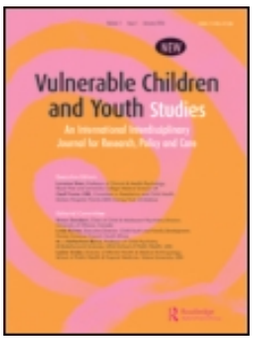

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Review of arts-based therapies for Canadian youth with lived experience of mental illness

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Canadian youth can experience a range of mental health problems and mental illness, many of which perpetuate into adulthood. In contrast with preventative and medical care for physical problems, youth who experience difficulties with mental health or illness meet restricted access to evaluation, diagnostic and treatment services. Obstacles vary from low funding levels for services to the fear of being stigmatised by society. Conventional therapies could be complemented by the use of arts-based therapies, which are reported to offer a tangible alternative and could relieve delays in treatment. However, research regarding the treatment options, monitoring and assessment of outcomes is based largely on narrative evidence or idiographic studies, thus constraining the dissemination of supporting evidence and limiting the range of treatments for use by practitioners. While arts-based therapies receive support from many areas, including people with lived experience of mental health problems and illness, it is argued that the development of a theoretical foundation and extensive empirical research are required to develop the potential that arts-based therapies have to offer.

Keywords: arts-based therapy; youth mental health; review

Introduction

Throughout the childhood and adolescence of most youth, preventative and remedial care is available to promote healthy development. Ideally, this should also contribute towards mental health, but in reality, youth can be subject to various mental health problems. Around 70% of mental illnesses are estimated to originate during childhood and adolescence (Mental Health Commission of Canada, 2009; World Health Organization [WHO], 2003). These include conditions such as disorders of attachment, anxiety and compulsion; eating disorders; phobias; depression; suicide; schizophrenia; bipolar disorder; stress; and post-traumatic stress disorder. Drug and substance abuse are sometimes seen as a cause but can also manifest as self-medication by those with mental health problems (Audrain-McGovern, Rodriguez, & Kassel, 2009; Lorberg, Wilens, Martelon, Wong, & Parcell, 2010; Tomlinson & Brown, 2012; WHO, 2003*)*. The human cost is sobering. Mental illness represents the second highest expenditure in hospital care in Canada, while suicide is the leading cause of non-accidental death for youth between 15 and 24 years (Canadian Mental Health Association [CMHA], 2009).

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Mental health has been defined as a state whereby people are able to succeed in the challenges of life at the full level of their capability (WHO, 2007). In Ontario, Canada, approximately 15–21% of children and youth will experience some form of mental illness (Ontario Ministry of Children and Youth Services, 2006), described as a clinical level of behaviours and emotions which bring distress or problems in typical functioning (Canadian Psychiatric Association [CPA], 2010). Across Canada, approximately 3.2 million youth between 12 and 19 years are at risk of developing depression, while 5% of male and 12% of female youth have experienced episodes of major depression (CMHA, 2009). This reflects WHO data using the total proportion of disability-adjusted life years (DALYs) (Sassi, 2006) which report that youth under 19 years represent over a quarter of the DALYs taken up by mental illness. This compares with around 6% of DALYs for youth from causes such as cancer and heart disease (WHO, 2003).

While these figures are serious, it is in relation to identification, assessment, diagnosis and treatment that the significance of the problem becomes clear. Only 25% of youth who require specialised mental health services receive them (Waddell, McEwan, Shepherd, Offord, & Hua, 2005). Barriers to care come from two main sources. The first is fear of stigmatisation (CMHA, 2009; WHO, 2003), so that seeking medical attention can be delayed by one-two years (Fraser, 2008); and only 50% of Canadians would reveal a relative's mental illness to colleagues (CMHA, 2009). The second is difficulty accessing suitable mental health services. Adolescents report a lack of youth-friendly programmes (Davidson & Manion, 1996; Youth Net/Réseau Ado, n.d.), while low funding means that 5.5% of the health-care budget covers illnesses that affect 15% of the population (CMHA, 2009). Agreement by First Ministers in 2005 to establish wait time targets for physical problems omitted services for youth with lived experience of mental illness[1] (Canadian Paediatric Society, 2006). In 2009, Health Canada outlined the benefits of a national wait time strategy, recommending this be accomplished within the following year.

Decisions regarding treatment for youth mental health problems can be challenging as conventional approaches include a range of counselling and therapeutic approaches and/or medications (Chorpita & Daleiden, 2009; WHO, 2003). A long-standing, but less typical, option exists as a separate area of treatment: creative and expressive arts-based therapies, including music, drama, dance and visual arts. There is evidence that both approaches offer potentially positive outcomes (e.g. Chorpita & Daleiden, 2009; Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007), but they rarely intersect. Conventional approaches have developed from theoretical bases and empirical testing. In contrast, creative arts-based therapies have not been sustained by a theoretical foundation or subjected to rigorous trials (Gussak, 2009; Huss, 2009).

