, b) group based, c) person-centred, and d) incorporating psychodynamic principles. The unavoidably brief character of the therapy demanded establishing of a positive therapeutic alliance early in the process and a more active approach on the therapist's side. Discouraging dependence while providing appropriate holding (Mander, 2006) was considered crucial. The many unique therapeutic factors of group therapy (Yalom & Leszcz, 2005) were considered in the manual, as were the potential challenges of group work in the context of depression. The need to relate and engage versus the tendency to isolate were expected in the group. Psychodynamic principles, generally highly valued among arts therapists and art therapists in particular (Karkou & Sanderson, 2006; Zubala et al., 2013), in this project concerned the role of unconsciousness, insight and relationships within the group reflecting connections with self and others. The person-centred character of the intervention followed the qualities listed by Rogers (1951): acceptance, genuineness and empathy, and other humanistic principles including belief in the natural human potential to grow and the central role of self-expression and creativity.

The ultimate aims of therapy highlighted, among others: instillation of hope, confidence building, encouraging creativity and self-expression, development of social support and increasing self-awareness and appreciation of others. Aims more specific to the particular group were developed following individual clinical assessments. Examples of main underlying problems of the group included: difficulties with forming relationships and trusting people, lack of self-confidence, tiredness, lack of motivation, social isolation and loss or bereavement. Psychological mechanisms responsible for the most common problems identified were then named and counterbalanced by a corresponding therapeutic aim (e.g.

relaxation in response to constant fighting, expression in response to blockage, awareness of others in response to self-consciousness – see Appendix 12 in Zubala, 2013).

The sessions offered general structure and flexibility at the same time and included: a) introduction (mostly verbal, invitation to participants to reflect on last session and/or time in-between sessions, 10-20 minutes), b) art making (usually individual work at shared table, 20-40 minutes), c) conclusion (sharing art work – visually and verbally, final reflections, 10-20 minutes). In most sessions a theme emerged in the introductory stage which was then explored by participants through art making. Structure was considered particularly important in the context of depression, when the sense of self and confidence are often low and making choices may be difficult (Brok, 2011). It was intended to relieve anxiety, leading to a more meaningful engagement with the process of therapy. Providing a safe space that did not affect the creative and therapeutic process was the key intention and participants were invited to change the structure and make choices at all times.

Setting

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

Therapist

A qualified art therapist with a special interest in depression volunteered to deliver group therapy in this project. The therapist offered her time to meet with the researcher on two occasions before the start of the treatment and was invited to comment on the

emerging treatment manual. Time was allocated before and after each session for the therapist and the researcher to consult the progress and share insights and suggestions for further intervention. Thus, it needs to be acknowledged that the actual intervention was shaped by both the treatment manual and the therapist's experience. During the sessions, the researcher was present but inactive and the clinical decisions were made by the therapist alone.

Participants

This pilot study looked to recruit participants who: a) were adults (age between 16 and 65), b) suffered from mild to moderate depression (based on self-disclosure and assessed through completion of PHQ-9), c) were willing not to engage in any other, new to them, psychotherapeutic treatments during the course of the study (unless they have already been in a long term therapy). Exclusion criteria applied to those a) who were not able to give an informed consent, b) whose English was not fluent enough to communicate meaningfully, c) who suffered from any mental health condition with a psychotic component (based on self-disclosure and observation), d) whose severity of depression might have affected their ability to complete the required questionnaires and might have significantly lowered the likelihood of regular attendance. It was accepted that the participants were treated as they would normally be in the NHS health care system while attending the arts therapies group. It was therefore understood that some or all of them might have been receiving pharmacotherapy and/or counselling sessions while in the art therapy group.

Participants were recruited during a two-week period from the community, through voluntary organisations and self-referred in response to online and paper advertising. A

total number of around 60 mental health services and community support groups were contacted via e-mail and post, of which some expressed a specific interest in advertising and promoting the project in their newsletters and bulletins. Information about the research was also distributed (in the form of leaflets and posters) in 28 different places in the city centre: nine GP practices, three Community Mental Health Teams, four community centres, student counselling services at three universities and a selection of several private services focusing on wellbeing and health. A dedicated website was additionally created, with downloadable pdf versions of both the information sheet and the consent form. This ensured that the potential participants could be given enough time to reflect on the project and its possible implications before making an informed decision to take part.

