

# Art as therapy: an effective way of promoting positive mental health?

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The aim of this study is to evaluate the contribution that creative arts can play in promoting positive mental health and well-being. The research is based on a case study of an innovative art therapy programme delivered by a community-based mental health organisation in Northern Ireland, as part of a supported recovery programme. The study reported here explored the experiences and perceptions of the service users through in-depth interviews and focus groups. The art as therapy course was credited with improvements in self-esteem and self-confidence. It provided a safe space for reflection on mental health issues. Participants described the programme as cathartic and a springboard for engagement in a wide range of further projects. It is concluded that this type of project which addresses mental health issues in a supportive, positive, non-clinical environment can encourage and facilitate empowerment and recovery through accessible creative programmes. However, to date these programmes are time-limited, small-scale and marginal to the approach adopted by statutory service providers.

## Introduction

There is considerable research evidence that highlights the effects that stigma and social exclusion can have on individuals and families who are affected by mental health and emotional difficulties (James, 1998; Porter, 1998; Byrne, 1999). People with mental health problems remain amongst the most socially excluded groups in the UK (Batty, 2001). In the UK mental health difficulties cost the nation more to care and treat and cause more suffering and disability than any other type of disorder. Yet, despite this, levels of understanding about mental health and emotional difficulties have remained low. Myths and stereotypes prevail and these have led to the disempowerment and stigmatisation of those who experience mental distress. The label mental illness is stigmatising and misleading as it encourages individuals to think of 'the mentally ill' as a separate category from 'normal people'. There is no universal

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definition of mental health, the subject is highly controversial and perceptions vary across cultures.

In the field of mental health, as in many other areas of disability, there is a tendency to consider problems as simply an issue of diagnosis and treatment. In this medical model, recovery is considered to be a reduction in symptoms and a reduced need for medical and social care services. Williams and Heslop (2005) suggest that the dominance of this medical model is largely because psychiatry, as a branch of medicine, has been the principle influence in policy and practice. However, for mental health issues, this model is extremely limited. It does not adequately address the interaction of social factors with biological ones in the construction of health and disease. Additionally, it tends to treat people with mental illness as passive recipients of services and treatments who need to be cured. People become patients, stigma proliferates, large sums are spent, treatments may be poisonous and worst of all people may be diverted from what may be much better ways to adjust to their problems (Smith, 2002). Critics of the medical model claim that judgements are value-laden and influenced by ideologies, political doctrines, traditions, cultural practices and prevailing discourses. Increasingly, there is a recognition that approaches based on the social model of mental distress which emphasise empowerment and capacity building can offer new ways of understanding mental health needs and promote recovery (Beresford, 2002). Within this model the value base is considered equally as important as the knowledge base. It is based on an understanding of the complex nature of human health and well-being and values the experiences and expertise of service users (Duggan *et al.*, 2002). The focus is on needs rather than classifications, diagnosis or labelling.

### **Mental health in Northern Ireland**

Northern Ireland is recognised as having the highest levels of social and health inequalities in the UK (Campbell, 1993; Haycock & Henscher, 1995; Moore *et al.*, 1996). The historical impact of poverty, unemployment, poor housing and more than 30 years of the political conflict known as 'the Troubles' has taken its toll on the mental health of the population in Northern Ireland. The prolonged period of civil unrest and sectarian violence has claimed over 3500 lives and has had a devastating effect on the psyche of Northern Ireland (Fay *et al.*, 1999). A recent report on mental health claimed that people in Northern Ireland felt traumatised by the Troubles and did not feel free to talk about their experiences. This report suggested that people wanted to discuss the effects of years of civil unrest but were frightened of the consequences. It was claimed that the old adage 'loose talk costs lives' predominated on the streets. Despite the ceasefires, people here still do not feel safe. Whilst at a political level there was a peace process, on the ground there is still a war psychology (Kapur & Campbell, 2002).