At present, the customary use of conventional approaches may, through the omission of creative arts-based therapies, limit the potential for optimal and timely treatment outcomes. To find a place among conventional treatments, arts-based therapies need to be shown to be developmentally appropriate, predictable, efficacious, cost-effective and replicable. Reaching that standard involves extensive research and requires communication between two separate cultures: arts and science. It is the goal of this article to recommend that the arts side of this balance be as thoroughly explored and evaluated as the science side in order to ascertain the optimum contribution of both approaches.

Arts therapy and therapists

Distinguishing characteristics of arts-based therapies

Arts-based approaches convey characteristics that can create distinct therapeutic opportunities. For youth who experience difficulty verbalising their mental health problems,

arts-based therapies can facilitate unique communication, acknowledging the subjective nature of their experiences (Fraser, 2008; Lyshak-Stelzer et al., 2007). It is within the venue of the artistic journey that expression and possible resolution are gained as arts-based therapies focus on the creative process, rather than on any finished piece of art (Moon, 1999). This process, in conjunction with the physical and emotional dimensions of arts experiences, allows individuals to express themselves, unblock emotions through displacement, for example, and circumvent the need for verbal representations.

Engagement in the artistic process can overcome stigmas and resistance to therapy, especially when the art form is relevant to the lives of youth and reflects their preferences (Alvarez, 2012; Emunah, 1985; Keen, 2008; Lightstone, 2012). This is particularly appropriate for youth who may not possess the vocabulary for their situation and can supersede the rapport found with therapists in conventional settings (Leafloor, 2012; Lyshak-Stelzer et al., 2007).

Similarly, group settings for arts-based therapies can extend therapeutic relationships when creative and interpretive processes are shared. The dynamics of the group regarding support, self-regulation and co-operation can provide additional value to the therapeutic process, with art activities used to initiate the start, navigate the process and mark the completion of group participation (Johns & Karterud, 2004; Wadeson, 2006). Changes due to new arrivals or discharges can alter the therapeutic setting (Lyshak-Stelzer et al., 2007) and may require individuals or groups to adjust their responses or stimulate additional self-reflection. In addition, the accessibility of arts activities facilitates youth in steering the direction of therapy, promoting a sense of empowerment and responding to adolescents' preference to share problems with peers (Davidson, Manion, Davidson, & Brandon, 2006; Emunah, 1985; Leafloor, 2012; Lightstone, 2012).

Although there is diversity within arts therapy contexts, the approach is unified by the belief that the interactions between therapist and person with lived experience are the crucial components of the healing process (Association des art-thérapeutes du Québec [AATQ], 2007; Australian and New Zealand Art Therapy Association [ANZATA], 2009). Furthermore, arts-based therapies reflect Goal One of the recent Mental Health Commission of Canada (2009, p. 6) report, to involve people with lived experience throughout treatment, supporting self-determination and self-reflection during therapy.

Effectiveness of arts-based therapies

Behaviours and conditions that precipitate participation in arts-based therapy programmes include disruptive and aggressive conduct, bipolar and associated conditions and post-traumatic stress disorder (Fliegel, 2005; Lyshak-Stelzer et al., 2007; Wadeson, 2006). Given the range of research topics to date, it can be problematic to draw overall conclusions about the effectiveness of arts-based therapies (Harden, Rosales, & Greenfield, 2004; Reynolds, Nabors, & Quinlan, 2000). Nonetheless, all the studies used in this article, whether assessed empirically or through narrative, reported successful outcomes in one or more settings (Fliegel, 2005; Lyshak-Stelzer et al., 2007). Positive results included mitigating the frequency and severity of clinical symptoms (Saunders & Saunders, 2000); improvements in social and cognitive functioning (Fliegel, 2005; Wadeson, 2006); and greater personal insight and meaning through the exploration of disruptive emotions (Frankl, 1967; Johnson, 1984; Moon, 1999).

Arts-based therapies have been reported to be the therapeutic preference of people with lived experience, with dance therapy, for example, evoking great joy and instilling meaning into their lives (Fliegel, 2005; Fraser, 2008). Participation in an art therapy group provided

opportunities to express difficult emotions within a collectively creative setting, as well as establishing hope and reducing fears of future traumatic feelings and stigmatisation (Johns & Karterud, 2004; Snow, D'Amico, & Tanguay, 2003). Research with adults in psychiatric hospitals found higher ratings for music therapy compared with other arts-based therapies, while all arts-based therapies combined were preferred to other therapeutic methods (Heany, 1992).