Twelve potential participants (or their relatives) contacted the researcher during the two weeks of recruitment, of whom seven signed the consent form. Two of them resigned from taking part due to the inconvenient days/times of therapy and the final group consisted of five participants, female and male, whose age ranged from 32 to 65. In order to protect participants' identities, either aggregated data or individual data with no age or gender labels attached will be presented in the following sections (the anonymous form of "she/he" will be used).

Quantitative methods: Questionnaires

In this study the severity of depression was a primary outcome measure, while the levels of anxiety and general wellbeing constituted secondary outcome measures. Participants were asked to complete three questionnaires (PHQ-9, GAD-7 and WHO-5) on three occasions: before the treatment (week 0), after the treatment (week 5) and during a

follow-up (week 16-17). The PHQ-9 was additionally filled in by each participant in the middle of the treatment (week 3). The researcher arranged to meet with the participants for collection of these data. The initial interview was offered immediately after a potential participant stated that she/he was willing to take part in this project and the earliest convenient date was agreed. The final interviews were arranged for the day after the last therapy session. The follow-up interviews were arranged individually in weeks 16 and 17 from the start of the project (11-12 weeks after the therapy has ended).

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

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

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

The validity and reliability of the aforementioned self-reporting scales used in this research were carefully checked, as was their applicability to the population in question. It

was believed that the combination of the questionnaires would provide a relatively comprehensive picture of various aspects of depression in response to the intervention, while not being too overwhelming for the participants. Achieving a balance between potentially available new knowledge (research value) and the participants' comfort was particularly important for the researcher.

Qualitative method: semi-structured interviews

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

The interviews with the participants were conducted by the researcher prior to and after the treatment, as well as in the follow-up. Their main purpose was to collect direct accounts from the participants of their expectations and experiences of an art therapy group. The interviews were conducted in a semi-structured format to allow for a person-centred approach as well as for scientific reliability and the reduction of researcher's bias. It needs to be noted that the interviews had a dual role and intended to enable the collection of data (research purpose) as well as the psychological assessment (clinical purpose) and were thus facilitated by the researcher who is a qualified psychologist. In addition, the qualitative data collected needed to reflect the two aims: the assessment of outcomes and process of therapy and the assessment of feasibility of a larger study. Themes relating to the assessment of feasibility will not be presented in this report due to limitation in the length of this paper (please refer to Zubala, 2013).

The initial and final interviews were audio recorded, while in the follow-up interviews notes were taken as needed. The findings resulted in a series of themes, which will be presented briefly in this report and in more detail in a separate publication.

Quantitative analysis

Due to a small sample and the assumed lack of normal distribution, the data collected through the questionnaires were analysed using a non-parametric statistical test (a related samples Wilcoxon test) to allow for comparison of the results before and after the treatment. Scores for each questionnaire completed by the participants were compared in combinations as follows: 1) the pre therapy (initial) with post therapy (final) result, 2) the pre therapy (initial) with follow up (follow-up) result. Additional comparisons were performed on the initial and interim scores as well as the interim and final scores of PHQ-9, for which such data were available.

A series of null hypotheses assuming the equality in the median of differences between mentioned scores were tested; the statistical significance of any observed changes was assessed and areas of highest significance were highlighted.

Qualitative analysis

Thematic analysis (Vaismoradi et al., 2013, Braun & Clarke, 2006) served as a general framework for approaching qualitative data. Template analysis (King, 2011) was then employed to allow for themes to emerge from both the interview schedule and the free-

flowing participants' responses. Qualitative data analysis software (NVivo, 2010) was used throughout the process to assist with the data storage, coding and classification.

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

Specific parts of the same datasets additionally enabled both the evaluation of the intervention and the assessment of feasibility of a larger study. The process of analysis was carried with both aims in mind and simultaneously. In practice, a separate category for the assessment of feasibility was created where any suitable pieces of information could have been placed.

Results

All five participants completed the full course of treatment, with an overall attendance rate of 87%. Also, all attended the initial, final and follow-up interviews in person and completed the set of questionnaires, with an exemption of one case when a participant missed her/his follow-up interview but agreed to communicate via email.