Additionally, the finding that in Northern Ireland the prescription of tranquillisers is 75% higher and that of antidepressants 37% higher than in England, and that overall mental health needs were 25% higher than in the rest of the UK, supports the view

that people in Northern Ireland have been traumatised by civil unrest and sectarianism (DHSSPS, 2001). A large-scale study on the effects of civil unrest found that mental health problems were linked to how much the Troubles had affected people's lives or their local area. It noted that mental health problems occurred more frequently among people living in less affluent areas, people with poor general health and amongst Catholics. The report concluded that a cessation of violence would not be enough to address the legacy of violence and intimidation and an active process of reconciliation was required to promote social inclusion and cohesion (O'Reilly & Stevenson, 2003).

Similarly, research by the Northern Ireland Association for Mental Health noted that one in four people in Northern Ireland will develop mental health problems in their lifetime, a figure significantly higher than anywhere else in the UK. The study found that between 30% and 40% of all sickness absence was due to some form of mental or emotional disturbance (NIAMH, 2003). In July 2003, the Royal College of Nursing highlighted the fact that mental health services in Northern Ireland were traditionally under-funded and limited due to years of political disinterest in mental health issues. They noted the need for increased therapeutic care and claimed that policy could not be discussed without reference to wider issues of rationing and a lack of round-the-clock service provision (RCN, 2003).

Mental health in-patient provision in Northern Ireland has been significantly higher than in England, which may reflect the lack of alternative provision, deficiencies in previous and current strategies and a longstanding lack of investment (NIMHLDR, 2005). The Northern Ireland Association for Mental Health claimed that mental health services had experienced chronic under-funding and, as a result, there was a severe lack of provision. Despite the government's commitment to care in the community there was a shortfall in appropriate services (NIAMH, 2003). Poor mental health places a huge burden on individuals, on families and society. It is also costly in financial terms. It has been estimated that the social and economic costs of mental disorder in Northern Ireland are more than the total spend on all health and social care for all health conditions (Sainsbury Centre for Mental Health, 2003).

In October 2002, the Northern Ireland Department of Health Social Services and Personal Security (DHSSPS) initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. This review is designed to address how best to provide services to people with specific mental health needs and to highlight methods that promote positive mental health in society. In its report on adult mental health, the commission noted that the civil conflict in Northern Ireland had cast a long shadow on the mental health of the community. It suggested that in a large proportion of cases needs were not met because people were reluctant to engage with existing services as they were not considered accessible or user-friendly (NIMHLDR, 2005).

### **Health promotion through the arts**

The Arts Therapies including Art, Dance, Music and Drama Therapy have their origins in early 20th-century psychiatry and its discovery of the unconscious. Much

of the existing research on art-based interventions has focused on the psychotherapeutically orientated forms of art therapy, where art therapy is associated with Freudian analysis and verbal psychotherapy (Naumburg, 1996). However, in the past 20 years there has been increasing interest in arts for health initiatives, where engagement in the creative process *per se* is seen to have therapeutic value. The importance of creative expression to healthy human development and recovery from mental distress is well established across international cultures. In India, the Sonag Aids project in Kolkata has run community projects in which music and street theatre have been used to deliver HIV prevention messages among sex workers (Aranthaswamy, 2003). In Rio de Janeiro, Brazil, a range of innovative arts initiatives use theatre, music and circus to engage young people living in socially deprived areas (Jurberg, 2002).

Closer to home, Hillman (2002) described the health benefits of participation in a community choir in Glasgow. Participants perceived statistically significant improvements to their general quality of life, and emotional well-being. Likewise, Stacey *et al.* (2002) concluded that singing had profound effects on the emotions, for example, inducing states of relaxation, which are particularly useful as an antidote to depression, anxiety and fatigue. Throughout the past two decades in Northern Ireland, increasing numbers of community groups have embraced the arts as a method of achieving their aims of promoting social capital and capacity building. It is widely recognised that engaging in the arts can make a key contribution to social and economic regeneration. In his review of the community arts in Belfast, Matarasso (1997) noted that there were a range of challenging and dynamic community arts initiatives across the city. Art as health initiatives are a more recent development and research on these projects has been extremely limited.