Arts therapists

The above factors underlie the belief that services should be delivered by qualified therapists who are also artists (Johns & Karterud, 2004; Moon, 1999), although arts-based therapies have been delivered in a multidisciplinary context (Harden et al., 2004). To reject this connection would negate the therapeutic aspects of the process and mute the language of artistic and psychological reflections between artists, that is, the therapist and the person with lived experience (Robbins, 1988). Therapists may also use their own artistic skills unilaterally to encourage the person with lived experience to approach his/her problems, thereby establishing a shared context for expression and exploration (Emunah, 1985; Moon, 1999).

Arts therapy training generally consists of postgraduate level courses, although entry requirements and eventual qualification vary. Although a background in the arts is desirable, social work, psychology, sociology or education is also acceptable (ANZATA, 2009; National Health Service [NHS], 2006). The final qualification is typically a Master's degree in the arts therapy field or a Master of Arts or Diploma in counselling with arts therapy as a specialisation.

Professional associations

As arts therapies for mental health problems and mental illness have grown in availability and diversity, associations have been created to uphold professional aims and standards. The Canadian Art Therapy Association (CATA), for example, was founded in 1977 and the Association des art-thérapeutes du Québec in 1981. Internationally, associations also advocate for and support the profession (e.g. Association for Dance Movement Psychotherapy UK [ADMTUK], 2003; Music Therapy New Zealand [MThNZ], 2011; National Association for Poetry Therapy [NAPT], 2008; National Coalition of Creative Arts Therapies Associations [NCCATA], n.d.). Such organisations offer assessment, evaluation and reporting tools (e.g. American Art Therapy Association [AATA], 2010); disseminate research through journals and conferences; provide career information and scholarships; and establish professional standards (CATA, n.d.; MThNZ, 2011).

Arts-based therapies and research

Arts-based therapy programmes have developed from diverse organisational structures, as well as a variety of therapeutic needs, philosophies and methodologies. Despite a steady contribution of reports and qualitative studies (e.g. Chilton & Alexandria, 2007; Mazloomian & Moon, 2007; Newell-Walker, 2002), the wide range of settings and methods have made evaluation of their appropriateness and efficacy challenging. While much of the literature records successful interventions, there is an absence of both an underlying theoretical foundation and the rigorous demands of empirical tests seen within conventional

research into the treatment of mental illness (Burleigh & Beutler, 1997; Eaton, Doherty, & Widrick, 2007).

Development of a theoretical base

Establishing theoretical bases is challenging given the variety of mental health problems and the diversity of arts-based therapies and therapeutic situations. Arts therapists view ephemeral arts-based interactions as the essence of the healing process and question whether the holistic value would be preserved if it was described within a theoretical framework (Burleigh & Beutler, 1997). However, this area is now beginning to develop (Huss, 2009).

Therapists have used interactive approaches to support people with lived experience to find meaning in their lives through individual choice and reflection, for example, logotherapy (Frankl, 1967; Hirsch, 1991; Makola & Van den Berg, 2009), and to increase reward from the contextual environment, for example, behavioural activation (Ritschel, Ramirez, Jones, & Craighead, 2011; Sturmey, 2009). Huss (2009) outlined a multilayered approach similar to Bronfenbrenner's (1979) ecological development model. From the centre, the first of several levels is *dynamic*, where art therapy expresses the subjective space of the person with lived experience, constructed with the therapist. The *humanistic level* involves reflection and insight, guided by the therapist. The *systemic level* represents changes within relationships and roles, using art as the process which supports this change. Finally, the *social level* uses art to influence society's structures and to support minorities, especially those who experience mental health problems. The theory is sufficiently flexible for its elements to be used in series or as an interrelated grid (Huss, 2009). Such theories herald future studies and provide a foundation from which to construct treatments.

Methodological challenges for arts-based therapy research

While research into arts-based therapies is increasing, there are limited numbers of published studies (Burleigh & Beutler, 1997; Frisch, Franko, & Herzog, 2006; Lyshak-Stelzer et al., 2007; Saunders & Saunders, 2000). As arts therapy training concentrates on narrative research studies, trainees are less familiar with the scientific research process (Rosal, 1989), although many arts therapy associations consider research to be part of their mandate (e.g. CATA, n.d.; MThNZ, 2011). Additionally, art therapies pertaining to youth form a specialised area, and research information may have to be gleaned from empirical studies and meta-analyses using adult (Heany, 1992; Johns & Karterud, 2004; Reynolds et al., 2000) or mixed-age samples (Ritter & Low, 1996; Saunders & Saunders, 2000). Samples can also vary to include clinical or non-clinical populations in hospitalised or incarcerated settings (Gussak, 2009; Lyshak-Stelzer et al., 2007; Reynolds et al., 2000). Reports have included narrative accounts, idiographic studies, descriptions of programmes (Burleigh & Beutler, 1997; Fliegel, 2005) and guidelines for operating therapeutic programmes (Johns & Karterud, 2004).