Assessment of changes in depressive symptoms: Outcomes from questionnaires

Scores for each questionnaire completed by the participants were compared to identify any changes. Table 1 lists the hypotheses and the results of testing. Figures 1, 2 and

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

Assessment of changes in depression levels (PHQ-9)

Statistically significant differences between the initial and the final, as well as the initial and the interim scores (both p=.042) in PHQ-9 suggest that the level of severity of participants' depression decreased after the course of art therapy. The decrease in depression levels remained equally significant (p=.043) in the follow-up assessment (as compared to the initial scores). For all participants the final and follow-up PHQ-9 scores were lower than the initial measurement. In addition, two of the participants, whose depression was initially relatively mild, did not present symptoms of depression in their final and follow-up assessments (score lower than 5).

A general trend towards a decrease in depression levels may be observed in participants' individual scores. The effect seems to be more linear for those participants whose depression was initially mild (P4 and P5), more complex for the participants with initially moderate depression (P2 and P3) and less obvious for the participant, whose depression was initially more severe. [Figure 1 around here]

Assessment of changes in anxiety levels (GAD-7)

No statistically significant difference was found between the initial, final and follow-up scores in GAD-7. The results were mixed for different participants, with three members of the group showing a decrease and two members an increase in anxiety levels at the end of the therapy. Both participants, whose anxiety increased during the project, showed a

slight decrease of depression levels. In the follow-up assessment, four participants revealed lower levels of anxiety in comparison with measurements pre-therapy, while one participant scored higher than in the initial assessment. *[Figure 2 around here]*

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

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

Summary of results

A statistically significant decrease in depression levels, assessed using a relevant questionnaire, was noted immediately after the treatment and in the 11 weeks follow-up in all five participants attending a brief group art therapy. Improvement in perceived wellbeing was noted by four participants immediately after the therapy and in the 11 weeks follow-up, although the effect was not statistically significant. No significant effect of therapy on the levels of anxiety was noted, while it increased for some participants and decreased for others.

Themes from initial, final and follow-up interviews: Brief summary

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

Initial interviews

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

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

and lightness in their lives and have meaningful and satisfying relationships with other people.

The interviews offered a further understanding of the usual coping strategies and resources available to participants. Most realised that involvement in satisfying activities throughout the day helped relieve their depression but they often found it difficult to engage due to low motivation. Social and family support was limited for most participants and they often mentioned family disputes or a lack of understanding from relatives as the factors contributing to their depression. At least three participants recognised altered thinking patterns when depressed, involving persistent negative thoughts and focusing on themselves. Simple coping mechanisms like repression were used and it was noted that directing the thought process on other people was helpful.

All participants had received some sort of professional mental health support at certain points in the past (support from GPs and psychiatrists, often antidepressants), and all had some experience of talking therapies, including CBT, CAT and counselling – all with varying effects. None of the participants had had experience of arts therapies before the project.

The participants expected their art therapy sessions to be challenging and a hard work, as well as a learning experience and an opportunity to relax, while "not talking but doing". They hoped that it would offer an outlet for emotions as well as new insights and rediscoveries. Although specific expectations seemed to have been present, some participants spoke about their uncertainty mostly and avoided admitting expectations.

Final interviews

In their final interviews, most participants felt that the reality of therapy was different to what they had expected. However, the analysis of comments in the final interviews showed that some or most of the initial expectations were met. The participants described their experience of art therapy as valuable, interesting and challenging and shared what they liked and disliked in the process. Feelings of achievement and relief were also mentioned. Some aspects of the therapy (like being in a group and self expression) had both pejorative and positive connotations.

Certain moments in therapy were identified by the participants as carrying more meaning than others. These significant, best remembered moments in therapy concerned either times when a particular personal insight was gained (e.g. rediscovered aspects of self, increased knowledge of self) or a connection or meaningful exchange between the group members occurred (typically triggered by engagement in discussion after art making). Often the most memorable moments indicated times when progress in therapy was made.

The outcomes of the therapy in most cases were not immediately obvious to the participants and they reported uncertainty of the treatment effects and doubts whether the therapy had been helpful. However, further responses revealed diverse areas in which changes were acknowledged by the participants. Among these were: increased awareness and appreciation of others; increased self awareness / knowledge of self / realisation of own needs; a sense of achievement; willingness and readiness to further explore own creativity outside of therapy sessions; friendship born within the group; increase of anxiety; and improvement in physical symptoms (better sleep, less headaches).