Following the publication of the Acheson Report *Inequalities in Health* (Department of Health, 1998) and the government's public health strategy, *Saving Lives: Our Healthier Nation* (Department of Health, 1999b), there is increasing recognition that solutions to major public health problems require multi-disciplinary interventions that take account of the social, cultural, economic and physical environments which shape people's experiences (Argyle, 2003). The *Art for Health* (Health Development Agency, 2000) report suggests that the arts may be one of the inter-agency approaches that the Acheson report viewed as being important in redressing social and health inequalities. The need for a more holistic approach to health which promotes social inclusion is also reflected in the Department of Health's (1999) National Service Framework for Mental Health, which stresses concepts of social inclusion and recovery.

The role that the arts can play in improving mental health outcomes is twofold. In conjunction with art therapists, they can be used as a therapeutic care strategy. Secondly, they can play a key role in breaking down mental health problems and can help reintegration into the wider community. There is a range of ways that art can make a contribution to promoting positive mental health. It can be a self-initiated activity providing a form of self-expression; it can be used to improve care environments; it can change the way society views mental illness; and can also provide service users with a voice (IPPR, 2003).

The connections between art and mental health have been enhanced through arts on prescription schemes developed in the early 1990s in the UK. These initiatives arranged client referrals from GPs or other healthcare workers to local arts initiatives. According to Appleby *et al.* (1997, the benefits of a non-pharmacological support based approach can be as effective as prescribed anti-depressants. As part of this holistic approach to health, the use of the arts as a therapeutic activity in its own right has increased dramatically. The link between art and health is now recognised to be a social process requiring extensive research and evaluation (Phillips, 2002).

### **The study**

The research was undertaken with STEER, a community-based voluntary sector organisation focused on mental health issues. It is the only independent mental health service user initiative in Northern Ireland and indeed on the island of Ireland. The organisation was established in 1998 when a group of like-minded people began discussing mental health services in their local area. STEER is an acronym, which refers to its core activities; Support, Training, Education, Employment and Research. These people come from a variety of backgrounds and have a range of direct and indirect experiences of mental health services. Their main aim is to pioneer new approaches in the provision of services through a partnership approach and provide a platform for the needs, views and opinions of people with primary and secondary experiences of mental health problems.

Under its support programme the organisation provides a number of schemes such as the supported recovery programme, the listening ear service and closed support groups. The supported recovery programme offers participants a choice of five modules; personal development, stress management, art as therapy, reflexology and computer skills. Each module lasts ten hours a week for a ten-week period. Admission is through referral from a doctor or psychiatrist and there is no charge for participation. Services are provided outside statutory mental health provision with the intention of supporting and re-integrating into the local community, those who have experienced mental health problems. The art as therapy module is facilitated by an art teacher and not an art therapist. The sessions do not include a verbal psychotherapeutic component and the overarching objective is to encourage personal development. The key concern is not quality of the artwork but the therapeutic value of producing it. The aim of this study is to explore the experiences and perceptions of the service users of this art as therapy module.

To facilitate the exploration of attitudes and opinions, a discussion group was established with service users in order to agree the most appropriate methodology. It was agreed that a qualitative approach would enable the service users to discuss their experiences and perceptions. As the researcher had worked with the voluntary group for over three years, it was agreed that she should facilitate the focus groups and undertake the interviews. Twenty in-depth interviews were undertaken; the issues raised in these interviews were followed up in two focus groups of ten service users.

The researcher contacted a random sample of those who had been involved in the programme and these people were invited to participate in the focus groups. Twelve of those who were interviewed were women and thirteen of those in the focus groups were women. The participants were aged between 18 and 55 years old. The interviews and focus groups were tape recorded and transcribed. The data was analysed using thematic analysis (see Lincoln & Guba, 1985) and three broad themes emerged; self-esteem, a safe space and empowerment. Findings are reported through summaries and discussions of themes illustrated by direct quotes.

### **Self-esteem**

Overall the participants were extremely positive about their experiences on the art as therapy module and there was a general consensus that it was therapeutic and facilitated mental well-being. Improved self-esteem and self-confidence were recurring themes in the interviews. Many of the interviewees described themselves as having low levels of self-confidence and self-worth. Typically, participants described themselves as 'down', 'low', 'worthless' and 'unable to function'. This affected their ability to communicate, interact with others, and their aspirations. The art classes provided a creative outlet for the participants and promoted self-esteem and confidence. This is well illustrated by the following quotes:

I was at rock bottom when I came here. I just thought that I was useless, worthless. This course has given me the space to think about myself and has improved my self-esteem no end. I feel good about myself.