Furthermore, the criteria for assigning people experiencing mental health problems to treatment programmes are seldom described and can be led by individual preference (Fliegel, 2005) or occur by default (Wadeson, 2006). Such processes offer little guidance regarding the selection of the most appropriate therapy for specific problems, personality types, gender or age groups. Reliable measurement for assessment of the individual receiving therapy and interactions with the therapist present further complications. For example, reliability testing on projective assessment tools such as the Draw a Story test for

youth at risk of aggression or depression used interrater reliability (Silver, 2008), but not Cronbach's α, a standard in quantitative research (Gliner, Morgan, & Leech, 2009, p. 159). Small heterogeneous samples further challenge the generalisability of research findings which reflect the unique circumstances and needs of people with lived experience (Fraser, 2008; Hazleton, 2008).

Dissemination of research findings

Information and findings regarding arts-based therapies are disseminated through journals, papers and Internet articles; however, mainstream research publications may not take contributions from this area into account. For example, the WHO (2003) publication, *Caring for children and adolescents with mental disorders: Setting WHO directions*, outlines a range of therapeutic approaches, but does not include arts-based therapies, possibly because they are not evidence based. Reviews of treatment options and efficacies also overlook such therapy options (Chorpita & Daleiden, 2009). This is unfortunate in several regards as it may narrow the apparent range of options available to practitioners and therapists; perpetuate the isolation of conventional and arts-based therapies; overlook the reported beneficial effects of arts-based therapies; and potentially constrain the opportunities for future development of therapeutic knowledge, practice and experience across the various fields of arts-based therapy.

Performances and exhibitions can be used to increase awareness of therapeutic experiences in conjunction with the goals of advocacy and reducing stigma (Fraser, 2008; Lamb, 2009). Although this may reach a diverse audience, it may also be smaller than via the academic journal route. Additionally, this mode of dissemination highlights the problem of publicising the benefits of arts-based therapies while ensuring that the conclusions are able to withstand empirical testing.

Research stakeholders

While accounts of the success of arts therapy are available to practitioners, researchers, policymakers and those with lived experience of mental illness, the utility of this information may be limited. Although all stakeholders intend to address the same problem, various disciplines entertain different goals for research findings (Shonkoff, 2000; Small, 2005). Researchers seek to accumulate knowledge by testing theory-based hypotheses. Practitioners need pragmatic information, including considerations of benefit and risk for use in the therapeutic setting. In contrast, policymakers need to balance specific agendas with societal demands while respecting budgetary limits and public reaction to chosen directions (Shonkoff, 2000).

Discussion

The current situation for the treatment of mental health problems presents practitioners of arts-based therapies with a conundrum. While such therapies offer alternative or complementary treatments, they operate outside mainstream approaches. This is partly due to the diversity of philosophies, practices and practitioners within the two fields. Although direct comparisons might not be appropriate, as the two approaches may be equally valid or complementary, arts-based therapies research needs to match conventional mental health research in theoretical foundations, methodology and evaluation (Armstrong, 2009; Mueller, Alie, Jonas, Brown, & Sherr, 2011). The disparity in quantifiable evidence makes

policy decisions challenging. However, recent studies demonstrate that empirical assessment of art therapies is possible (see Lyshak-Stelzer et al., 2007; Mueller et al., 2011). Wider issues also exist encompassing the training and qualification of practitioners, the criteria for therapy selection and the assessment of outcomes.

Conclusion

The findings of this review indicate an urgent need for extensive research into the potential benefits of arts-based therapies as an effective treatment method. Equally important is the need to expand youth-friendly services for all youth with mental health issues. Arts-based and conventional therapies need to work together, as well as with youth, in the best interests of each young person. However, without rigorous research and the dissemination of peer-reviewed studies, arts-based therapies are unlikely to acquire the credentials to stand alongside conventional treatment options, nor will deeper understandings of the approach be refined. In addition to establishing the potential benefits of arts-based therapies, those who have mental health issues may well be better served through access to a wider range of treatment options of assured quality.

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Note

1. In order to reflect the range of individual circumstances that are involved within the therapeutic setting, the terms "patient" and "client" have been avoided in favour of "people", "youth", "individuals", "people with lived experience" and "youth with mental health problems or illness". Although it is recognised that this terminology may be at odds with that currently used in applied and clinical settings, it more closely reflects the general goals and spirit of the Mental Health Commission of Canada (2009) report, *Toward recovery and well-being: A framework for a mental health strategy for Canada.*

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