Certain themes were common and seemed most significant in participants' evaluation of the process of their therapy and these were named by the researcher as:

"being in a group", "challenges of therapy", "depression as elephant" and "meaning of therapy".

Participation in the therapy was considered challenging by the participants. Being and working in a group seemed to have been the most remembered and valued and simultaneously the most distressing and unwanted experience in the therapy. For most participants it was difficult to make art in front of others and to share feelings in the discussion at the end of sessions. Therefore being in a group was identified as one of the biggest challenges the participants experienced alongside the difficulties with self-expression and spontaneous creativity (i.e. difficulties with being spontaneous in using art materials and deciding on the content of an artwork).

One participant recognised that the subject of depression often remained "an elephant in the room" and others admitted that they were often anxious or not comfortable with bringing it up for discussion in fear that this would cause distress in the group, although they shared the willingness to explore the nature of depression further. The paradox of the need for deeper exploration of the subject combined with anxiety and the apprehensiveness of sharing painful experiences with others was apparent.

Finally, most participants were inclined to reflect on the process of therapy and recognised that the therapy was meaningful to them although were often unable to precisely locate the meaning in context. Potential ability of the art therapy to enhance creativity and motivation was considered especially relevant to depression. The areas which triggered new insights concerned openness towards others and their problems, new ideas about the essence of creativity and spontaneity and reflections on the expression and awareness of emotions.

Follow-up interviews

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

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

Discussion

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

RCT-based research seem to support the tendency to shorten the total time of treatment, while intensifying it by providing therapeutic sessions more often than once a week (Castillo-Perez et al., 2010; Erkkila et al., 2011). A similar approach was adopted in this study, but the findings seem to indicate that a longer treatment might be preferred by participants and potentially lead to more consistent outcomes.

All five participants completed the full course of treatment and attended interviews at three points in time. Willingness to accept the offered therapy and compliance with treatment may be explained by autonomous motivation, which is among the factors contributing to the success of psychotherapeutic interventions (Zuroff et al., 2007). The fact that the participants needed to take initiative to sign up for their therapy seemed to have explained their heightened motivation to complete the treatment and the willingness to engage in the challenging aspects of the process, as reported by the participants and observed by the researcher. Although a detailed feasibility assessment is not a subject of the current report, it is worth mentioning that the brief recruitment of just over two weeks and in a local area only resulted in interest exceeding expectation and the researcher was in fact contacted by volunteers willing to participate beyond the timeframe of this project. This indicates the attractiveness of art therapy for adults who experience depression and has clear implications for a potential larger trial. With sufficient time given for reflection and making a decision to consider this form of therapy, participants are likely to complete the full course of treatment.

Although the sample was too small to allow for generalisation, a statistically significant tendency of depression scores to lower following the therapy was observed. Similar results were obtained from a number of arts therapies studies (Erkkilä et al., 2011; Jeong et al., 2005; Thyme et al., 2007). While the current study did not include a control

group, it may not be concluded with certainty whether this effect occurred as an implication to the therapy or whether it was due to other reasons, including a possible spontaneous recovery from depression (Ankarberg & Falkenström, 2008).

The results concerning anxiety and wellbeing were inconclusive, while no statistically significant differences were found between the pre and post therapy scores. The lack of confirmation of an impact of the therapy on these factors does not, however, equal an absence of such influence. In the follow-up an improvement of subjective wellbeing levels was noted in the scores of four out of five participants. The positive impact of arts therapies on general wellbeing has been widely recognised (Karkou & Sanderson, 2006) but, to the authors' knowledge, has not yet been documented in the treatment of depression.

In the current study a decrease of anxiety levels was noted in the scores of three out of five participants while two participants experienced an increase of anxiety. This may potentially be a temporary effect of the therapy, which might have been too brief to adequately support participants who may need longer time for benefiting from the treatment. Supposing that the course of the therapy was too short to offer substantial improvement, it is possible that the therapy ended when some of the participants were experiencing increased anxiety, a "spike" (Hayes at al., 2007) often expected in the middle of the treatment. A longer therapy would potentially allow to address those anxieties. Alternatively, the effect may be an example of a common in psychotherapy phenomenon that an approaching end of the treatment itself, regardless its duration, causes an increase of anxiety, when facing the reality outside of the therapy room becomes inevitable.