If you have been told all your life you are useless you believe it. The classes gave me confidence and a belief in myself.

One of the women noted that the classes had been extremely beneficial as they had enabled her to address her negative self-image:

I was overwhelmed with feelings of worthlessness. I just had no belief in myself. This has given me a new lease of life. I am not particularly good at it but I am not tortured anymore by these feelings. I am more confident and less anxious.

A female service user explained that she had come through a marriage breakdown and her confidence had plummeted. She felt unable to participate in activities which she had once taken for granted:

You know my confidence just nose-dived. I was so depressed I hadn't the heart for anything. For instance after twenty-two years of driving I couldn't face it. My children didn't understand but I just couldn't do it. I feel that I am starting to get back my identity and know who I am.

The art classes led to improved self-esteem, which in turn enabled participants to engage in more positive social behaviour. A number of the participants claimed that the classes gave them the self-esteem to address underlying mental health difficulties that they had hitherto felt unable or unwilling to discuss. The group was described as a valuable means of support:



I am anorexic and have been since I was a teenager. Yet it took me until I was thirty-six to actually face up to it and admit that I needed help. I had the confidence to admit that many other problems were related to my problem with food. I thought that I was weak and stupid and it was my fault.

Another woman explained that the classes encouraged her to relax and she had acquired the ability to enjoy participating in group activities:

All my life I have had panic attacks and anxiety which meant I just could not function. I never did anything or left the house in case I took one. The classes encouraged me to relax and for the first time I had peace of mind.

Improved self esteem was also described as a barrier to negative influences. It acted as protection against influences which would set back improvements in mental health. One of the men likened his increased confidence and heightened self-esteem to a shield which buffered him against risk:

In many ways feeling good about yourself is like having a shield to protect you. I used to be destroyed by people saying things which were just thoughtless. Now I can deal with them without getting depressed or feeling hopeless.

Others suggested that they felt less vulnerable and fragile and were less prone to negativity:

I just feel as I am stronger more resilient and better able to cope. Not dependant or useless. For me it is very satisfying and uplifting. For the first time in my life I feel a sense of worth.

A number of the respondents suggested that as well as the therapeutic benefits of engaging in the creative process, the acquisition of new skills and knowledge also had a positive effect on self-confidence and self-belief:

I always thought that art was something for other people but I have discovered that I have talent in this area.

I really enjoyed the classes and it was a bonus to realise that I was actually good at it. It did wonders for my confidence.

There is a broad consensus within the literature that positive self-esteem is crucial to mental and social well-being. It influences choices, aims, goals and the ability to deal with life's challenges (Rutter, 1992; Harter, 1999; Mann *et al.*, 2004). According to Macdonald:

The most basic task for one's mental and emotional and social health, which begins in infancy and continues until one dies, is the construction of his/her positive self-esteem. (Macdonald, (1994, p. 19)

Mann *et al.* (2004) have argued that an understanding of the development of self-esteem and its active promotion and protection are critical to the enhancement of both physical and mental health. Similarly, in this study many of the respondents suggested that recovery from mental health distress was impossible without addressing poor levels of self-confidence and self-esteem, although this may be difficult to achieve. Typically, the respondents spent a considerable period contemplating participating in this programme before they actually enrolled. The single biggest factor in

their decision to get involved was the feeling of having ‘nothing to lose’. One man suggested that he had reached the ‘end of his tether’ whilst another said he was fed up ‘suffering in silence’. Emotional well-being was not something that was openly discussed in this culture. Mental illness was associated with shame, failure and weakness. Coping alone with mental health difficulties was described as ‘constant pressure’.

The majority of respondents reported that they had continued their art activities outside the classes and the therapeutic effect of the classes was a lasting one. Some had become involved with other community art groups and classes whilst others continued independently. There was however a disappointment that the range of activities in this area was extremely limited. It was suggested that additional classes and activities would be welcomed but individuals did not know who to ask or how to lobby for additional resources in this area.

### **A safe space**

A second theme to emerge from these interviews was the safe space which was provided by the art as therapy course. It was claimed that the prolonged effect of civil disturbance and the troubles had created an atmosphere where it was difficult to discuss pain and personal suffering. The atmosphere of hostility and distrust associated with the conflict had an adverse effect on well-being and quality of life. The political landscape of Northern Ireland caused people to feel vulnerable and uneasy. Anxiety and distress were described as part of everyday life. Commonly, participants noted that they had ‘suffered in silence’ as they felt they could not and should not discuss their problems:

Here you just don’t talk about it. Everybody knows the problems but nobody talks about them.

Until recently it was dangerous to talk about how you felt or what you knew. It was drilled into us from childhood to say nothing. You never know who you might be talking to. You were always on your guard which after a while wears you down.

One of the men suggested that the fear of passing on sensitive information or inadvertently saying something inappropriate had caused him severe mental distress:

I just could not cope with the strain of it all. It was like you were being watched all the time. It was constant and unbearable, it wrecked my health. I just could not handle it.

In many cases people developed their own coping strategies and did not seek help until they had reached crisis point. This community based programme was described as a ‘safe space’ in which to begin the process of recovery. Many participants claimed the feeling of security meant that they felt free to address and explore personal issues for the first time. The project promoted a supportive, reflective environment that enabled individuals to deal with their experiences in a way that had hitherto been deemed impossible.

As well as providing a sanctuary away from the conflict, the project was as described as a ‘haven’ because it was not part of the statutory mental health services.



Statutory services were viewed with suspicion and mistrust. A number of participants claimed they had totally disengaged with statutory services as they were deemed to be too risky. This non-engagement was partly due to a suspicion of medical intervention associated with becoming 'labelled' in official records. Fear of what would be written and recorded about them and how this might be used against them influenced interaction with existing services. There was widespread belief that discussing mental distress with officials would cause prejudice and ultimately limit opportunities. This fear of labelling and prejudice is illustrated by the following quotes:

I don't want to be judged by people sitting there looking down their noses at me. You are just a number to them, they don't care. They just dismiss you as mad and hand out the pills.

I wanted to get my life back together without the stigma of being unstable or mad. The stigma is more disabling than the actual illness, so why would you put yourself through that?

The community-based initiative had reduced some of the barriers around discussing mental health issues and fostered a sense of hope. The classes did not require interaction or discussion. Individuals could work in silence or interact with their peers. The atmosphere was described as supportive and relaxing, there was no pressure to behave in a certain way or to fit in with others. For many the art classes were cathartic as they provided a release for stress and anxiety.

I suppose the key thing here is the atmosphere. I am not seen as psychotic or labelled in any way. I am an individual with individual issues.

Here there is no pressure to interact socially but if you want to talk you can. I can be honest and not be frightened of what people will think. Talking to someone who has been through something similar makes all the difference.

## **Empowerment**

According to Fay *et al.* (1999), one of the most devastating after effects of trauma is the sense of disempowerment that it can bring. This powerlessness represents a barrier which inhibits the participation of adults in the life of their local area. Communities become fragmented and disillusioned. Many of the participants mentioned how they had been empowered by their participation in these classes and this had manifested itself in a wide range of ways. In some cases the classes had acted as 'stepping-stones' and 'springboards' to a range of other activities. Individuals claimed that the course had given them more independence and encouraged them to participate in other activities such as voluntary groups, adult education and paid employment. Through their art, individuals were encouraged to express their feelings and this was described as both therapeutic and liberating. Meeting new people and interacting in this environment was also important in terms of an increased sense of freedom. One man explained how the course had impacted on his life:

When I agreed to do the course I really had little interest in it, well I had little interest in anything. I don't believe I had ever even held a paintbrush before. Now I have enrolled on a foundation course and I have been to a summer school. It's like at last it is okay to be me.

Another respondent suggested that the course allowed her to feel positive about herself for the first time in her life. She had been prescribed medication for her depression by her GP but would not take it. She associated the medication with being a failure and was ashamed and embarrassed by her mental distress:

My father said I was stupid, my husband treated me like a doormat. I had nothing interesting to say and my children were embarrassed by me. I was so depressed I never left the house for 18 months. Now that seems like a different person, I now have a voluntary job and am doing a computer course.