Interviews with the participants indicate that in the current study the increase of anxiety should perhaps be considered alongside the need for meaningful connections and

relationships. While 'being in a group' was valued by the participants, it presented challenges and was met with growing anxieties. More in-depth analysis of this and other themes emerging from this project will be presented elsewhere.

Limitations

The main limitation of this study was the lack of a control group potentially enabling comparison and conclusions regarding efficacy. A short timeframe, additionally limited by the lengthy process of obtaining necessary ethical approvals meant that a pilot trial could not be attempted. However, the assessment of effectiveness or results of a statistical significance were not among the aims, as were not achievable within the set boundaries of time, budget and expertise. Instead, all efforts were made to ensure that a sound basis for further research was created and trends rather than effects were observed. Assessment of feasibility of a larger study was considered very seriously and the project followed the procedure of a pretest, posttest and follow-up study as rigorously as was possible, given the limitations of resources.

If the study was to be conducted with the participation of patients using NHS services for their mental health condition, participants with co-morbid mental health diagnoses could be easily excluded to ensure better control of variables. In this study the participants' formal diagnoses could not be confirmed, as they were recruited directly from the community. This 'real life' research, however, accepted that the participants were recruited based on what they disclosed and a simple clinical assessment during the initial interview with the researcher.

Other limitations to this study included: a lack of formal recruitment of a therapist and a lack of opportunities for potential participants to enrol in the project using communication channels other than e-mail.

Conclusions

In this study a brief art therapy group for adults suffering from mild to moderate depression was evaluated based on treatment outcomes and participant experience. It may be concluded that a brief group art therapy may be a safe, acceptable and valuable intervention for adults suffering from depression. While it remains unclear whether the particular intervention was effective, it was received well by the participants and may potentially allow for a number of benefits, including a decrease in the symptoms of depression and an improvement in the subjectively perceived wellbeing. Although no certain conclusions may be drawn as to whether the art therapy or other factors were responsible for the changes observed in this study, a trend was recorded for the depression scores to lower immediately after the therapy and remain on similar or even lower levels during the follow-up assessment. The statistically significant results as well as participants' feedback regarding their therapy are promising and open an area for further research exploration.

Areas of psychological wellbeing which may potentially be enhanced through arts therapies include an increase of: acceptance of depression and its challenges, creativity and readiness to express emotions, sense of self and awareness of others, readiness for meaningful communication and relationships. Additionally, arts therapies may potentially bring a sense of achievement, a sense of balance and new insights and may facilitate growth

and finding meaning for adults suffering from depression. However, arts therapies practice with depression is demanding and brings challenges to both the therapists and the clients. It is thus important that the therapists understand the concepts core to depression and likely to play a vital role in the therapy process, e.g. time, layers of symptoms covering the main problem, the feeling of being trapped, the need for hope and relaxation to relieve initial tension (Zubala et al., 2014b).

It needs to be noted that these conclusions should be placed within the context of this particular brief group art therapy intervention only and do not claim to offer an evaluation of arts therapies practice in general. However, by proposing and successfully implementing a creative research design while providing promising findings, this pilot study has offered a background for further larger scale research, extended in size and scope in the future.

It is recommended that controlled studies are undertaken to evaluate arts therapies for depression. These should adopt suitable creative research designs and focus on the process as well as the outcomes to offer findings meaningful to academic and clinical populations, and to the depression sufferers themselves. Evaluating treatment outcomes as well as participant experience of the therapy is crucial for a comprehensive assessment of arts therapies' potential to address depression. Therefore, further similar pilot studies are much needed in other arts therapies disciplines. Well conducted and creative projects could eventually lead to comprehensive large scale evaluations, establishing the unique role that arts therapies might play in a global challenge to tackle depression.

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Table

Null Hypothesis	Sig.	Decision
The median of differences between **PHQ9initial** and **PHQ9final** equals 0.	.042*	Reject the NH
The median of differences between **PHQ9initial** and **PHQ9interim** equals 0.	.042*	Reject the NH
The median of differences between **PHQ9interim** and **PHQ9final** equals 0.	.279	Retain the NH
The median of differences between **PHQ9initial** and **PHQ9follow-up** equals 0.	.043*	Reject the NH
The median of differences between **GAD7initial** and **GAD7final** equals 0.	.492	Retain the NH
The median of differences between **GAD7initial** and **GAD7follow-up** equals 0.	.197	Retain the NH
The median of differences between **WHO5initial** and **WHO5final** equals 0.	.223	Retain the NH
The median of differences between **WHO5initial** and **WHO5follow-up** equals 0.	.068	Retain the NH

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

Figures

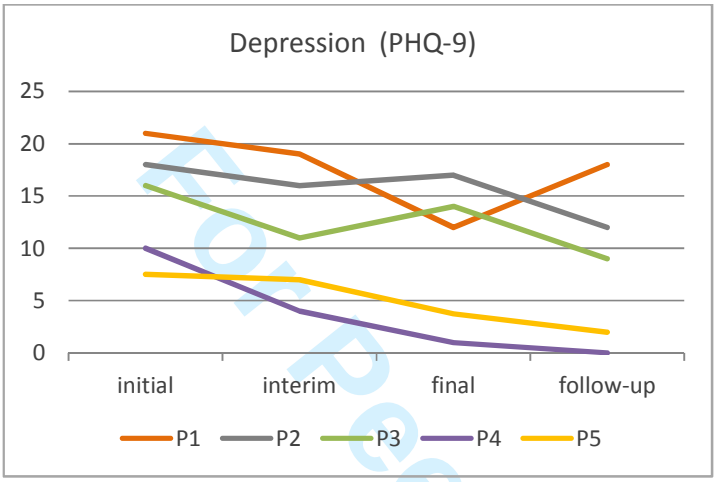

Figure 1: Individual scores on PHQ-9 measured in four points in time: pre therapy ('initial'), during therapy ('interim'), post therapy ('final') and in follow-up (follow-up). ('P' indicates individual participants.)

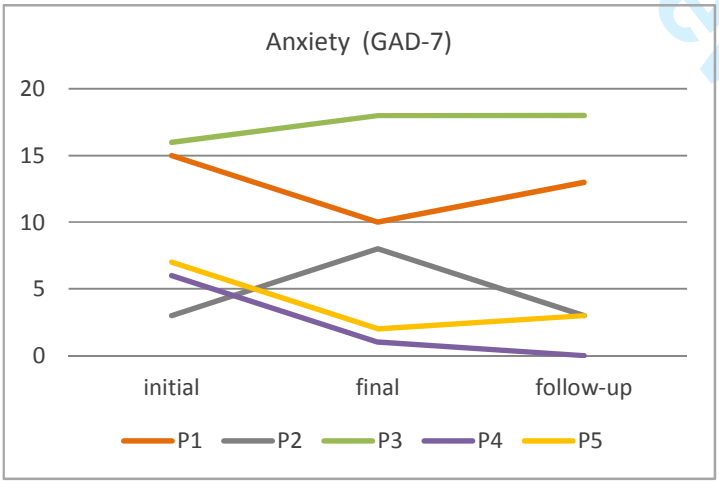

Figure 2: Individual scores on GAD-7 measured in three points in time: pre therapy ('initial'), post therapy ('final') and in follow-up ('follow-up'). ('P' indicate individual participants.)

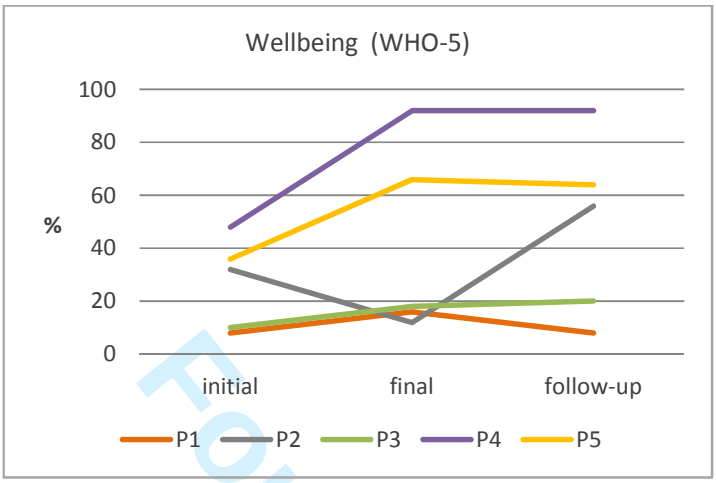

Figure 3: Individual scores on WHO-5 measured in three points in time: pre therapy ('initial'), post therapy ('final') and in follow-up ('follow-up'). ('P' indicate individual participants.)