Again the ethos of the group was identified as a significant factor in facilitating empowerment. There was a general agreement that being treated as a citizen and an equal rather than a patient or someone to be pitied was empowering. The atmosphere was described as extremely significant as it encouraged and fostered independence. The focus was always on what could be achieved rather than the limitations. This ethos was contrasted sharply with the prevailing attitude in statutory services. It was claimed that mainstream state provision emphasised what was wrong with the person rather than what they were capable of. The focus on taking medication in order to 'get better' was described as 'frustrating' and 'distressing':

I might look fine but inside I'm in bits. The doctors haven't time to listen it's not their fault. Here you have time to sort your thoughts out and realise that it's not hopeless.

Another respondent claimed that the success of this group was straightforward. Those who had experienced mental health difficulties were the real 'experts' and people preferred to discuss their issues and views in situations where their views were valued and respected. It was claimed that actually being listened to and acknowledged as important contributors was the key to effective, empowering mental health interventions:

It's not all about rules and who is in charge. I can relax as it is informal and I feel comfortable. For the first time I can decide what to do, I know what's best for me.

One of the woman explained that she had always felt that the medical profession had not believed her mental health difficulties and this was extremely frustrating:

Just because I looked all right, they assumed I was alright. I tried to explain and they just looked at me. One nurse told me I should be grateful for what I had and to get on with it. At last there is a release from all this pent up emotion.

There is a general agreement that people with mental health problems are one of the most excluded groups in society. This initiative offered opportunities for participants to help resolve this exclusion. It had acted as a catalyst for improved self-esteem, confidence and participation in mainstream activities. The service users commented on the lack of community support for mental illness and suggested that this scheme existed in a vacuum. The isolated nature of this scheme was described as frustrating, and unacceptable. For some people, involvement provided a starting point towards moving on and recovery but there was no natural progression. There was a general agreement that there were not sufficient services available for those suffering from

mental distress and services tended to be available when illness had become established rather than focusing on early intervention.

## Conclusion

The use of art as therapy is not new. However, the evidence that art promotes public health and enhances social inclusion remains elusive (Hamilton *et al.*, 2003). This research is limited and small-scale but it does demonstrate the positive impact of participatory art for those with mental health difficulties. The therapeutic properties of engaging in this initiative are indisputable. Service users reported increased levels of self-esteem and empowerment. The course provided a positive stimulus for people who had been experiencing ill health and had a range of beneficial effects.

There were however criticisms of the lack of availability for such schemes and the lack of understanding about their potential. Participants were frustrated that they were given a 'taste of hope' but when the course ended they were largely on their own or back to traditional forms of medication and intervention. The narratives of the service users confirm the difficulty in accessing community-based mental health services. There was a broad agreement that similar activities focusing on positive mental health were required. Numerous studies have highlighted the fact that Northern Ireland has high levels of health and social inequalities which are not adequately addressed by the medically dominated model of health (Lazenbatt *et al.*, 2001). The evidence here supports the contention in a number of studies (Campbell & Donnelly, 1996; NIAMH, 2003), that there is a need to locate more mental health services in the community. The lack of accessible services was described as an important barrier to recovery.

Creative, accessible solutions to address mental ill health are an essential component of an effective intervention programme. Awareness of art therapies and their potential benefits remains relatively low amongst policy makers, the public and those who commission services. While traditional forms of Freudian art-based therapy have tended to be shrouded in mystique and regarded as the preserve of those with specialist training in the field, socially orientated art for health projects are much more accessible and versatile (Argyle, 2003). Further research in this area is required to enable an informed debate on resource allocation and local and national service development. As Barnes and Bowl (2001) have noted, if empowerment in mental health services is to be realised, it is imperative that the views of the consumers of services are collected in a systematic and rigorous manner and used to inform the planning and delivery of such services. Art therapy programmes can significantly affect the quality of individuals' lives and their ability to recover from mental ill health, yet to date these innovative schemes are over-subscribed, under-funded and marginal to mainstream mental health services.

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